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SYMPOSIUM INTRODUCTION: DECIPHERING POSNER'S INSURANCE JURISPRUDENCE

*Jesse A. Langer**

This issue chronicles the impact of Richard A. Posner, Chief Judge of the United States Court of Appeals for the Seventh Circuit, on insurance law. Significantly, this issue evidences the broad approach to insurance that is characteristic of this *Journal*. In addition to the standard insurance contract disputes addressed in the forward by Professor Stempel, the articles, notes and comments consider Posner's jurisprudence in the fields of ERISA, Social Security and tort law, each of which regulate the distribution of risk in the American economy.

JEFFREY W. STEMPEL

Jeffrey W. Stempel's forward, entitled "*An Inconsistently Sensitive Mind: Richard Posner's Cerebration of Insurance Law and Continuing Blind Spots of Econominalism*," provides a thoughtful perspective on Posner's jurisprudence. Stempel explains that Posner's law and economics approach demonstrates his sensitivity to contractual agreements as well as his propensity to render decisions favoring the market. Posner is also keenly aware of the impact legal theories have on resolving disputes. Accordingly, Posner takes great care in justifying precedent and explaining why one jurisprudential approach is better suited for a particular case. Yet, as Stempel suggests, it is this "econominalism" that has led many critics to label Posner as overly conservative and, at times, insensitive.

Posner's oft perceived callousness is most evident when he considers cases within the employment context. Stempel argues that Posner's employment decisions fail to recognize the realities of the employment marketplace. These decisions reflect attempts to fit discrimination into judicially constructed pigeonholes. Though this formalism is effective in dealing with contractual disputes, Stempel contends that it falls short when confronted with issues of statutory interpretation.

In analyzing several of Posner's insurance decisions, Stempel concludes that Posner adeptly maintains the integrity of the insurance relationship. Posner goes further than most insurance decisions; that is, he considers the impact of risk on the special relationships forged between

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insurers and insureds. To that end, Posner's approach has had a significant impact on insurance jurisprudence.

* * *

The pieces by Eric D. Beal and Beatrice A. Beltran focus on Posner's systemic approach to insurance law. They provide the framework necessary to analyze, and perhaps critique, the articles on individual issues such as Social Security, the Employee Retirement Income Security Act of 1974 (ERISA), and the role of the Americans with Disabilities Act (ADA) in monitoring discriminatory insurance practices.

ERIC D. BEAL

The first piece, entitled "*Posner and Moral Hazard*" by Eric Beal, explores Posner's use of moral hazard to interpret contracts and resolve contract disputes. Beal contends that moral hazard, e.g., -- the tendency for insureds to act carelessly because the risk inherent in their actions is borne by the insurer -- is useful in analyzing both sides of the insurance contract. Thus, Beal argues that moral hazard serves as an indicator of insurer behavior with respect to the insurance contract.

Beal explains that insurance and moral hazard concerns are present in most contracts. Contracts allow parties to allocate risk according to the specific circumstances underlying the transaction. Accordingly, courts should consider the influence of moral hazard on both the insurer and the insured. Beal notes, however, that courts often apply interpretative rules to contract disputes that induce bad incentives among contracting parties such as opportunism and withholding of information. Nevertheless, Beal concludes that Posner's decisions demonstrate the efficacy of moral hazard in analyzing insurance contracts.

BEATRICE A. BELTRAN

Beatrice Beltran's Comment, "*Posner and Tort Law as Insurance*," considers the on-going debate over the proper function of the tort law system with respect to insurance. Commentators are divided over whether the tort system serves as a means to compensate victims or as a deterrent mechanism. Beltran argues that the tort law system fails as a form of insurance because the system often undercompensates accident victims. Victims of serious accidents who successfully litigate or settle a claim, and receive some monetary compensation, are not really "made whole" as the tort system purports to do. To this end, Beltran takes issue with many

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modern insurance theorists who contend that the tort system is ineffective in regulating risk because it over-compensates victims.

Beltran asserts that the tort system is best viewed as a deterrent of risk-inducing behavior and less as a compensating mechanism—e.g., a form of insurance. Beltran buttresses her position by analyzing some of Posner's insurance decisions. Posner focuses on the tort system's deterrent function because there are other mechanisms, such as indemnity agreements, that de-emphasize the system's compensatory role. The Beltran article provides the reader with an opportunity to consider the interplay between the tort system and the insurance paradigm.

* * *

The remaining pieces address Posner's impact in specific areas of insurance law. These articles are in no way a comprehensive representation of Posner's insurance decisions. Rather, these pieces consider some of the more controversial and complex issues in insurance and Posner's attempts to establish a consistent jurisprudence.

BARBARA A. SHEEHY

The third piece, "*An Analysis of the Honorable Richard Posner's Social Security Law*" by Barbara Sheehy, discusses Posner's considerable effort to unravel the Social Security Act (SSA) and review determinations of the Social Security Administration. Sheehy is concerned with the role of the Circuit Court of Appeals in administering a nation-wide disability program. The United States Supreme Court's certiorari process often leaves the Circuit Court as the final arbiter of claims arising under the Act. Sheehy analyzes some of Posner's Social Security decisions regarding standing, judicial review and several substantive Social Security issues. Posner's approach, though controversial and often critical of the current system, incorporates a sensitivity and effort necessary to ensure fair administration of the SSA.

ALDO R. EDWARDS VAN MUIJEN

The next piece, entitled "*Posner and ERISA: A Survey*" by Aldo Edwards van Muijen, surveys the entire spectrum of Posner's ERISA decisions. Edwards considers (1) Posner's use of the insurance paradigm to resolve these disputes and (2) Posner's role in deciphering this complex statute. As a result of his extensive research, Edwards determines that Posner adopts a middle ground between judicial activism and strict textualism when interpreting the convoluted text of ERISA. Posner's

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decisions balance a result-oriented economic analysis with a close reading of the statute. Posner's approach is intended to produce consistent results with respect to the statutory text, though often to the detriment of insurance principles. Edwards concludes that Posner's ERISA decisions, though not without criticism, apply the statutory text in an even-handed manner. Ultimately, as Edward's survey indicates, Posner's decisions continue to influence ERISA jurisprudence.

ROBERT SIMPSON

Robert Simpson's Comment, "*Another Trip into the Great Swamp: The Seventh Circuit's Preemption of the Illinois Unclaimed Property Act Under ERISA*," also considers Posner's ERISA jurisprudence, specifically his approach to ERISA's preemption doctrine. Simpson analyzes Posner's decision in *Commonwealth Edison Co. v. Vega*. In *Vega*, Posner determined that Illinois could not collect unclaimed benefits owed to plan beneficiaries, under the Illinois Unclaimed Property Act (IUPA), because the state law was preempted by ERISA. Simpson argues that Posner's decision is sensible; in fact, Posner had to decide the way he did when considering what would occur if states were allowed to collect unclaimed benefits.

If Posner had allowed Illinois to collect unclaimed benefits under IUPA, then he would have unleashed the contents of a Pandora's box. State courts would face a host of problems in enforcing this doctrine. The courts would have to determine which state laws apply and contend with an ever-increasing amount of litigation as states fought over who possessed rights to the proceeds. Thus, Simpson concludes that Posner not only considered the problems *Vega* would create for Illinois, but the impact a judgment for the State would have on the entire pension plan system.

LORI BLOCH IZZO

Lori Bloch Izzo's Case Note, entitled "*Doe v. Mutual of Omaha Insurance Company: The ADA Does Not Regulate the Content of Insurance Policies, But What Have Cameras, Braille Books or Wheelchairs Got to Do With It?*," critically assesses Posner's interpretation of Title III of the Americans With Disabilities Act (ADA). In *Mutual of Omaha*, Posner passed upon the issue of whether Title III of the ADA regulates insurance policies containing caps on AIDS-related treatment. Posner construed the ADA narrowly and determined that the Act does not regulate the content of insurance policies. Izzo undertakes a detailed statutory analysis and concludes that the ADA supports a more expansive interpretation.

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Specifically, Izzo argues that AIDS-related caps in health insurance policies violate Title III of the ADA. The statutory text of Title III employs sweeping language and, therefore, reinforces the ADA's purpose as an expansive anti-discrimination statute. Izzo then takes issue with Posner's use of analogy to support his decision favoring the insurer. Posner's examples involving consumer items such as cameras and Braille books misses the mark because insurance is a nebulous commodity. Izzo offers a different analogy -- that of a bank loan -- and concludes that the court's narrow interpretation will have serious implications on the ability of disabled individuals to purchase insurance and function in society.

THEMES

Several themes unify these articles with respect to Posner's insurance jurisprudence. First, Posner's decisions reflect an intellectualism and sensitivity lacking in many other insurance decisions. Emphasized most directly by Sheehy, Edwards also discusses this theme with respect to Posner's ERISA decisions. Beal captures Posner's sensitivity in his use of "moral hazard" to better understand the motivations underlying contractual arrangements. This theme also resonates in Beltran's analysis of the debate concerning the role of tort law in the insurance paradigm.

These articles also focus on the apparent conflict between Posner's pragmatic approach and the exercise of statutory interpretation. As suggested by Stempel, this conflict is most acute when applied within the employment context. Izzo underscores this element of Posner's jurisprudence, and suggests that Posner's interpretation of Title III ignores the overall purpose of the ADA as an anti-discrimination statute. Essentially, Posner appears to favor a formalistic approach over a more pragmatic view of the employment market.

Both Edwards and Simpson assess Posner's approach to statutory interpretation with less criticism. This may be attributed, in part, to the fact that both authors concentrate solely on Posner's ERISA jurisprudence. As Stempel suggests, much of Posner's ERISA decisions deal with insurance coverage, and it is here where Posner excels. Simpson compliments Posner for his ability to consider the systemic implications of ERISA. Edwards notes Posner's attempt to develop a consistent jurisprudence. Ultimately, these articles allow the reader to consider Posner's ability to interpret contractual agreements and to determine whether his approach is successful in cases falling outside of the typical insurance contract dispute.

Perhaps the most unifying theme shared by these articles is the significant impact Posner has had on the law of insurance. His decisions

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have helped to reinforce the insurance relationship and its application throughout society. Posner's work is especially noteworthy considering the difficulty judges face in negotiating competing interests while remaining within the letter of the law. While not without criticism, the following articles demonstrate that Posner approaches each case with an admirable professionalism.

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AN INCONSISTENTLY SENSITIVE MIND: RICHARD POSNER'S CEREBRATION OF INSURANCE LAW AND CONTINUING BLIND SPOTS OF ECONOMINALISM

*Jeffrey W. Stempel**

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* Professor of Law and Associate Dean for Academic Affairs, William S. Boyd School of Law, University of Nevada at Las Vegas. Special thanks to Professor Tom Baker and the Connecticut Insurance Law Journal for inviting my participation in this most interesting symposium issue. Thanks also to Dean Richard Morgan, Ann McGinley, Kory Staheli and Kent Syverud. This project was supported by the James A. Rogers Research Fund. I am particularly indebted to but unable ever to repay Prof. Arthur Leff, whose untimely death in 1981 deprived the legal academy of one of its outstanding scholars and citizens. *See* Arthur Allen Leff, *Economic Analysis of Law: Some Realism About Nominalism*, 60 VA. L. REV. 450, 473, n.60 (suggesting that in response to Posner's summary of Llewellyn's *The Common Law Tradition: Deciding Appeals*, "but for the transaction costs involved in returning from the dead, Llewellyn would cheerfully strangle Posner.").

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III. POSNER AT THE INTERSECTION OF INSURANCE, EMPLOYMENT, AND CIVIL RIGHTS: *DOE V. MUTUAL OF OMAHA INSURANCE CO.* AS MICROCOSM 65

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INTRODUCTION

More than a quarter-century ago, in reviewing the first edition of Richard Posner's now-iconic *Economic Analysis of Law*,[1] the late Arthur Leff remarked upon the degree to which the book displayed the sensitive mind of the author at work.[2] As a first-year law student absorbing Leff's critique (it remains the best book review I have ever seen and it sure beat reading cases), I was at first struck by the compliment. Although Leff clearly admired Posner's work and was a fair critic throughout, there was no mistaking that he was indeed a critic.

Pointing out the debatable assumptions of the Posnerian thesis, Leff poked significant holes in the seeming seamlessness of Posner's treatise,[3] presaging and inaugurating the academic and political debate over law and economics that would ensue over the next decade or so.[4] In particular, Leff criticized Posner's blind spots[5] and submerged value choices.[6] In particular,

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1. RICHARD A. POSNER, ECONOMIC ANALYSIS OF LAW (1972).

2. Arthur Allen Leff, *Economic Analysis of Law: Some Realism About Nominalism*, 60 VA. L. REV. 450 (1974). Leff describes Posner's mind as "supple, strong, and even (in a sense) sensitive," *id.* at 462, and Posner himself as "bright, talented, and sensitive." *Id.* at 482.

3. *Id.* at 452-72 (criticizing Posner for excessive use of one-sided assumptions, a crabbed view of society, and narrow concept of efficiency).

4. *See, e.g.*, Symposium, *Efficiency as a Legal Concern*, 8 HOFSTRA L. REV. 485 (1980); *see also* Guido Calabresi, *About Law and Economics: A Letter to Ronald Dworkin*, 8 HOFSTRA L. REV. 553 (1980); Ronald Dworkin, *Why Efficiency?*, 8 HOFSTRA L. REV. 563 (1980). The debate over Posner's work and Chicago School Economic Analysis continued into the 1980's, *see*, for example, Robin West, *Authority, Autonomy, and Choice: The Role of Consent in the Moral and Political Visions of Franz Kafka and Richard Posner*, 99 HARV. L. REV. 384, 390, 400-01 (1985)(criticizing Posner's assumption that consumers uniformly consent to wealth-maximizing transactions) and the 1990's, *see*, for example, Mark M. Hager, *The Emperor's Clothes Are Not Efficient: Posner's Jurisprudence of Class*, 41 AM. U. L. REV. 7 (1991)(criticizing Posner's writings in *Problems of Jurisprudence* (1990) as remaining imprisoned by many of his normative biases attacked by Leff).

5. Leff, *supra* note 2, at 452 (describing Posner as "single-minded," and the *Economic Analysis of Law* as "four hundred pages of tunnel vision"). *Id.* at 456 (stating that Posner makes "critical early moves" in assumptions that are problematic but affect his work throughout).

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Leff noted Posner's reflexive preference for the "market" over the "government," seemingly without regard for the facts and circumstances of the problem under review as well as Posner's preference for the status quo of wealth distribution (i.e., inequality).[7] Leff labeled this value-laden commitment to the Chicago School model of economics as applied to law by Posner, "American Legal Nominalism."[8]

Thus, coming during this critique, I found it a bit jarring to see the word "sensitive" applied to what Leff has characterized earlier as Posner's unrealistically narrow, tough-minded cost-benefit, wealth maximization analysis of law and the world at large. With the hindsight of 20 years, I can now appreciate Leff's insight and accuracy. Posner, despite his status as a lightning rod of criticism as well as adulation, has during the ensuing years demonstrated a good deal of sensitivity and intellectual subtlety and progression. Although still grating at times, *Economic Analysis of Law* has evolved into a less doctrinaire tome.[9] Posner himself also made major contributions in less commercial areas of the law, particularly statutory interpretation.[10] He has moved away from the more rigid microeconomic view of the world to a legal philosophy of pragmatism, a philosophy that eschews rigid absolutes.[11] Since ascending to the Seventh Circuit bench in 1981, Posner has consistently rendered interesting, well-written, and largely

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6. *Id.* at 455-58 (suggesting that Posner's assumptions reflect value choices more than empirical facts).

7. Leff, *supra* note 2, at 456-59, 462-69, 477-85. Leff continued his discussion of the limits of overly pure and politically conservative economic analysis in subsequent work. *E.g.*, Arthur Allen Leff, *Law And ?*, 87 YALE L.J. 989 (1979).

8. Leff, *supra* note 2, at 459.

9. John J. Donohue III & Ian Ayres, *Posner's Symphony No. 3: Thinking About the Unthinkable*, 39 STAN. L. REV. 791, 791-94 (1987) (praising and criticizing Posner's Third Edition of *Economic Analysis of Law*). *See generally* RICHARD A. POSNER, ECONOMIC ANALYSIS OF LAW (5th ed. 1998) (continuing to push the Chicago School line of economic analysis but discussing other factors that mitigate against the pure application of an economic model to legal issues).

10. *See, e.g.*, RICHARD A. POSNER, OVERCOMING LAW (1995) [hereinafter OVERCOMING LAW]; RICHARD A. POSNER, CARDOZO: A STUDY IN REPUTATION (1992); RICHARD A. POSNER, THE PROBLEMS OF JURISPRUDENCE (1990) [hereinafter PROBLEMS OF JURISPRUDENCE]; Richard A. Posner, *Legislation and Its Interpretation: A Primer*, 68 NEV. L. REV. 431 (1989) (presenting a summary of Posner's insights on interpretation and citing to his earlier work); Richard A. Posner, *Legal Formalism, Legal Realism, and the Interpretation of Statutes and the Constitution*, 37 CASE W. RES. L. REV. 179 (1987).

11. Posner identifies himself as a pragmatist throughout two of his writings. OVERCOMING LAW, *supra* note 10; PROBLEMS OF JURISPRUDENCE, *supra* note 10.

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moderate judicial opinions while at the same time retaining the occasional capacity to shock or anger.

In short, Posner is far less the micro-economic extremist reflected in the first edition of his justifiably celebrated work. But at the same time, he remains subject to the grip of "American Legal Nominalism" (or "econominalism" for short).[12] This article's thesis is that the degree to which these blind spots affect Posner's judicial performance can vary considerably with the subject under review. On insurance cases, discussed at length below,[13] Posner is almost without judicial peer. But where the topic is employment discrimination or civil rights, Posner's econominalism plays an arguably counterproductive role and insensitivity often replaces sensitivity. The Posnerian preference for the private and the wealthy continues as well. Although it seldom affects Posner's insurance decisions, one sees it in cases involving statutory construction.[14] Although Posner correctly brings the same comprehensive methodology to contracts and statutes, his statutory interpretation remains less sensitive and satisfying than his contract interpretation. In a recent case of note addressing the application of the Americans With Disabilities Act to insurance policies, Posner's econominalist resistance to government and remedial legislation unfortunately trumped his usual excellence on matter of insurance.[15]

By praising Posner's insurance opinions, I do not mean to denigrate his other work (and here comes the academic's inevitable "but"), but one cannot help but notice a continuing problem (at least I think it is a problem). Posner's insurance opinions tend to display far more sensitivity than do his opinions on issues of employment law, civil rights, and discrimination. One

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12. Leff found the use of the shorter term "econominalism" in lieu of "American Legal Nominalism" to be "tempting" but "obviously barbaric." Leff, *supra* note 2, at 459 n.26. Having little of Leff's moderation and decency, I adopt the more barbaric but shorter term "econominalism" to describe the imbedded value choices and political preferences found in Posner's work.

13. *See infra* notes 19-60 and accompanying text (discussing Posner's insurance decisions in general); *see also infra* notes 61-123 and accompanying text (discussing specific cases decided by Posner).

14. *See infra* notes 142-242 and accompanying text (discussing Posner on employment discrimination and statutory issues).

15. *See infra* notes 201-242 and accompanying text; *see also* Lori Bloch Izzo, Note, *Doe v. Mutual of Omaha Insurance Company: The ADA Does Not Regulate the Content of Insurance Policies, But What Have Cameras, Braille Books or Wheelchairs Got To Do With It?*, 7 CONN. INS. L.J. 263 (2000) (discussing Doe v. Mutual of Omaha Insurance Co., 179 F.3d 557 (7th Cir. 1999)).

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can even argue that his employment law cases are occasionally marked by an insensitivity bordering on callousness.[16] The seeming contradiction seems equally counterintuitive: sensitive about insurance but insensitive about individuals, discrimination and worker's rights? Since the Legal Realist movement, courts have been thought to be the other-way-around, showing empathy and even sympathy for individual rights claims but not in commercial matters.

This article both seeks to codify its compliment to Posner's cerebral approach to insurance questions, while at the same time noting and exploring the degree to which Posner's approach to other cases may lag behind his admirable analyses of insurance law. Along the way, particular note will be given to specific Posner insurance cases, most of which I regard as models for scholarly and judicial analysis, as well as to noninsurance cases that would have benefited from heightened sensitivity and less devotion to the econominalist ideal.

I. POSNER ON INSURANCE: A GENERAL THESIS AND REVIEW OF SIGNIFICANT CASES

Perhaps ironically, it is in the area of insurance law, a field historically viewed as dry and formalist, that Posner's pragmatism and sensitivity may be at its zenith. His intellectual and reflective approach to law and policy shines in this area. Unlike so many insurance cases, which read as if written by a robot using A.L.R. software, Posner's insurance opinions are notable in that they address the underlying structure of risk and insurance and its relation to the world, including the appropriate mix of incentives and equity. They are sensitive to the relations between insurers, policyholders, third parties, and the outside world. The explanatory power of text is respected but not idolized. The meaning of policy provisions is determined with healthy regard for the context and purpose of the insuring arrangement rather than myopic focus on a word or phrase in isolation.[17] Even when one disagrees with a Posner insurance opinion, one cannot help but be impressed by it in relation to much of the discussion of insurance coverage that fills the case reports.

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16. Ann C. McGinley & Jeffrey W. Stempel, *Condescending Contradictions: Richard Posner's Pragmatism and Pregnancy Discrimination*, 46 FLA. L. REV. 193, 230-35 (1994) (arguing that Posner's employment opinions occasionally reflect unfair and scorning criticism of workers).

17. *See infra* notes 19-60 and accompanying text (discussing Posner's insurance opinions); *see infra* notes 61-123 and accompanying text (discussing particular cases).

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Posner is, in short, one of the best judicial examples of what I term the "cerebration" of insurance law -- increased focus and in-depth analysis of not only policy language but the intent, purpose, and context of insurance arrangements as well as the role of risk and insurance in the modern world. Posner opinions do not simply quote past dicta, decree results, or apply superficially similar precedents without analysis. His opinions tend to explore at length the structure of the question (coverage, regulation, bad faith) and site the decision in the broader field of insurance law. Where necessary, history, equity, and public policy are deployed in the service of the decision. One may not always agree with it, of course, but one gets an education when reading a Posner insurance opinion.

The sheer productivity of Posner makes it difficult to systematically characterize and classify his insurance law and coverage opinions. In the time and space constraints afforded this article in this issue of the Connecticut Insurance Law Journal, the task is impossible (at least for me). But after years of reading Posner on insurance in non-systematic fashion coupled with a more systematic review for this article, it appears to me that he deserves attention in this area as in so many others for a variety of reasons.[18]

First, although generally considered a political and economic conservative, Posner cannot be fairly classified as favoring insurance companies in litigation -- an allegation frequently leveled at other conservative jurists.[19] However, although Posner opinions side with the

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18. This article's focus on Posner is not intended to suggest the absence of the other Seventh Circuit judges' important role in these decisions. Although Posner is the author of the decisions discussed in this paper, each majority opinion had at least one (and usually two) judges joining. Nonetheless, the content of the opinion is normally thought to reflect especially upon the authoring judge. As such, I will treat Posner-written judicial opinions as Posner analyses rather than group analyses notwithstanding that such treatment may obscure both compromises among the bench and the contribution of other judges.

19. *Compare* Level 3 Communications, Inc. v. Fed. Ins. Co., 168 F.3d 956 (7th Cir. 1999) (construing the insured-vs.-insured exclusion favorably to the policyholder), *and* Patz v. St. Paul Fire & Marine Ins. Co., 15 F.3d 699 (7th Cir. 1994) (finding a pollution exclusion not to bar CGL coverage), *and* Harbor Ins. v. Cont'l Bank Corp., 922 F.2d 357 (7th Cir. 1990) (finding coverage for a company in a suit against the directors and officers), *with* Ackerman v. Northwestern Mut. Life Ins. Co., 172 F.3d 467 (7th Cir. 1999) (finding a complaint against an insurer not to have pleaded fraud with sufficient particularity), *and* Wis. Power & Light Co. v. Century Indem. Co., 130 F.3d 787 (7th Cir. 1997) (finding no coverage for environmental cleanup costs), *and* Essex Ins. Co. v. Kasten Railcar Servs., Inc., 129 F.3d 947 (7th Cir. 1997) (holding that an exclusion in originally issued policies continues as part of renewal policies despite the absence of an express statement to this effect; coverage is precluded).

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policyholder with some frequency,[20] neither can he be considered a judge unduly favorable to policyholders or motivated by a pronounced desired to take from the cash-rich and give to the poor.[21] In short, he appears to me to be refreshingly neutral and moderate in the face of the frequent "us-against-them" world of coverage litigation, where many judges appear to display an instinctive but not well-articulated preference for either insurers or policyholders.

Second, and consistent with the first observation, Posner is refreshingly amoral in his approach to insurance coverage disputes. Frequently, one finds courts succumbing to the siren song of party briefs that seek to paint either insurer or claimant as the good guy or bad guy of litigation. Consider the morality play insurers have staged (with considerable success) in environmental coverage litigation, where the policyholder seeking liability protection is regularly characterized as a socially undesirable "polluter" rather than a business sued for past operations leading to pollution claims.[22] His

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20. *See, e.g.*, Doe v. Blue Cross & Blue Shield United of Wis., 112 F.3d 869 (7th Cir. 1999) (finding equitable estoppel potentially applicable to an insurer under ERISA and reversing and remanding summary judgment against the insured); Rozenfeld v. Med. Protective Co., 73 F.3d 1543 (7th Cir. 1995) (finding a medical malpractice claim to be subject to a second policy with higher limits for the policyholder than the first, lower-limit policy); Curtis-Universal, Inc. v. Sheboygan Emergency Med. Servs., Inc., 43 F.3d 1119 (7th Cir. 1994) (finding that the wording of a liability policy requires coverage for "unfair competition" alleged by a third party despite an insurer argument that the term has a more narrowly understood meaning in connection with CGL advertising injury coverage); Patz v. St. Paul Fire & Marine Ins. Co., 15 F.3d 699 (7th Cir. 1994) (finding coverage under a pre-1986 CGL "sudden and accidental" exception to a pollution exclusion for discharges that were not intentional but were also neither abrupt nor swift); Eljer Mfg., Inc. v. Liberty Mut. Ins. Co., 972 F.2d 805, 809 (7th Cir. 1992) (finding CGL to be triggered over a longer period of incorporation of defective product rather than the time of actual leaking of pipes and damage to homes); Harbor Ins. Co. v. Cont'l Bank Corp., 922 F.2d 957 (7th Cir. 1990) (reversing finding for insurer due to error in trial court and articulating "larger settlement" rule for articulation of D & O claims).

21. *See, e.g.*, *Essex Ins. Co.*, 129 F.3d at 947 (holding that in absence of specific language or other evidence to the contrary, an exclusion found in original policy continues to be part of renewals of the policy); Hamlin, Inc. v. Hartford Accident & Indem. Co., 86 F.3d 93, 95-96 (7th Cir. 1996) (applying "impaired property" exclusion in CGL to precluded coverage); Truck Ins. Exch. v. Ashland Oil, Inc., 951 F.2d 787 (7th Cir. 1992) (enforcing knowledge of fraud exclusion in professional services policy); Cont'l Cas. Co. v. Am. Color, Inc., 817 F.2d 1287 (7th Cir. 1987) (finding cancellation effective upon mailing by insurer because of clear policy language).

22. *See* Jeffrey W. Stempel, *Reason and Pollution: Correctly Construing the "Absolute" Exclusion in Context and in Accord With Its Purpose and Party Expectations*, 34 TORT & INS. L.J. 1, 58-59 (1998) (identifying and criticizing this litigation tactic of liability insurers).

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assessment appears not to be affected by such characterizations. He may implicitly point out good guys and bad guys when he criticizes bad faith or duplicitous performance but one seldom gets the feeling he has become emotional about the issue.[23]

Third, and related to the nonmoralist observation: Posner does not appear to become emotionally involved in the cases or treat coverage issues as something more than that simply because the underlying facts are more lurid. This lack of emotion is an arguably positive feature of econominalism identified long ago by Leff.[24] For example, in *Prudential Insurance Co. v. Athmer*,[25] Posner held that the secondary beneficiary son of a murdering primary beneficiary wife could recover the proceeds of the husband's life insurance policy and this was not inconsistent with the general rule that beneficiaries who murder may not profit from the estates and insurance policies of the deceased.[26] He was similarly constrained when confronted with the salacious facts of another spousal murder for insurance.[27] In some contexts, such as the employment and civil rights cases discussed in this article, Posner's lack of empathy makes his decisions subject to criticism. For insurance coverage decisions, however, detachment of this sort is almost always a virtue. Some of Posner's insurance decisions may, of course, be viewed by some as "too cold," but the best examples of this I have found date

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23. *See, e.g.*, Stone Container Corp. v. Hartford Steam Boiler Inspection & Ins. Co., 165 F.3d 1157 (7th Cir. 1999) (discussing coverage dispute between liability insurer and boiler insurer in neutral, matter-of-fact terms); *Eljer Mfg., Inc.*, 972 F.2d at 809 (discussing the issue of property damage trigger in liability insurance with focus on policy language and nature of underlying claim rather than in terms of empathy for either policyholders or insurers).

24. Leff, *supra* note 2, at 460-61 (noting that, unlike many observers, Posner does not reflexively say "how awful" when confronted with sad facts such as eviction or personal injury, but rather avoids emotion and looks at net systemic effects).

25. 178 F.3d 473 (7th Cir. 1999).

26. While providing sufficient facts to inform the reader ("[h]is wife had him murdered . . . by her 18-year-old lover and three of his 16-year-old pals"), Posner does not dwell on the made-for-TV-movie sordidness of the crime and focuses factually on the murdering mother-wife's lifetime incarceration, the son's estrangement, and the remote-to-impossible chance that the murderer would ever actually enjoy the insurance policy benefits if given to the son. *Id.* at 474, 476-79.

27. *See, e.g.*, Harmann v. Prudential Ins. Co., 9 F.3d 1207, 1208 (7th Cir. 1993) ("In 1981 Debra Hartmann moved out of the marital abode and in with her lover, a tennis pro -- and gun-store clerk -- named Korabik. They decided to murder Werner [Hartman] before he could divorce her.").

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from the 1980s and not the 1990s, which is consistent with the general view of scholars that Posner's jurisprudence has evolved favorably.[28]

Fourth, and connected the second observation, Posner does view the good faith obligation of contract law with some seriousness.[29] In both insurance cases and other contract situations, he had inveighed against a party "hoking up" defenses to contract nonperformance[30] and emphasized the economic benefits of a legal regime that provides an incentive for contracting parties to behave honestly and to expend reasonable efforts to keep their promises.[31]

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28. *See, e.g.*, Anderson v. Marathon Petroleum Co., 801 F.2d 936 (7th Cir. 1986) (finding no duty by contracting entity to protect subcontractor workers from danger of silicon dust from sandblasting done by subcontractor); Smith v. N. Am. Co. for Life & Health Ins., 775 F.2d 777 (7th Cir. 1985) (upholding insurer's argument for rescission of health policy due to inaccuracy in application regarding blood pressure treatment in the face of a widow's argument that conditional receipt language created coverage); Sur v. Glidden-Durkee, 681 F.2d 490, 499 (7th Cir. 1982) (Posner, J., dissenting) (arguing against majority holding that worker enjoys continued health care coverage for wife and child with birth defect based on representations by employer agent; in this dissent, Posner is almost stridently Chicago School in his use of law and economic analysis, essentially rerunning the arguments in his book that Leff parodied in part -- that the court's decision saves an individual but hurts society by increasing the future costs of employer-provided health insurance; majority opinion "opens up breathtaking vistas of liability"); *see also* Senkier v. Hartford Life & Accident Ins. Co., 948 F.2d 1050 (7th Cir. 1991) (refusing to find that death during treatment for Crohn's Disease was an "accident" under ERISA-provided insurance policy).

29. *See, e.g.*, Mkt. St. Assoc. Ltd. P'ship v. Frey, 941 F.2d 588, 595 (7th Cir. 1991) ("The contractual duty of good faith is thus not some newfangled bit of welfare-state paternalism or . . . the sediment of an altruistic strain in contract law, and we are therefore not surprised to find the essentials of the modern doctrine well established in nineteenth-century cases. . . .") (citations omitted); AMPAT/Midwest, Inc. v. Ill. Tool Works, Inc., 896 F.2d 1035, 1041 (7th Cir. 1990) ("The parties to a contract are embarked on a cooperative venture, and a minimum of cooperativeness in the event unforeseen problems arise at the performance state is required even if not an explicit duty of the contract.").

30. *See, e.g.*, Harbor Ins. Co. v. Cont'l Bank Corp., 922 F.2d 357, 363 (7th Cir. 1990) (applying Illinois law and discussed at length *infra* notes 61-87 and accompanying text); *AMPAT/ Midwest, Inc.*, 896 F.2d at 1041 (applying Illinois law); *Mkt. St. Assoc. Ltd. P'ship*, 941 F.2d at 588 (applying Wisconsin law).

31. *See, e.g.*, *In re* New Era, 135 F.3d 1206 (7th Cir. 1998) (finding an insurer to have acted in bad faith by "hiring its opponent's lawyer to sell out the opponent" by prosecuting action that if successful will effectively strip policyholder of rights); Hamlin, Inc. v. Hartford Accident & Indem. Co., 86 F.3d 93, 94 (7th Cir. 1996); *Mkt. St. Assoc. Ltd. P'ship*, 941 F.2d at 594. In *Market Street*, Posner stated:

> But it is one thing to say that you can exploit your superior knowledge of the market -- for if you cannot, you will not be able to recoup your investment you made in obtaining that knowledge -- or that you are not

Posner's opinions reflect a solid understanding of the concepts underlying not only contract law but also insurance and the insurer-policyholder relationship concerning such matters as the duty to defend, the duty to cooperate, and the "duty" to settle, moral hazard, and the distinction between liability risk and business risk.[32] He also appreciates the language, doctrine, and positions specific to particular lines of insurance.[33]

Fifth, Posner is not a slavish literalist of contract text interpretation[34] but accords it measured respect.[35] In construing insurance policy and other

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> required to spend money bailing out a contract partner who has gotten into trouble. It is another thing to say that you can take deliberate advantage of an oversight by your contract partner concerning his rights under the contract. Such taking advantage is not the exploitation of superior knowledge or the avoidance of unbargained-for expense; it is sharp dealing. Like theft, it has no social product, and also like theft it induces costly defensive expenditures, in the form of over-elaborate disclaimers or investigations in the trustworthiness of a prospective contract partner, just as the prospect of theft induces expenditures on locks.

Id.

32. *See, e.g.*, Great Cent. Ins. Co. v. Ins. Servs. Office, Inc., 74 F.3d 778 (7th Cir. 1996) (describing role of ISO in workings of modern property/casualty insurance); Charter Oak Fire Ins. Co. v. Travelers Ins. Co., 45 F.3d 1170, 1172-74 (7th Cir. 1995) ("[W]e do not find any basis . . . for interpolating into a contract of liability insurance a promise by the insurer to handle a claim in a manner that will minimize the business risk, as distinct from the liability risk, to the insured.").

33. *See, e.g.*, Milam v. State Farm Mut. Auto. Co., 972 F.2d 166 (7th Cir. 1992) (dealing with bouncing tires as part of uninsured motorist coverage and the problem of phantom or hit-and-run drivers causing injury to insureds); Cont'l Cas. Co. v. Pittsburgh Corning Corp., 917 F.2d 297 (7th Cir. 1990) (discussing the nature of excess insurance and pricing).

34. *See, e.g.*, Level 3 Communications, Inc. v. Fed. Ins. Co., 168 F.3d 956 (7th Cir. 1999) (holding that the "insured vs. insured" exception to a Directors & Officers liability insurance policy does not apply in full to preclude coverage merely because a director (who was clearly an "insured" under the policy) resigned during suit and became member of a plaintiff's class suing incumbent directors and company that would reimburse them (also "insureds" under the policy)). Posner's solution in *Level 3 Communications* was to allocate recovery and preclude insurance only for former director-insured's share. *Id.*

35. *See, e.g.*, Cole Taylor Bank v. Truck Ins. Exch., 51 F.3d 736, 737 (7th Cir. 1995). In *Cole Taylor Bank*, Posner stated:

> Waiver is one of a multitude of contract doctrines that allow oral testimony to modify the terms of an apparently clear written contract. There is no more vexing question in contract law than when a written contract can be rewritten by oral testimony. "Always" is an unsatisfactory answer because it defeats one of the main purposes of written contracts, which is to protect a contracting party against the vagaries of juries. "Never" is equally

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contract language, his test for clarity is whether the mythical "reasonable layperson" without additional information would know with certainty what is meant by the contract language.[36] He does not pull out a dictionary and then read a term with literal breadth if doing so does not comport with the ordinary lay understanding or the purpose of the transaction.[37]

Sixth, and in related fashion, Posner attempts to assess insurance contract meaning (and other contract meaning so far as I can tell) according to the purpose of the transaction and the context of the dispute.[38] He realizes that contracts are not sacred texts to be pondered over in search of only textual meaning but are instruments designed to accomplish commercial or other purposes. Policies need to be read carefully but contextually, with a consideration of both the context provided by the contract as a whole and the context of the transaction.[39] Policyholders purchase insurance to accomplish

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> unsatisfactory, because of the acute danger of misinterpretation by a reader ignorant of the contract's commercial setting.

Id.

36. *See, e.g.*, Conn. Gen. Life Ins. Co. v. Sun Life Co., 210 F.3d 771, 773 (7th Cir. 2000); Stone Container Corp. v. Hartford Steam Boiler Inspection & Ins. Co., 165 F.3d 1157 (7th Cir. 1999); *Cont'l Cas. Co.*, 917 F.2d at 300 (stating "interpretation, like other legal methodologies, is at bottom a practical art.").

37. *See, e.g.*, *Level 3 Communications, Inc.*, 168 F.3d at 957 (citations omitted). In *Level 3*, Posner explained that

> when the application of a rule leads to a truly whacky result, a more than suspicion arises that the parties can't have set so high a value on clarity that they would have thought such an application a proper interpretation of the rule. This is true whether the rule is statutory or contractual.

Id. (citations omitted).

38. *See, e.g.*, *Conn. Gen. Life Ins. Co.*, 210 F.3d at 773 (assessing the issue of arbitration consolidation in light of purpose of contract); Rhone-Poulenc, Inc. v. Int'l Ins. Co., 71 F.3d 1299 (7th Cir. 1999) (determining whether the policy at issue is primary, "pure" excess by intent, or "excess by coincidence"); Harbor Ins. Co. v. Cont'l Bank Corp., 922 F.2d 357, 365-68 (7th Cir. 1990) (assessing obligations of an insurer in light of the risk management goals of a policyholder and the purpose of the insuring agreement).

39. *See, e.g.*, Rozenfeld v. Med. Protective Co., 73 F.3d 154, 157 (7th Cir. 1996) ("[T]he best 'rule' may be to attend carefully to the specific wording of the policy *and the character of the liability insured against. . .*") (emphasis added). In *Rhone-Poulenc, Inc. v. International Insurance Co.*, 71 F.3d 1299, 1304 (7th Cir. 1995), Posner stated:

> Every competent person engaged in translation or interpretation understands that you cannot figure out the meaning of a sentence just by looking up every word in it in the dictionary. The meaning of a sentence inheres in the relationships among the words, relations given by the rules of grammar, and not just in the meaning of the words considered one by

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particular goals of risk management and insurers sell particular products in order to profit through risk distribution (and investment of premium proceeds), designing the product to attempt to cover certain profitable risks while avoiding unprofitable or unpredictable risks. Sorting out the meaning of insurance policies in particular situations, many of which were unanticipated by the parties or unaddressed in the policy or other documents, frequently requires courts to utilize more than just a dictionary or an instinctive reaction. Posner appreciates this and adjudicates insurance controversies with an eye toward purpose and context.[40]

Seventh, and of course related to the previous observations, Posner has a moderate, reasonable and nuanced view of the ambiguity doctrine. It has long been fashionable for courts to declare that they will not bend, twist, or distort a contract in order to deem it ambiguous.[41] Posner not only avoids this pitfall, but also avoids the opposite and equally erroneous temptation to deem problematic language clear and unambiguous.[42] He also properly treats the

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> one in isolation from each other . . . "I have a pair of loafers" seems clear enough. But its meaning depends on whether the sentence preceding it is "I'm disappointed with my research assistants this year" or "I have comfortable shoes."

Id.; see also Bidlack v. Wheelabrater Corp., 993 F.2d 603, 609 (7th Cir. 1993) ("We could argue back and forth till we were blue in the face over the proper interpretation of the language relating to the retirees' health benefits without reaching a confident conclusion, if all we had to go on was the written contract itself.").

40. *See, e.g.*, Great Cent. Ins. Co. v. Ins. Servs. Office, 74 F.3d 778, 785 (7th Cir. 1996) (discussing the role and function of ISO as it bears on the question of alleged liability of ISO to insurer using ISO rate data: "ISO is an enterprise rather than an individual, and its ability to prevent its employees from making careless mistakes whether of unlimited liability for the consequence of those mistakes might be to jeopardize its existence or make it unduly timid about proposing less than astronomical rates"); *Rhone-Poulenc, Inc.*, 71 F.3d at 1305 (applying Illinois law) ("Suppose, to take the simplest case, that each policy states that it is inapplicable if the insured is covered by other insurance. Such a series of identical conditions cannot be enforced. That would leave the insured with no insurance, even though he had bought much insurance. So the courts invalidate the identical conditions and require each insurer to contribute pro rata to the satisfaction of the insured's claim, in effect converting a series of excess policies into [pro-rata] primary policies.").

41. *See, e.g.*, E. Assoc. Coal Corp. v. Aetna Cas. & Sur. Co., 632 F.2d 1068, 1075 (3d Cir. 1980), *cert. denied*, 451 U.S. 986 (1981) (courts "should not torture the language of the policy in order to create ambiguities"); J. Ray McDermott & Co. v. Fid. & Cas. Co., 466 F. Supp. 353, 361 (3d Cir. 1980). *See* JEFFREY W. STEMPEL, LAW OF INSURANCE CONTRACT DISPUTES § 4.08 (2d ed. 1999 & Supp. 2000).

42. *See supra* note 36; *infra* notes 44-45 and accompanying text (discussing in detail where Posner is willing to consider extratextual factors because a contract is sufficiently

ambiguity rule (a.k.a. the *contra proferentem* principle that ambiguous language is construed against the drafter) as "merely a tiebreaker" to be employed after other indicia of meaning (such as purpose and context) fail to resolve the meaning of language unclear on its face.[43] At the same time, Posner's primary focus is text and determination according to linguistic meaning where text is clear. He has staked out an interpretative position that admits additional evidence of contract meaning only when there is "objective" evidence (e.g., usage in trade, specialized understanding of terms, etc.) that suggests a meaning other than that reflected on the page of the contract.[44]

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ambiguous to benefit from application of such information). Posner has not, to my knowledge, expressly stated that he seeks to avoid cleaving to a false contractual clarity. Rather, he simply does so in his decision-making and implicitly endorses the concept.

43. *See, e.g.*, *Harbor Ins. Co.*, 922 F.2d at 366; Cont'l Cas. Co. v. Pittsburgh Corning Corp., 917 F.2d 297, 300 (7th Cir. 1990). In *AM International, Inc. v. Graphic Management Associates, Inc.*, 44 F.3d 572, 575, 576 (7th Cir. 1995), a breach of contract case with obvious implications for insurance policy construction, Posner explains in some detail his view of contract law:

> Rules of law are rarely as clean and strict as statements of them make them seem. So varied and unpredictable are the circumstances in which they are applied that more often than not the summary statement of a rule . . . is better regarded as a generalization than as the premise of a syllogism. Take the rule that if a contract is clear on its face, the court will not permit the taking of evidence to contradict that "clear" meaning. The famous contract in Raffles v. Wichelhaus . . . was clear on its face. It called for the shipment of a specified amount of cotton from one port to another on the ship *Peerless*. Clear as a bell. Only there were two (if not more) ships *Peerless*, and it was impossible to tell which one the contract referred to. The contract was unclear because clarity in a contract is a property of the correspondence between the contract and the things or activities that it regulates, and not just of the semantic surface.
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> . . . .
>
> The rule that the judge must be satisfied that extrinsic evidence creates a legitimate ambiguity before he can submit the dispute over the contract's meaning to the jury is a sensible rule . . . .

Id. at 575-76 (citations omitted).

44. *E.g.*, *AM Int'l, Inc.*, 44 F.3d at 575 (citations omitted) (emphasis added). In *AM International*, Posner reasoned:

> There has to be a means by which the law allows these surfaces [of the standard textual reading of a contract] to be penetrated, but without depriving contracting parties of the protection from the vagaries of judges

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Eighth, Posner appreciates that insurance law remains largely a matter of state law but also accounts for the growing body of a federal common law of insurance in ERISA cases.[45] A surprisingly large number of insurance coverage opinions do not expressly tell the reader the applicable controlling law applied by the court.[46] This is to me a surprising shortcoming of many

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> and juries that they sought by reducing their contract to writing. A review of the doctrines that allow this penetration of semantic surfaces suggests that the key is the distinction between what might be called "objective" and "subjective" evidence of ambiguity. . . . By "objective" evidence we mean evidence of ambiguity that can be supplied by disinterested third parties . . . . The ability of one of the contracting parties to "fake" such evidence, and fool a judge or jury, is limited. By "subjective" evidence we mean the testimony of the parties themselves as to what they believe the contract means. Such testimony is invariably self-serving . . . [but] "[o]bjective" evidence is admissible to demonstrate that apparently clear contract language means something different from what it seems to mean; "subjective" evidence is inadmissible for this purpose. . . . [A party who attacks the clear textual meaning of a contract must show] that anyone who understood the *context* of the contract would realize it couldn't mean what an untutored reader would suppose it meant . . . .

Id. (emphasis added). This is not to say that I agree with every word of Posner's analysis or his operationalization of the concept in all subsequent cases. Posner's objective/subjective distinction could be interpreted to provide too high a barrier to useful extrinsic evidence of meaning or could needlessly raise the transaction costs of litigating insurance coverage disputes.

In addition, Posner's view that only "objective" extrinsic evidence cuts it for purposes of showing that seemingly clear language does not mean what it seems to say presumably does not foreclose the receipt of evidence on waiver, estoppel, fraud, or related doctrines.

45. *E.g.*, *Harbor Ins. Co.*, 922 F.2d at 362-64 (recognizing that insurance coverage is controlled by Illinois law and engaging in extensive analysis of Illinois precedents on the issue of "mend the hold" doctrine); Herzberger v. Prudential Ins. Co. of Am., 205 F.3d 327, 329 (7th Cir. 2000) (using federal common law to determine degree to which ERISA administrator's authority is discretionary in deciding benefits questions); Rossetto v. Pabst Brewing Co., 217 F.3d 539, 541 (7th Cir. 2000) (noting that ERISA plans are to be construed under federal common law rather than state law, and that federal common law also governs construction of collective bargaining agreements pursuant to federal labor statutes).

46. *See, e.g.*, Keene Corp. v. Ins. Co. of No. Am., 667 F.2d 1034 (D.C. Cir. 1981). *Keene*, of course, is the famous case that adopted the continuous trigger or multiple trigger (based on exposure, injury or manifestation) for commercial general liability coverage in connection with long-tail asbestos claims and permitted the policyholder to designate which policy among multiply-triggered policies will be tapped for specific claims. Despite this momentous conclusion of obvious import, the court does not specifically state the controlling applicable law. Because of the multiple jurisdictions interested in the case, I have always read *Keene* as being decided on general principles of contract and insurance law that, at least as of

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coverage opinions, particularly since state law is practically "constitutionalized" as the rule of decision for insurance disputes under the McCarran-Ferguson Act.[47]

I do not mean to overstate this "problem." One normally can quickly glean the applicable law from scanning the case and noting the precedent cited, but not always. In some areas of insurance law, moreover, the applicable law is crucial to the outcome, as in the case of pollution liability coverage (gradual discharges are covered in some states if unintentional but other states require the discharge to be abrupt), bad faith (some states permit punitive damages, some do not), apportionment of responsibility (some allocate by time on the risk, some by time and policy limits, some refuse to allocate against a policyholder), and other areas.[48] In many areas insurance law is rather consistent among states. All jurisdictions profess to follow the ambiguity rule, for example. But as discussed above and as apparent from reading case law, courts vary in their aggressiveness in the invocation of this doctrine.[49] In light of the importance of state law and its variegation (as well as the emerging federal common law of ERISA coverage), it is refreshing (and helpful to readers) that Posner consistently identifies the applicable law

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1981, could be said to be consistent from state to state. But I could be wrong. Since the decision, it has become clear that the particular state law applied can make a rather dramatic difference in the trigger of liability coverage and any subsequent allocation of coverage responsibility among insurers and policyholders. *See* STEMPEL, supra note 41, at §§ 2.02, 14.09, 14.10; Jeffrey W. Stempel, *Domtar Baby: Misplaced Notions of Equitable Apportionment Create a Potential Thicket of Unfairness for Policyholders*, 25 WM. MITCHELL L. REV. 769, 776-824 (1999) (describing dramatic differences in jurisdictions on these points). Even before the *Keene* decision, there was some indication that courts applying different law might decide the issue differently. *See, e.g.*, Ins. Co. of No. Am. v. Forty-Eight Insulations, Inc., 633 F.2d 1212 (6th Cir. 1980), *cert. denied*, 454 U.S. 1109 (1981) (applying Illinois and New Jersey law and finding that exposure is the proper measure of liability trigger and requiring pro-rata allocation of coverage by years in question).

47. *See* 15 U.S.C. §§ 1011-12. The McCarran-Ferguson Act was first enacted in 1945 to overrule the Supreme Court decision in *United States v. South-Eastern Underwriters Ass'n*, 322 U.S. 533 (1944), and provides that insurance shall be governed by state law and that federal law does not alter this baseline norm absent clear and authoritative statement in federal statutory scheme. STEMPEL, *supra* note 41, § 2.03[a].

48. *See* STEMPEL, *supra* note 41, §§ 10.01, 14.09, 14.10, 14.11 (discussing state differences in these areas).

49. *Id.* § 4.08[g] (dividing jurisdictions into strong, weak, and moderate states regarding use of ambiguity as decisionmaker in coverage disputes).

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governing his decisions.[50] He also appears to faithfully follow the state-based nuances of insurance law.[51]

Ninth, Posner decides cases with considerable self-consciousness about both his own jurisprudential approach and the implications of legal theory and judicial approach for real case outcomes. His opinions are liberally salted with discussions of legal approaches and explanation (usually persuasive) as to why the approach or characterization chosen leads to a better result in the instant case and in general application.[52] In the long tradition of academics, Posner is a self-citer, one who frequently notes his previous decisions to support and emphasize the point.[53] He frequently repeats assessments,

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50. *See, e.g.*, Prudential Ins. Co. v. Athmer, 178 F.3d 473 (7th Cir. 1999) (applying Illinois law and discussing varying state law approaches to recovery of insurance benefits when policyholder has been murdered, expressly selecting use of federal common law as wiser course in case of serviceman's life insurance due to preference for uniformity in cases involving federal employees).

51. *See, e.g.*, Curtis-Universal, Inc. v. Sheboygan Emergency Med. Servs., Inc., 43 F.3d 1119, 1123 (7th Cir. 1994) (applying Wisconsin law) ("[T]he criterion for interpreting a term in an insurance policy is how the insured would reasonably have understood it."). To some extent, the Wisconsin rule of law quoted by Posner in *Curtis-Universal* is more favorable to the policyholder than Posner's own statements of contract interpretation. Posner appears generally to interpret a contract in the same manner as a reasonable layperson with no connection to the transaction would understand the words of the contract. Focusing on the insured's understanding appears to be Posner yielding to the standard announced under Wisconsin law. As a practical matter, of course, it may make little difference. Under Posner's announced contract views, even contract language clear on its face against the policyholder may be subject to objective extrinsic evidence that shows the reasonable policyholder's understanding to be otherwise.

52. *See, e.g.*, Level 3 Communications, Inc. v. Fed. Ins. Co., 168 F.3d 956, 958 (7th Cir. 1999):

> A simple, flat rule is deliciously clear and easy to apply, but it may be both underinclusive and overinclusive in relation to the purpose that animates it. A standard, like "no coverage for collusive suits or lovers' quarrels," is contoured exactly to its purpose, but it cannot be applied without a potentially costly, time-consuming, and uncertain inquiry into the nature of the underlying dispute sought to be covered. It is apparent from the wording [of the D & O policy] that the parties opted for the rule, not the standard, in agreeing to the "Insured versus Insured" exclusion.

Id. (citations omitted).

53. *E.g.*, *id.* at 957 (citing prior Posner opinions on rules, standards and clarity in support of current musings on subject).

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undoubtedly for the benefit of litigants and readers unfamiliar with or forgetful of his prior pronouncements on the topic.[54]

Although this may be seen as repetition and ego by some, the serial self-invocation of law's most successful modern agenda entrepreneur,[55] I find it useful. Posner more than any other modern judge relentlessly gives even his short decisions an intellectual flavor and focuses on the importance of legal principles and approaches so that discerning readers appreciate the stakes of even seemingly mundane decisions. His work, although obviously advocating his view of law and the world, generally raises the discourse about law and legal precedent.

Tenth, Posner writes well, with clarity, wit, and distinctively memorable prose.[56] His opinions are a joy to read,[57] which is no small attribute given that his audience is lawyers, judges, and professors whose eyes understandably may begin to glaze over a bit after working lifetimes spent

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54. For example, Posner's general (and very good) discussion of contract meaning in *AM International, Inc. v. Graphic Management Associates*, 44 F.3d 572, 577 (7th Cir. 1995) is often repeated, at least in part, in later cases. *See, e.g.*, *Level 3 Communications*, 168 F.3d at 958 (discussing rules, standards and clarity in terms similar to those used in prior Posner opinions).

Posner first discussed the "mend the hold" doctrine of contract law in *Harbor Insurance Co. v. Continental Bank Corp.*, 922 F.2d 357, 363 (7th Cir. 1990). He has since alluded to that opinion and addressed the doctrine in several subsequent cases. *See, e.g.*, Herremans v. Carrera Designs, Inc., 157 F.3d 1118, 1123 (7th Cir. 1998) (finding doctrine applicable in pay dispute); *Level 3 Communications*, 168 F.3d at 959 (finding argument inapplicable in instant case).

55. William N. Eskridge, Jr., *A Social Constructionist Critique of Posner's Sex and Reason: Steps Toward a Gaylegal Agenda*, 102 YALE L.J. 333, 333 (1992) (book review) ("Posner is law's most successful agenda entrepreneur since Oliver Wendell Holmes, Jr.").

56. *See, e.g.*, *In re* New Era, Inc., 135 F.3d 1206, 1208 (7th Cir. 1998) ("[T]hese bankruptcy appeals have a tangled history, an unbelievable present, and no future."); Old Republic Ins. Co. v. Chuhak & Tecson, P.C., 84 F.3d 998, 999 (7th Cir. 1996) ("We have consolidated for argument and decision the appeals in two cases, virtually identical, mysteriously assigned to two different judges of the same district court -- who reached opposite results, the second judge disagreeing so violently with the first that he imposed sanctions on the plaintiff in the second case for relying on the first judge's opinion"); Great Cent. Ins. Co. v. Ins. Servs. Office, 74 F.3d 778, 785 (7th Cir. 1996) ("ISO is an enterprise rather than an individual, and its ability to prevent its employees from making careless mistakes [leading to liability] might be to jeopardize its existence or make it unduly timid about proposing less than astronomical rates.").

57. *See, e.g.*, Allendale Mut. Ins. Co. v. Bull Data Sys., Inc., 32 F.3d 1175, 1176 (7th Cir. 1994) ("Marx once said that every great event or character in history appears twice, the first time as tragedy and the second as farce (he had in mind Napoleon and his nephew). This case bids fair to illustrate the adage.").

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reading opinion after opinion. Despite the wealth of material contained in them, Posner's opinions are seldom long and often read with the pace of a bestseller. He peppers his sober scholarly verbiage with punchy commonspeak and contractions.[58] From the pen of a weaker jurist, what might seem like a failed attempt to write for the masses instead normally provides clearer explanation with fewer words.

Posner's writing flair is of course a general asset of his judging. For insurance, however, an area customarily damned as boring and technical, his writing skill has even greater value in that it makes insurance opinions considerably more interesting and worth reading. This tends to serve insurance law as a subdiscipline by expanding the number of readers, and perhaps even practitioners or scholars of insurance. At some point, insurance opinions also become interesting not only because they are well-written but because Posner has written them. This issue of the *Journal*, for example, will probably be read by many who do not specialize in insurance matters simply because Posner is the topic of the issue.[59]

In this section, I attempt to provide some support for my sweeping general praise of Posner through examining his approach to specific cases of interest or note. In a sense, I am taking a "greatest hits" approach to Posner's insurance law opinions (as determined by me, perhaps even a more dubious source than Dick Clark). I do this both for expediency (I simply have not had the time or energy or depth of mind to rigorously evaluate all of his work according to the criteria set forth above in the time available) and because it will increase accessibility to the reader, who can make his or her own assessment as well.

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58. *See, e.g.*, Hamlin, Inc. v. Hartford Accident & Indem. Co., 86 F.3d 93, 94 (7th Cir. 1996) ("If the lack of a defender causes the insured to throw in the towel in the suit against it, the insurer may find itself obligated to pay the entire resulting judgment or settlement even if it can prove lack of coverage."); Cole Taylor Bank v. Truck Ins. Exch., 51 F.3d 736, 740 (7th Cir. 1995) ("[T]he victim of a breach of contract is not required upon learning of the breach to wail and tear his hair."); Bidlack v. Wheelabrator Corp., 993 F.2d 603, 609 (7th Cir. 1993) ("We could argue back and forth till we were blue in the face over the proper interpretation of the language relating to the retirees' health benefits.").

59. Posner's succinct clarity does, however, present a problem for one commenting on his work. In summarizing Posner opinions, it is very hard to state the case better than Posner has done in writing the opinion. As a result, a discussion of Posner opinions lends itself to relatively long quotations from the opinions. Consequently, this article has more block quotations than I would prefer. However, I frequently find myself unable to express the concept under review better than Posner, and have elected to quote Posner at some length throughout this article despite its tendency to expand the article.

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A. *Harbor Insurance Co. v. Continental Bank Corp.*

Perhaps my favorite Posner opinion is *Harbor Insurance Co. v. Continental Bank Corp.*,[60] which centered on a Directors' and Officers' liability policy. Continental was one of the largest, wealthiest banks in America but floundered in the 1980s, in substantial part because it had bought $1 billion in loans from the now-infamous Penn Square bank. Penn Square, located in an Oklahoma strip shopping center and led by an aggressive but reckless entrepreneur,[61] had written a lot of bad loans -- and sold most of them to Continental and other banks that should have known better, generating its own smaller version of the savings and loan solvency crisis that took place later in the 1980s. When Penn Square collapsed and the $1 billion on loans proved uncollectible, Continental

> itself collapsed, and although it was saved at the last minute by the Federal Deposit Insurance Corporation its stock became virtually worthless, precipitating a flurry of lawsuits by investors who had bought the stock just before the collapse. The suits charged securities fraud -- specifically, that Continental had concealed the bad news about the Penn Square loans in order to keep up the price of its stock.[62]

Continental, like most large companies, had D & O Insurance. Its D & O policy, like most such policies, provided coverage for judgments or settlements against directors or officers or for the company if it was legally indemnifying the defendant officers or directors. A "wrongful act" in these policies is generally defined as an error or omission -- and the individual defendants in the Continental shareholders litigation were accused of plenty of such acts. The D & O policy, however, while covering errors and omissions, typically excludes coverage for intentionally caused injury, fraud, criminal wrongdoing, certain regulatory violations, or conduct outside that permitted by the company's authority.[63] Harbor and Allstate, Continental's two D & O insurers, rejected coverage and filed a declaratory judgment taking the position that "the behavior of the directors had been so egregious

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60. 922 F.2d 357 (7th Cir. 1990).

61. *See* JONATHAN R. MACEY & GEOFFREY P. MILLER, BANKING LAW & REGULATION 276 (2d ed. 1997); PHILLIP L. ZWEIG, BELLY UP: THE COLLAPSE OF PENN SQUARE BANK (1985); MARK SINGER, FUNNY MONEY 153-59 (1985); *Penn Square Bank Failure: Hearing Before the House Committee on Banking, Finance and Urban Affairs*, 97th Cong., 2d Sess. 392 (1982).

62. *Harbor Ins. Co.*, 922 F.2d at 359 (citations omitted).

63. STEMPEL, *supra* note 41, § 19.01.

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that, even in the unlikely event that such conduct could be fitted within the good faith proviso in Continental's charter, federal and state law would forbid Continental to indemnify the directors for any liability they incurred as a result of that conduct."[64]

Continental settled the two suits, one certified as a class action, for $17.5 million and then counterclaimed against the insurers for coverage. "Harbor and Allstate now changed their tune. No longer did they argue that the directors' conduct had been so egregious as to make indemnification by Continental offensive to public policy. They argued that Continental had settled the cases prematurely; the directors had been guilty of no misconduct at all!"[65] Despite this dramatic change of tune, the insurers won a judgment of noncoverage after trial in the district court.[66]

Writing for the Appeals Court panel, Posner found the trial court's refusal to admit a copy of the declaratory judgment complaint as "evidence" to or consider the insurers' shifting position incorrect. The complaint "was the cornerstone of Continental's effort to establish the insurers' liability with the help of the doctrine of 'mend the hold.'"[67] From there, Posner launched into a mini-treatise of this formerly obscure contract law doctrine and also launched something of a cottage industry in commenting on the significance of the rediscovery of what might have been previously seen as a 19th century doctrine in desuetude.

The court's invocation of the doctrine is an admonition to lawyers that they should be more careful about talking out of both sides of their mouths in representing clients.[68] Although too much can be made of this and other professionalism concerns, the "mend the hold" doctrine does stand for the proposition that, in disputes, one must eventually take a reasonably concrete position. However, if one's reasonably concrete position at trial differs from the position taken in pretrial, the adversary should at least have the chance to cross-examine on this point and use the earlier position as evidence of the suspicious convenience of the current position.

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64. *Harbor Ins. Co.*, 922 F.2d at 359.

65. *Id.* at 360.

66. *Id.* at 362.

67. *Id.*

68. *See* Eugene R. Anderson & Nadia V. Holober, *Preventing Inconsistencies in Litigation With a Spotlight on Insurance Coverage Litigation: The Doctrines of Judicial Estoppel, Equitable Estoppel, Quasi-Estoppel, Collateral Estoppel, "Mend the Hold," "Fraud on the Court" and Judicial and Evidentiary Admissions*, 4 CONN. INS. L.J. 589 (1998).

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In *Harbor Insurance Co.*, Posner makes this point with clarity and depth in surprisingly few pages (almost fewer than I can here summarize his assessment). He takes the reader on a condensed tour de force, implicitly revealing that the adversary system does not as promised always result in counsel overturning every stone in search of information.

> Demonstrating a curious incuriousity about language, none of the lawyers was able to explain to us the meaning of this phrase, which at times indeed they made complete nonsense of -- alas, with judicial authority. . . . [b]ut they agree as they must that it is the name of a common law doctrine that limits the right of a party to a contract suit to change his litigating position. In fact the phrase is a nineteenth-century wrestling term, meaning to get a better grip (hold) on your opponent.[69]

Posner then describes the first case to use the term, an 1877 U.S. Supreme Court decision, "although the essential features of the doctrine can be found in much earlier cases" and the doctrine's first appearance in Illinois was 1905.[70] He reviews Illinois law, focusing on the most prominent "modern" state case (a 1953 Illinois Supreme Court opinion) and notes mention of the doctrine in decisions in eight other states.[71] According to Posner's analysis, the "mend the hold" doctrine, in essence, states that a party with a fixed litigation position in a contract dispute is stuck with that position and may not take an opposite view absent the presence of significant intervening factual information.

Posner reaches this view with considerable sensitivity to the need to reconcile the "mend the hold" doctrine with concepts of pleading in the alternative and a due process-like right of litigants to present their case based on the most favorable evidence available at the time of trial.[72] Consequently, a party in contract litigation can and should be confronted with "prior inconsistent statements" about the matter, but can nonetheless prevail if it persuades the factfinder that its prior position was wrong and its current position right because this is what facts previously unavailable show and not

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69. *Harbor Ins. Co.*, 922 F.2d at 362 (citation omitted).

70. *Id.*

71. *Id.* at 363.

72. *See id.* at 364-65 (reconciling "mend the hold" doctrine with Rules of Civil Procedure, particularly Rules 8, 11, and 15).

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because the party has simply decided that Position B resonates more with the jurors than Position A.[73]

Posner correctly treats the "mend the hold" doctrine as part of Illinois's substantive contract law rather than a rule of litigation procedure, thus making it applicable in cases involving state law under the *Erie* doctrine.[74] As part of contract law, the name of the doctrine is

> quirky, but the doctrine itself, appropriately configured . . . can be seen as a corollary of the duty of good faith that the law of Illinois as of other states imposes on the parties to contracts. A party who hokes up a phoney defense to the performance of his contractual duties and then when that defense fails (at some expense to the other party) tries on another defense for size can properly be said to be acting in bad faith. [Illinois case law] explicitly connects the "mend the hold" doctrine to considerations of good faith and ethical obligations in contract relations.[75]

This concern for treating seriously the good faith obligation in contract law generally, as well as insurance law, is a recurrent Posner theme, and also serves to distinguish his opinions from most.[76]

In essence, Posner read the record in *Harbor Insurance Co.* as reflecting two insurers taking inconsistent positions on coverage to the detriment of a policyholder. At the very least, a factfinder was entitled to know about this inconsistency and to then determine whether it was the result of expanding knowledge or simply litigation expediency. *Harbor Insurance Co.* also found the original underlying complaint admissible because it (a) showed that the insured directors named as defendants were in fact exposed to liability; and (b) the complaint could be properly used for impeachment of the insurers when they claimed the insureds were not at risk.[77]

Posner also used the dispute as a forum to make useful statements regarding the ambiguity principle of insurance contract interpretation and the manner in which lump sum settlements may be allocated between insured and

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73. *See id.* at 363-65.

74. *See id.* at 364.

75. *Id.* at 363 (citations omitted).

76. *See, e.g.*, Mkt. St. Assoc. Ltd. P'ship v. Frey, 941 F.2d 588, 593-95 (7th Cir. 1991); AMPAT/Midwest, Inc. v. Ill. Tool Works, Inc., 896 F.2d 1035, 1041 (7th Cir. 1990).

77. *Harbor Ins. Co.*, 922 F.2d at 365.

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uninsured amounts. After setting forth the standard rule that ambiguous contract language is construed against the drafter,[78] he continues:

> Given this rule -- if there is an ambiguity, the insured wins -- why would there ever be an occasion for attempting to resolve an ambiguity in an insurance contract by evidence? . . . Reconciliation is possible along the following lines. If an insurance contract is ambiguous either party should be allowed to introduce evidence to disambiguate it. But if, all such evidence having been considered, the meaning of the contract is still uncertain, then the insured wins. In other words, the interpretative principle (favor the insured) is merely a tie-breaker.[79]

In a nutshell, Posner sets forth what I regard as the intelligent version of the ambiguity doctrine (use it as a last resort tiebreaker when other indicia of meaning fail).[80] In this same vein, he had valuable insight to offer on the appropriate role of an expert witness for insurance coverage litigation. At trial, the insurers had offered a lawyer's expert testimony to the effect that Continental's charter did not permit indemnification of the directors under the circumstances of the underlying claim. Posner rejected the view that expert testimony was completely off limits: "The charter is ambiguous, and therefore testimony, including expert testimony . . . by a lawyer -- was a permissible aid to interpretation."[81] Therefore, a "lawyer experienced in indemnification matters was a proper witness to opine on the probable

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78. *See also* BARRY R. OSTRAGER & THOMAS R. NEWMAN, HANDBOOK ON INSURANCE COVERAGE DISPUTES § 101 (10th ed. 2000); STEMPEL, *supra* note 41, § 4.08 (summarizing ambiguity or *contra proferentem* rule).

79. *Harbor Ins. Co.*, 922 F.2d at 366 (citing Cont'l Cas. Co. v. Pittsburgh Corning Corp., 917 F.2d 297, 300 (7th Cir. 1990)).

80. I include the concept of a party's reasonable expectations, particularly those of the policyholder, as part of the material that can be used to indicate contract meaning before one resorts to the *contra proferentem* tiebreaker. *See* Jeffrey W. Stempel, *Unmet Expectations: Undue Restriction of the Reasonable Expectations Approach and the Misleading Mythology of Judicial Role*, 5 CONN. INS. L.J. 181 (1998). Insurance law precedents and doctrine tend, however, to argue for a more restricted role of party expectations. *See generally* Symposium, 5 CONN. INS. L.J. 1 (1998). Posner's views on this issue are unclear but not necessarily inconsistent with my own. *See, e.g.*, AM Int'l, Inc. v. Graphic Mgmt. Assocs., Inc., 44 F.3d 572, 574-76 (7th Cir. 1995) (permitting consideration of "objective" extrinsic evidence of meaning even where face of contract text appears to have clear meaning).

81. *Harbor Ins. Co.*, 922 F.2d at 365.

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meaning of the charter."[82] However, Posner found the instant case to have gone too far both in using dissimilar judicial precedent as a basis for his opinions and to have "permit[ted] a lawyer to testify to the legal meaning of indemnification."[83] Even so, the error "would be harmless if Continental's suggested interpretation of the charter were highly implausible. But it is not."[84]

Because *Harbor Insurance Co.* was to be remanded to the trial court, which had found for the insurers, there had not been a decision on allocation of the settlement between the insurers and Continental. Should Continental prevail on remand, the trial court would need to address the issue, prompting the Seventh Circuit to set forth its views on the matter.

> How much of that amount [the $17.5 million paid by Continental to settle the claims] represents indemnification of the directors and other insured persons against whom claims had been made for their liability to the plaintiffs? Harbor and Allstate say none of it -- or at most $20,000, for that was the demand of the named plaintiff in the suit that

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82. *Id.* at 366.

83. *Id.* at 366-67.

84. *Id.* at 366. Posner's assessment of the expert witness issue is helpful but in my view a bit too restrictive. He is apparently fine with experts talking about general understandings and activity, "industry practice" if you will. He is uncomfortable with expert witnesses who are lawyers discussing case law as this may undermine the role of the judge, to whom the jury is supposed to look for guidance as to the law.

Perhaps. But this part of *Harbor Insurance Co.* may need to be read with a grain of salt. Posner was particularly upset with the substance of the expert's testimony rather than its form. The lawyer expert testified

> on an examination of the word "indemnity" as it is used in judicial opinions. There, however, the word frequently is used not to describe an explicit term in a contract but instead to denote one of several noncontractual legal doctrines, such as the doctrine governing indemnification of one joint tortfeasor by another. There was no basis for an assumption that the draftsmen of Continental's charter, in authorizing the company to indemnity its directors and officers for expenses caused by their (allegedly) wrongful acts, meant to incorporate some doctrine of tort law.

Id. (citations omitted). On remand, *Harbor Insurance Co.* was assigned to a new trial judge, who issued an extensive ruling on several in limine motions brought by the parties concerning expert witness issues. Harbor Ins. Co. v. Cont'l Bank Corp., No. 85-C7081, 1991 U.S. Dist. LEXIS 15272 (E.D. Ill. Oct. 25, 1991). There were no further reported opinions for *Harbor Insurance Co.*, suggesting the case settled.

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named the directors, and that suit unlike the other was not certified as a class action. But this is incorrect. That suit *was* certified as a class action, when the judge approved the settlement; moreover, the other suit was against directors and officers as well as against Continental, albeit the directors and officers were not identified by name.

Continental on the other hand claims, with equal unreason as it seems to us, that the insurers must be obligated to it for the full $17.5 million. This argument assumes, quite without evidence, that Continental's liability derived solely from the wrongful acts by the five directors named in the suit. . . . *To the extent that the amount for which Continental settled was larger than it would have been but for the misfeasance of [persons other than the named defendants] Continental's entitlement to reimbursement in this suit would be cut down.* . . .

. . . .

[o]n remand it will be necessary for the district court to determine how much larger the settlement was by virtue of the activities of persons against whom no claim within the meaning of the policy was made, and to cut down Continental's $17.5 million claim against the insurance companies accordingly.

. . . .

The point of the insurance policies plus the provision in Continental's charter for indemnifying the directors was to insure them against liability and then shift the liability for this insurance to Harbor and Allstate -- was, in other words, to eliminate the solvency risk [this may make plaintiffs target the deep pocket uninsured company rather than the shallower pocketed directors and officers]. To allow the insurance companies an allocation between the directors' liability and the corporation's derivative liability for the directors' acts would rob Continental of the insurance protection that it sought and bought. *We conclude that the entire $17.5 million of joint liability should be allocated to the directors and therefore that Continental is entitled to*

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> *recover up to the insurance limits, except for the portion, if any, of Continental's derivative liability that was due to the conduct of other directors, officers, or employees* [not named as defendants], *besides those directors and officers against whom claims were made within the meaning of the policy.* All of this is on the assumption that Continental establishes liability in the new trial that we are ordering.[85]

With the rather swift brush of a pen (or word processor), Posner both "decided" the instant dispute (assuming the facts at trial unfold as expected), set forth a rule of allocation for D & O policies, and said a good deal about his more comprehensive, cerebral, approach to insurance law and coverage litigation.

A frequent issue with D & O insurance is the apt allocation of responsibility for settlement payments between insurer and company. As noted, typically, a corporation cannot obtain insurance coverage for certain claims (although it may be able to obtain Errors & Omissions coverage that does many of the same things). However, companies can purchase D & O coverage that will not only protect these individuals (and make it more likely that qualified persons will be willing to accept such positions) but, as noted in the *Harbor Insurance Co.* opinion, provided what might be termed collateral protection to the company when it is sued in tandem with insured officers and directors. The existence of the D & O insurance both protects the individuals and indirectly protects the company. In addition, the conventional D & O policy typically excludes coverage for claims of fraud (but not misrepresentation) and punitive damages or criminal fines (which may be deemed uninsurable as a matter of law under controlling state law).

This coverage mixture frequently creates allocation questions. Most litigation results in settlement so it is hardly surprising that after a suit against the company and directors, settlement results. In its aftermath, there will be questions regarding the amount of funds paid on behalf of the corporation-vs.-directors and paid for uncovered-claims-vs.-covered-claims. Most D & O policies do not impose a duty to defend on the insurer but provide that reasonable defense costs are part of the "loss" insured under the policy. Consequently, sorting out the settlement often raises issues of defense cost allocation. Most of the time, the company (which has indemnified the individuals in most cases) and the insurer(s) settle the matter based on an

85. *Harbor Ins. Co.*, 922 F.2d at 367-68 (citations omitted) (emphasis added).

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equitable assessment of sorts fueled to some degree by business considerations (e.g., How badly does the insurer want to continue to write coverage for the policyholder or affiliated entities? Will a hard line stance create bad buzz about the carrier among brokers or other prospective policyholders?).

As of 1990, surprisingly few reported cases had addressed the issue of settlement allocation, with relatively little law at all predating the 1980s. *Harbor Insurance Co.* was thus an important case because it affected an area as yet relatively unfixed in doctrine (and remaining so to this day in spite of the upsurge in D & O coverage litigation spurred by the Savings & Loan solvency crisis). In *Harbor Insurance Co.*, Posner lays down a relatively straight-forward rule that seeks to vindicate the purpose of the D & O policy. In doing so, he is consistent with his general approach to contract meaning and relations. He focuses of course on contract language but will not strain to find clarity in the face of uncertain policy language. He would rather consider additional evidence of contract meaning, both specific extrinsic evidence if it is available (e.g., a letter or conversation illuminating the agreement) and the overall purpose of the policy and context of the transaction. The "larger settlement rule" enunciated by *Harbor Insurance Co.* was sensitive to both context and purpose -- and has proven to be influential as well.[86]

Harbor Insurance Co. is thus consistent with Posner's general view that contract and insurance law should not be excessively formalistic (e.g., ambiguity is resolved against the insurer-drafter in knee-jerk fashion) or textually literalist (e.g., a word is given its literal dictionary meaning). Rather, judicial effort is made to decide the case in a manner consistent with the aims of the contract transaction so that the decision gives the parties what they contracted for, including good faith performance. Despite having championed the concept of efficient breach in his law-and-economics writings, Posner recognizes that efficiency is not the same as opportunistic

86. *See, e.g.*, Nordstrom, Inc. v. Chubb & Son, Inc., 54 F.3d 1424 (9th Cir. 1995); Safeway Stores, Inc. v. Nat'l Union Fire Ins. Co., 64 F.3d 1282 (9th Cir. 1995); Nodaway Valley Bank v. Cont'l Cas. Co., 916 F.2d 1362, 1366-67 (8th Cir. 1990), *aff'g* 715 F. Supp. 1458 (W.D. Mo. 1989) (endorsing larger settlement approach to D & O allocation). *But see* Piper Jaffrey Companies v. Nat'l Union Fire Ins. Co., 38 F. Supp. 2d 771, 774-75 (D. Minn. 1999) (noting that *Nodaway Valley* has been characterized as both a "larger settlement" rule case and a "relative exposure" rule case, the latter being an approach to allocation that attempts to determine the degree to which settlement funds were paid in connection with risk posed by insured claims relative to uncovered claims).

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behavior. Contracting parties still need to play by the rules and observe good faith and fair dealing. A party that talks out of both sides of its mouth receives little sympathy. Implicitly, Posner is suggesting that contracting parties in disputes must be candid and consistent with one another. It is okay for a widgetmaker to refuse to deliver because it got a better price from another buyer but it is not okay to falsely tell the buyer left in the lurch that delivery was impossible because of force majeure events. Although not express in *Harbor Insurance Co.* or other opinions, Posner also seems to appreciate that insurance contracts are different than other contracts in terms of prepayment, reliance, and the foregoing of other commercial options. As a result, insurers will be held to somewhat more exacting standards regarding breach and performance.

B. *Eljer Manufacturing, Inc. v. Liberty Mutual Insurance Co.*

Another Posner case of significant importance and interest is *Eljer Manufacturing, Inc. v. Liberty Mutual Insurance Co.*,[87] which addressed the issue of when property damage claims are "triggered" under a commercial general liability (CGL) policy. Policyholder Eljer manufactured a plumbing system, installed in perhaps as many as a million homes between 1979 and 1986, that was "invariably behind walls or below floors or above ceilings, so that the repair or replacement the unit requires breaking into the walls, floors, or ceilings."[88] When the Eljer systems began leaking in many homes within a year of installation, claims ensued,[89] leading Eljer to seek a declaration of the applicability of its Liberty Mutual primary insurance policies (in effect from 1979 to 1988) and its Travelers excess policies (in effect from 1982 to 1986). It was estimated that ultimately five percent of the systems would fail and be subject to claims.[90]

The issue before the court was the manner in which liability policies are "triggered" in such situations. The CGL provides, both in its better known "bodily injury" section and in its "property damage" section, that the policy is invoked by an allegation of actual injury. Specifically, the standard CGL policy requires an allegation of "physical injury to tangible property" to

87. 972 F.2d 805 (7th Cir. 1992) (applying Illinois law to the coverage trigger issue with reference to New York law apparently applicable to some of the underlying claims).

88. *Id.* at 807.

89. Individual claims and class actions affected "almost 17,000 of the systems." *Id.* at 808.

90. *Id.* at 807.

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trigger property damage coverage. The Eljer plumbing systems were like a ticking "time bomb" and posed the question of whether "the person or property in which the defective product is implanted or installed physically injured at the moment of implantation or installation -- in a word, incorporation -- or not until the latent harm becomes actual?"[91]

Posner, over the modest dissent of Judge Cudahy,[92] concluded that the incorporation of the defective plumbing systems constituted a sufficiently concrete injury to trigger policies in effect at the time of installation.[93] Posner recognized that this decision was in at least some tension with the general rule of liability insurance that finds negligence alone insufficient to trigger coverage. There must be some injury allegedly stemming from the policyholder's negligence or other wrongdoing.[94] Posner found sufficient injury in the corrupting of the home's infrastructure because of the plumbing system. The homes were, as a practical matter, damaged by the incorporation of the plumbing systems, which could not easily be removed, and diminished the value of the homes. In addition, denying coverage until the metaphorical (or perhaps actual) roof fell in was regarded as too strident a reading of the CGL.[95]

Posner applied a comprehensive inquiry to the task of interpreting the CGL trigger question in *Eljer Manufacturing*. Acknowledging that the word "injury" generally connotes "harmful change in appearance, shape, composition or some other physical dimension,"[96] Posner balanced this factor (which argued for requiring an actual leak to trigger the CGL) with the "objective of the parties to insurance contracts."[97]

> The purpose of insurance is to spread risks and by spreading cancel them. Most people (including most corporate executives) are risk averse, and will therefore pay a premium to avoid a small probability of a large loss. Once a risk

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91. *Id.*

92. *Id.* at 814 (Cudahy, J., dissenting). Cudahy took issue with Posner primarily over his reading of Illinois precedent but conceded that Posner's resolution was a reasonable one. There is no hint of outrage, passion, or strong analytic disagreement in the dissent. *Id.*

93. *Id.* at 809-12.

94. STEMPEL, *supra* note 41, § 14.09.

95. *Eljer Mfg., Inc.*, 972 F.2d at 809-12.

96. *Id.* at 809.

97. *Id.* at 808-09.

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> becomes a certainty -- once the large loss occurs -- insurance has no function.[98]

Posner's analysis also includes considering that the policyholder in question is a relatively sophisticated commercial entity,[99] the analogy of fixtures in the law of real property,[100] and the background and drafting history of the 1973 version of the occurrence-basis CGL.[101] In particular, Posner noted that the CGL covered "loss of use" of property that was not itself physically injured. He reviewed New York and Illinois case law and found no clear answer, but thought his *Eljer* holding consistent with Illinois and other law that had not required dramatic tangible damage to qualify as injury under either the property damage or bodily injury provisions of the CGL.[102] "[T]he drafting history of the property-damage clause and the probable understanding of the parties to liability insurance contracts, persuade us that the incorporation of a defective product into another product inflicts physical injury in the relevant sense on the latter at the moment of incorporation."[103]

On the whole, Posner decides *Eljer Manufacturing* through a sort of practical reasoning that seeks to provide the promised risk-spreading protection to the policyholder without forcing the insurer to cover losses that are merely speculative.[104] By determining that incorporation of the defective plumbing constitutes a proper CGL property damage trigger, Posner provides expected and fair protection to the policyholder through a yardstick that can be applied with some clarity and certainty in determining the responsibilities of the insurers involved in such matters.

Posner recognizes that *Eljer Manufacturing* is a bit of a trailblazer and might be criticized in some quarters for arguably focusing on dates of negligence rather than dates of injury. He justifies this approach in *Eljer Manufacturing* and subsequent decisions as necessitated by the comparatively long interval between conduct and injury as well as the difficulty in

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98. *Id.* at 807. Posner's view of human nature as risk averse is consistent with his scholarly economic analysis of law. *See, e.g.*, RICHARD A. POSNER, ECONOMIC ANALYSIS OF LAW 12-13 (4th ed. 1992).

99. *Eljer Mfg., Inc.*, 972 F.2d at 809.

100. *Id.* at 810.

101. *Id.* at 809-11.

102. *Id.* at 811-13.

103. *Id.* at 814.

104. *Id.* at 810.

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ascertaining the timing and extent of injury.[105] In addition, although *Eljer Manufacturing* allows policyholders to invoke the protection of now-expired policies in effect at the time of installation, *Eljer Manufacturing* does not, as is the case for bodily injury claims such as asbestos exposure, trigger all insurance continuously from the date of installation to the date of the third-party's claim.[106] Thus, *Eljer Manufacturing* cannot be seen as dramatically expanding insurer liability but does prevent insurers from engaging in opportunistic cancellation when made aware of manifested plumbing leak problems that present the ticking time bomb to the policyholder-manufacturer.

C. *Stone Container Corp. v. Hartford Steam Boiler Inspection & Insurance Co.*

Stone Container Corp. v. Hartford Steam Boiler Inspection & Insurance Co.,[107] is not a case involving great public controversy, but illustrates well the context-based, purposive, sensitive reasoning Posner applies to the text of insurance policies in coverage disputes. Policyholder Stone Container Corporation ("Stone Container"), a manufacturer of wood products, operated a "pulp digester" at its plant. This machine made 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 caused 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 fragment of the pulp digester tank into the air. 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."[108]

In the wake of this disaster arose a contest between two insurers over their respective coverage responsibilities. Stone Container had a boiler and machinery insurance policy from Hartford Steam Boiler as well as an all-risk policy from Lloyd's of London. The boiler insurer argued that it was not responsible because of an exclusion in its policy for losses caused by an

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105. *See, e.g.*, Rozenfeld v. Med. Protective Co., 73 F.3d 154, 158 (7th Cir. 1996) (explaining and defending the *Eljer* rationale).

106. STEMPEL, *supra* note 41, § 14.09 (discussing the prominence of continuous trigger CGL coverage for bodily injury claims involving asbestos and other injurious products).

107. 165 F.3d 1157 (7th Cir. 1999).

108. *Id.* at 1159.

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"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 Container and Stone commenced a declaratory judgment action against only Hartford Steam Boiler, seeking a determination that the boiler policy provided primary coverage.[109] 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 Seventh Circuit reversed, with Posner writing for the Court.

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)."[110] "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." 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."[111] 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." 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."[112]

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

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109. 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.*

110. *Id.*

111. *Id.* at 1159-60.

112. *Id.* at 1160.

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did not included steam-pressure-based blowups. Posner rejected this suggestion as too narrow as both 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. . . . [E]ven 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."[113]

Posner found it a more difficult question regarding 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.[114]

Posner concluded that the pulp digester was neither one of the enumerated 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.[115]

Posner 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 Posner, 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

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113. *Id.*
114. *Id.* at 1159 (quoting boiler policy).
115. *Id.* at 1160-61 (emphasis added).

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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."[116] Posner regarded this as the correct approach to extrinsic evidence and the ambiguity principle in both noninsurance and insurance contracts. (He also noted 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.)

Posner concluded that 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; therefore, the boiler insurer (Hartford Steam Boiler) was not required to provide coverage. The coverage burden for this "nonboiler" risk fell on the all-risk insurer (Lloyd's). *Stone Container* is eminently sensible and measured in both approach and tone. It appreciates the nature of the business and the types of insurance purchased by the manufacturer. It examines policy language closely but not myopically with the benefit of contextual perspective. Appreciating that difficult construction problems do not inevitably reflect ambiguous contracts, it discerns the reasonable meaning of the policies and renders a sensible, seemingly correct coverage decision.

D. *Connecticut General Life Insurance v. Sun Life Insurance of Canada*

In a major insurance-ADR imbroglio, Posner has also reached a sound result sensitive to the facts of the case and modern business dealings. In *Connecticut General Life Insurance Co. v. Sun Life Assurance of Canada*,[117] reinsurers and retrocessionaires were in conflict both over duties of payment and the tribunal or tribunals that would decide the issue. Three retrocessionaires (Sun Life, Phoenix, and Cologne) "agreed to reinsure workers' compensation reinsurance policies issued" by seven retrocedents. The contract had been negotiated for the reinsurers (some of which were reinsuring and some of which were providing reinsurance) by Unicover, a "middleman" in the workers' compensation reinsurance market.[118]

The companies then sought disparate orders compelling arbitration, subsequent to an arbitration provision in the insurance policy. The

116. *Id.* at 1161.
117. 210 F.3d 771 (7th Cir. 2000).
118. *Id.* at 772.

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retrocessionaires sought a single arbitration, which was denied by the trial court and appealed to the Seventh Circuit. The appellate court per Judge Posner remanded the case for consolidation of the arbitrations. Posner took the view that although a court could not meddle in the arbitral process, the question of arbitrability generally was for the court rather than the arbitrators, unless a matter was by contract committed to the arbitrators.[119]

Posner then addressed the limited utility of the *expressio unius est exclusio alterius* (the listing of things included implies the exclusion of those things not listed) canon of contract construction as illustrated by the case.[120] The contract language did provide for treating the retrocessionaires as a single party but not for treating retrocedents as a single party. According to Posner, this was not a textual bar to consolidating the arbitration because the

> sensible answer . . . is that the contract itself makes the [retrocedents] one party but not the [retrocessionaires] so that making the [retrocessionaires] a single party for purposes of arbitration suggests if anything an intent to have a single arbitration proceeding when there is a single dispute, even if it's a dispute with more than one of the [retrocedents]. . . . The parties could foresee that any dispute [would involve Unicover and] Unicover didn't want to be in the position have having to arbitrate separately. . . . Another straw in the wind is the provision for arbitration in Chicago, which just happens to be Unicover's headquarters but not that of any of the other parties.[121]

Posner continued: "We cannot say that these textual inferences are conclusive in favor of consolidation, but they support it, as do practical considerations, which are relevant to disambiguating a contract, because parties to a contract generally aim at obtaining sensible results in a sensible way."[122]

In this opinion, as in others like *Harbor Insurance Co.* and *Eljer Manufacturing*, Posner takes a considered view of contract language but is not fixed on text to the exclusion of practical considerations and the sensible resolution of business disputes consistent with judicial economy and other public policy considerations. Through clear contract language, the parties

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119. *Id.* at 770-71.

120. *Id.* at 771 (citing William N. Eskridge, Jr., *Norms, Empiricism, and the Canons in Statutory Interpretation*, 66 U. CHI. L. REV. 671, 676-77 (1999)).

121. *Id.* at 775.

122. *Id.*

may behave idiosyncratically or even stupidly, but Posner's implicit default rule for contract construction and dispute resolution is that the resolution of the dispute should make commercial and social sense. Despite the current infatuation with arbitration and ADR among most judges (and other members of the legal profession), consolidation of arbitration has tended to be a backwater reminiscent of the pre-1970s judicial hostility toward arbitration in that many decisions (cited unsuccessfully by the losing retrocedents in *Connecticut General*) have resisted consolidation in holding or dicta or both. Posner breaks out of this judicial rut and renders a useful decision on both arbitration and insurance.

II. CONTINUING CONCERNS ABOUT POSNER, EMPLOYMENT LAW, CIVIL RIGHTS, DISCRIMINATION, AND THE SCOPE OF REMEDIAL LEGISLATION

In the related areas of contract law and ERISA, Posner has frequently demonstrated breadth, depth, and sensitivity regarding the meaning of agreements disputed by parties. Where the interests of employees and commercial entities clash, however, he can be accused of being more sensitive to the latter. Similarly, his normally rewarding examination of contract and insurance principles can be diluted into what can be characterized as simple conservatism when this issue becomes the scope and reach of the ERISA statute and its benefits conferred to workers. When construing antidiscrimination statutes, Posner's sensitivity to context, reality, and purpose on occasion fades into what appears to some as simply resistance to a liberal statute he probably thinks wrongheaded. Where such legislation abuts insurance, Posner's jurisprudence is interesting, arguably correct, but disturbingly resistant to the rights of workers at the expense of opposing commercial entities.

A. *Posner's ERISA Decisions: Less Satisfying than his Insurance Opinions?*

Many ERISA cases are essentially insurance coverage cases. But many are also federal preemption cases, pension benefit cases, fiduciary duty cases, workplace rights cases and, of course, statutory interpretation cases. Consequently, a comprehensive examination of ERISA law and Posner's contribution to it probably merits a volume (or at least the note found in this

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issue)[123] rather than a section of this article. To limit the task, I am addressing (too briefly, perhaps) Posner's ERISA decisions bearing on insurance coverage and also his ERISA writings that reflect on worker status and construction of the statute. In the realm of ERISA, which is neither pure contract nor pure insurance, Posner continues to provide well-reasoned opinions that are, for the most part, sensitive to facts, context, litigants, and the law but with some slippage away from his exemplary work on insurance matters.

In *Herzberger v. Standard Insurance Co.*,[124] Posner addressed the issue of when ERISA plans have discretionary authority over health benefits claims. A continuing ERISA controversy is the degree of freedom a benefit plan administrator (usually a health insurance company claims adjuster) has in denying such claims. Employers and insurers prefer to have total discretion so that any benefit denials are final and not subject to successful court challenge. Beneficiaries prefer to categorize a plan as providing coverage subject to certain contractual standards and norms of acceptable health insurance. Courts have had some difficulty in determining from the plan documents whether the plan's decision authority is discretionary or circumscribed.

In *Herzberger*, Posner sought to bring some clarity to Seventh Circuit precedents (some of them authored by Posner). He framed the issue as

> whether language in plan documents to the effect that benefits shall be paid when the plan administrator upon proof (or satisfactory proof) determines that the applicant is entitled to them confers upon the administrator a power of discretionary judgment, so that a court can set it aside only if it was "arbitrary and capricious," that is, unreasonable, and not merely incorrect, which is the question for the court when review is plenary ("de novo").[125]

Finding some of the case law unclear or arguably in tension, the court issued the *Herzberger* opinion to "clarify our position and reduce the tension."[126] In particular, Posner deemed it "highly desirable to have a

123. Aldo R. Edwards van Muijen, Note, *Posner and ERISA: A Survey*, 7 CONN. INS. L.J. 195 (2000).

124. 205 F.3d 327 (7th Cir. 2000).

125. *Id.* at 329 (citations omitted).

126. *Id.* at 330.

uniform national rule" because of the movement of workers and the multi-state operations of employers.[127]

> The very existence of "rights" under such plans depends on the degree of discretion lodged in the administrator. The broader that discretion, the less solid an entitlement the employee has and the more important it may be to him, therefore, to supplement his ERISA plan with other forms of insurance. In these circumstances, the employer should have to make it clear whether a plan confers solid rights or merely the "right" to appeal to the discretion of the plan's administrators.[128]

To clarify matters, Posner and the *Herzberger* panel, after circulating its draft opinion to the entire Seventh Circuit, issued and "commend[ed] to employers" what it deemed "safe harbor" language for employers to use if they wish to have their plan benefits decisions reviewed under the more deferential arbitrary and capricious standard used with discretionary plans.[129]

Although future beneficiaries will undoubtedly want to claim that the absence of such "safe harbor" language provides plenary review, Posner suggested that this was not necessarily a persuasive argument, stating that

> [i]n some cases the nature of the benefits or the conditions upon it will make reasonably clear that the plan administrator is to exercise discretion. In others the plan will contain language that, while not so clear as our "safe harbor" proposal, indicates with the requisite if minimum clarity that a discretionary determination is envisaged.[130]

Under Posner's construct, employers appear to have an advantage of either using the "safe harbor" language, which is presumably conclusive, or litigating the issue of the standard established by plan documents containing other language. Beneficiaries have something of an advantage as well under *Herzberger* in that

> the mere fact that a plan requires a determination of eligibility or entitlement by the administrator, or requires proof or satisfactory proof [or similar provisions] does not give the employee adequate notice that the plan

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127. *Id.* at 330-31.
128. *Id.* at 331.
129. *Id.*
130. *Id.*

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> administrator is to make a judgment largely insulated from judicial review by reason of being discretionary.[131]

On the whole, however, Posner's system seems slanted toward employer prerogatives at the expense of fair treatment of workers and beneficiaries. To be sure, Posner will require employers to "prove" that they have discretionary authority (and interprets arbitrary and capricious review as being review for reasonableness). But he has (a) given employers a roadmap for giving themselves discretionary authority as a matter of law rather than making firmer contractual commitments to workers and (b) still permits employers who fail to follow his roadmap to nonetheless litigate the issue, engaging in a war of attrition if necessary to stave off employee claims.

In *Herzberger*, Posner is concerned enough to encourage straight talk from the employer but seems too quick to assume that the boilerplate benefit plans issued by most employers are part of some meaningful conversation between management and workers. Although perhaps forced into this position by the statute, Posner seems to have embraced employer prerogatives and a "bargain" model of employment contracting that many would find inconsistent with the reality of the workplace. For example, Posner defends the current regime of deference to plan administrators so long as the plan documents adequately establish the discretion of the administrator on implicit freedom of contract grounds.

> An ERISA plan can stipulate for deferential review; it might be entirely rational for an employee to accede to and even prefer such a plan -- it might be cheaper. But the stipulation must be clear, and cannot merely be assumed from language that in the closely related setting of insurance contracts has never been thought to entitle the insurer to exercise a discretionary judgment in determining whether to pay an insured's claim. An employer should not be allowed to get credit with its employees for having an ERISA plan that confers solid rights on them and later, when an employee seeks to enforce the right, pull a discretionary judicial review rabbit out of his hat. The employees are entitled to know what they're getting into, and so if the employer is going to reserve a broad, unchanneled discretion to deny claims, the employees should be told about this, and told clearly.[132]

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131. *Id.* at 332.
132. *Id.* at 332-33.

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Posner's concern for full disclosure is admirable. His notion that the average worker needing a job is in a position to pick and choose among employers (even in a booming economy) according to the standard of review language in the company health care plan is surreal. Concern for protecting worker expectations might take better judicial form if courts were to limit the employer's ability to adopt "discretionary" benefit plans or to put more teeth into the notion of what constitutes "reasonable" coverage decisions by plan administrators. This more worker-protective path is in my view not foreclosed by the ERISA statute, despite precedent.[133] For example, we have seen since 1995 movement by the Supreme Court away from an incorrect approach to ERISA preemption of state law toward one more consistent with the federal courts' traditional approach to preemption.[134] Rather than treating cases like *Herzberger* as classic illustrations of neoclassical contract negotiation, Posner could benefit from recognizing that the model is not particularly apt in many employment contracts. His "rational actor, economic analysis, business context" orientation serves him well in most insurance matters, particularly inter-insurer or commercial policyholder disputes. It is perhaps not as useful an orientation for reaching statutory and contractual justice in other contexts.

Rossetto v. Pabst Brewing Co.,[135] involved "the much-litigated issue of when a right to health benefits that is granted to retired workers by a collective bargaining agreement (or an ERISA plan, but that is not this case) survives the termination of the agreement."[136] After the expiration of Pabst's agreement with the machinists' union in 1995, the brewer closed its plant in 1996. The Machinists claimed that their health benefits survived the agreement. Pabst argued that the benefits could be effective only so long as the collective bargaining agreement was in effect. Addressing the issue of whether this determination could be made as a matter of law, Posner once again provided an explanation of the role of text and other factors in judicial construction of contracts.

> If [Pabst's position] is right -- if someone who read these provisions without knowing anything about their background or real-world context would say, "Yes, it sure looks as if the

133. BARRY R. FURROW ET AL., HEALTH LAW § 8-6 (2d ed. 2000).

134. *Id.* § 8-3. *See, e.g.*, N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645 (1995).

135. 217 F.3d 539 (7th Cir. 2000).

136. *Id.* at 541.

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> provisions are in effect only for the term of the agreement in which they appear" -- then Pabst is off the hook as a matter of law (that is, the case would not reach the jury) unless the plaintiffs can adduce (1) objective evidence of (2) a latent, or, as it is sometimes called, an extrinsic ambiguity. A "latent ambiguity" is an "ambiguity" . . . that is recognized as such only when a contract -- clear on its face -- clear, that is, to the uninformed reader -- is applied to a particular dispute.
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> . . . .
>
> The doctrine of latent ambiguity comes into play . . . only if someone who read the contract without knowledge of its real-world context of application would think it clear. If even this innocent reader would find the contract unclear -- if, that is, an ambiguity is apparent just from reading the contract without having to know anything about how it interacts with the world -- then the contract has what is called a patent, or intrinsic, ambiguity, and the evidence is admissible to cure it.[137]

The Court then applied the Seventh Circuit's default rule that there is a presumption of an end to benefits when the agreement ends rather than a vesting of benefits in the worker but that the worker may be able to overcome this presumption by pointing to text or other factors suggesting a different meaning of the agreement.[138]

In *Rossetto*, and in earlier ERISA-collective bargaining agreement disputes over longevity, Posner's analysis is sound and relatively charitable toward the affected workers. One could take the view that when an employment agreement or benefit plan is over, it's over and no further right to benefits remains. Indeed, this was the position of Judge Easterbrook and others in dissent when Posner first wrote for the en banc Seventh Circuit on this issue in the key case of *Bidlack v. Wheelabrator Corp.*,[139] In this area, then, Posner has not been the conservative ideologue painted by this critics.

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137. *Id.* at 539-43.

138. *Id.* at 544.

139. 993 F.2d 603 (7th Cir. 1993) (Posner writing for a majority including Judges Cudahy, Flaum, Ripple, Kanne and Rovner); *Id.* at 614 (Easterbrook, J., dissenting) (joined by Judges Bauer, Coffey and Manion).

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To be sure, he has not given away the store to former employees seeking benefits -- they must demonstrate objectively that the agreement is susceptible to being construed as providing ongoing benefits after termination. But Posner is far less protective of the employer closing operations than other judges on his court.

B. *Posner on Employment Discrimination: Consciousness Imperfectly Raised; Vestiges of Econominalism*

Employment discrimination cases depart further from the insurance and contract model. Instead of party-generated rights and obligations based on agreement, usually for commercial gain or risk transfer and spreading (contract and insurance), we have antidiscrimination statutes created "in derogation" of the common law that largely permits employers to do whatever they want, short of intentional physical injury, to workers. Where nondiscrimination statutes are not applicable, the employment-at-will doctrine retains considerable vitality and permits employers to discharge workers for frivolous reasons ("What an ugly tie, clean out your desk.") or manage them in frivolous ways ("I suppose I could hire a secretary for the office, but I think it's good for Ph.D's to spend a couple hours a day at the photocopy machine."). Under the common law legal regime, the employer is king of the workplace castle, period. Tort law may intrude in the case of egregious conduct and worker's compensation law imposes strict liability for job-related injuries, but in return limits recovery to scheduled amounts. But where there is claimed racial, sexual, ethnic, religious, age, or disability discrimination, the relatively newfangled (dating only from the 1960s) tangle of antidiscrimination law and regulation may intrude on the employer in a significant way.[140]

I have previously argued (with considerable assistance) that in throwing a pregnancy discrimination claim out of court in 1994,[141] Posner both gave Title VII short shrift in a manner at odds with his professed pragmatism. He also exhibited condescending scorn for the plaintiff, a discharged retail store

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140. *See* Pryor v. Seyfarth, Shaw, Fairweather & Geraldson, 212 F.3d 976, 979 (7th Cir. 2000) "Title VII is not a "good cause" statute; it creates a remedy against caprice invidious discrimination (or, as here, retaliation), not against caprice." *Id. See generally* Ann C. McGinley, *Rethinking Civil Rights and Employment at Will: Toward a Coherent National Discharge Policy*, 57 OHIO ST. L.J. 1443 (1996).

141. Troupe v. May Dep't Stores Co., 20 F.3d 734 (7th Cir. 1994).

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clerk.[142] I won't belabor that case or other pre-1995 Posner discrimination cases today other than to reassert that Professor McGinley and I stand by our criticism of Posner's approach to the statute and decision in that case. Of greater interest and relevance to this article is Posner's more recent discrimination decisions. Since 1994, Posner's writings in this area have on occasion been excellent, but have also showed continuing underappreciation of workplace realities and continuing overnarrow reading of the antidiscrimination laws.

Pryor v. Seyfarth, Shaw, Fairweather & Geralson,[143] provides an example of Posner's better side on employment discrimination issues. A secretary at the large, Chicago-based Seyfarth firm claimed that a partner sexually harassed her on the basis of five incidents, which involved comments on her looking through a "Frederick's of Hollywood" catalogue and asking "can I see some pictures of you in some of the outfits that you have bought from Frederick's of Hollywood?"[144] He also asked Pryor to look at a book of women in bondage and commented flirtatiously (in the Court's view) or lecherously (in her view) on her attire. Posner described the incidents as either "innocuous" or "mildly flirtatious" save for the possibly offensive invitation to peruse women in bondage, but this was "not so offensive as to constitute actionable harassment" because it was as a matter of law insufficiently severe to have "actually changed the conditions of the plaintiff's workplace."[145] To do so, offensive, sexually-oriented behavior must be of a quantum and type to offend a reasonable person, not a "hypersensitive" one.

Posner's assessment seems correct even to a liberal. Although Title VII clearly suggests that it is not "okay" for law firm partners to attempt to engage women co-workers in S & M voyeurism, a single incident without more (e.g., forcing Pryor to look, grabbing her, continued insistence, etc.) is not a sufficiently big deal to change the work environment. Even Judge Illana Diamond Rovner, frequently in opposition to Posner on discrimination cases, agreed and joined Posner's opinion without dissent.[146]

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142. Ann C. McGinley & Jeffrey W. Stempel, *Condescending Contradictions: Richard Posner's Pragmatism and Pregnancy Discrimination*, 46 FLA. L. REV. 193, 230-35 (1994).

143. 212 F.3d 976 (7th Cir. 2000).

144. *Id.* at 977. Frederick's is known for stylishly outlandish and provocative women's wear.

145. *Id.* at 976.

146. *Id.* The *Pryor* panel included Judge Rovner and Seventh Circuit Judge Terence Evans, another generally liberal judge who dissented from Posner's decision in *Doe v. Mutual of Omaha Insurance Co.*, 179 F.3d 263 (7th Cir. 1999), stated that ADA does not apply to the

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Posner then proceeded to reverse the trial court's summary judgment for the law firm by noting that Pryor was subsequently discharged for "glueing an artificial fingernail on the finger of a friend in the ladies' room" at the firm.[147] The firm defended the discharge as permitted under the law so long as it was not motivated by Pryor's filing of a discrimination claim. According to Posner, "the circumstances leading up to the discharge, however, cast enough suspicion on the motive for firing Pryor to entitle her to a trial."[148] Posner then marshaled a considerable array of evidence that could support a reasonable factfinder's conclusion that the discharge of Pryor was pretextual and in retaliation for her having complained (albeit perhaps hypersensitively) about sexual harassment.[149]

In short, a case like *Pryor* suggests that Posner remains no leftist (it takes more than one suggestion to look at a dirty magazine to constitute harassment) but neither is he unrealistically resistant to the possible retaliatory conduct of employers when employees allege harassment. In *Pryor*, Posner also displays some appreciation for the grittiness of the real world (the employer might have been looking for a seemingly nondiscriminatory way to get back at Pryor for complaining) that is often absent in his other employment decisions.

In other discrimination cases, Posner's voice is mainstream and helpfully informative. For example, in *Bourbon v. KMart Corporation*,[150] he concurs in a panel opinion written by Judge Rovner affirming a trial court summary judgment for the employer in a retaliatory discharge claim brought under state law.[151] Posner's concurrence addresses the lurking (but unaddressed by the

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content of insurance policies. *See infra* notes 201-42 and accompanying text (discussing *Mutual of Omaha*).

147. *Pryor*, 212 F.3d at 979.

148. *Id.*

149. *Id.* at 980. Posner stated:

> A reasonable jury could find that after and because Pryor filed a claim, the firm was 'laying' for her, biding its time to create a space between the date of the claim and the date of the discharge, and in the interval gathering pretextual evidence of misconduct to provide a figleaf for its retaliatory action. Of course we do not hold that this is the correct interpretation of the events, only that the matter is sufficiently in doubt to require a trial.

Id.

150. 223 F.3d 469 (7th Cir. 2000).

151. *Id.* at 471 (finding Illinois retaliatory discharge protections limited and the record as a matter of law would not permit reasonable fact-finder to conclude that proffered reasons for discharge were pretextual).

parties) issue of whether such cases are controlled by the *McDonnell-Douglas* order of proof applicable to discrimination cases brought in federal court[152] (on the theory that this is procedure applicable in federal litigation regardless of the underlying state claim) or instead is controlled by the state's methodology of proof (on the theory that this is part of controlling state substantive law under the *Erie* doctrine).[153] Although cynics might see this as Posner beginning to make a case for applying state protocols, which will tend to be less favorable to discrimination plaintiffs than the *McDonnell-Douglas* standard, I see it as Posner the intellectual seeking to clarify the law (albeit with something of an advocacy brief for a broad construction of the sphere of state law control under *Erie*).[154]

In *Thorn v. Sundstrand Aerospace Corp.*,[155] Posner reviewed trial court summary judgments for the employer in two age discrimination suits, affirming one dismissal and reversing the other. Although the district court decisions were "replete with findings that are not proper in summary judgment proceedings, for example, findings that credit fiercely contested testimony,"[156] Posner took an aggressive view of appellate court summary judgment decisionmaking power. "[S]ince the review of summary judgment is plenary, errors of analysis by the district court are immaterial; we ask

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152. Under *McDonnell-Douglas v. Green*, 411 U.S. 792, 802 (1973), a discrimination plaintiff survives summary judgment by establishing that he or she was qualified for a position and suffered an adverse employment action. The defendant must then articulate a legitimate, nondiscriminatory reason for the adverse action. When that occurs, the plaintiff still needs to prove discrimination, which it may do by showing that the employer's reason is pretextual. On the whole, the *McDonnell-Douglas* approach is regarded as pro-plaintiff because it reduces the claimant's initial need to "prove" discrimination to keep the case in court. *See* Reeves v. Sanderson Plumbing Prod., Inc., 530 U.S. 133 (2000). For a further description and analysis of *McDonnell-Douglas*, see Ann C. McGinley, *Credulous Courts and the Tortured Trilogy: The Misuse of Summary Judgment in Title VII and ADEA Actions*, 34 B.C. L. REV. 203, 230-35 (1993) (arguing that many courts erroneously treat employer's articulation of nondiscriminatory reason for discharge as proof of nondiscrimination as a matter of law), Catherine Lanctot, *The Defendant Lies and the Plaintiff Loses: The Fallacy of the "Pretext-Plus" Rule in Employment Discrimination Cases*, 43 HASTINGS L.J. 57, 141 (1991) (arguing that lower courts have strayed from *McDonnell-Douglas* in treating employer's articulation of nondiscriminatory reason for discharge as conclusive proof of nondiscrimination).

153. *Bourbon*, 223 F.3d at 473-77.

154. Of course, after *Gasperini v. Center for Humanities, Inc.*, 518 U.S. 415, 429 (1996) (holding New York rule on seeking new trial and setting aside verdict to be substantive rather than procedural), Posner may well be correct.

155. 207 F.3d 383 (7th Cir. 2000).

156. *Id.* at 386.

whether we would have granted summary judgment on this record."[157] Although Posner is correct as to the scope of judicial power, he is arguably insensitive to the potential for error when cases are decided by appellate courts removed from close scrutiny of trial or pretrial evidence. Posner seems to see no greater potential for error or possible bias when a trial judge is so enthusiastic to grant summary judgment for a defendant that he rushes toward the impropriety of impermissible fact-finding.[158]

On the substance of the ADEA claims,[159] which involved workers who were "riffed" (discharged as part of a reduction in force or RIF), Posner holds that the *McDonnell-Douglas* approach to proof of discrimination applies to RIF cases.[160] This is something of a break for plaintiffs, although one Posner dilutes by stating that the prima facie case of age discrimination is not satisfied unless the plaintiff is replaced by a "much" younger worker, a requirement found nowhere in the statute.[161]

On the merits of the cases, Posner found that one plaintiff (Thorn, a 61-year-old), who had received glowing reviews in his work, was denied the opportunity to keep his skills up to date because the employer told him they thought he was "only going to be here for another year or so."[162] There was also evidence of pretextual evaluations by the employer designed to set up the

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157. *Id.*

158. *See* Jeffrey W. Stempel, *A Distorted Mirror: The Supreme Court's Shimmering View of Summary Judgment, Directed Verdict, and the Adjudication Process*, 49 OHIO ST. L.J. 95 (1988) (arguing against more aggressive view of permissible summary judgment use reflected in Supreme Court's 1986 trilogy of cases).

159. Or possibly the "procedure" of ADEA cases. *See supra* note 152-56 and accompanying text (discussing Posner's concurrence in *Bourbon v. KMart Corp.*, in which he discusses the status of the *McDonnell-Douglas* approach to discrimination proofs under the *Erie* doctrine).

160. *Thorn*, 207 F.3d at 386 (requiring that a plaintiff prove that he is in the ADEA protected class and that "he is performing his job satisfactorily [and] was replaced by a much younger worker and that the defendant then produce evidence that it had a noninvidious reason for the discharge -- in an age discrimination case, that the reason was not the plaintiff's age.").

161. *Id.* In fairness to Posner, the pro-plaintiff *McDonnell-Douglas* standard, or the disparate impact theory of discrimination, is not found in the text of antidiscrimination laws. Posner has company in requiring a "much" younger replacement to trigger an inference of discrimination, but this seems an unnecessary softening of the *McDonnell-Douglas* formula. If a 41-year-old is replaced by a 39-year-old, the employer should be able to use this as rather powerful evidence of nondiscrimination but not to gut the *McDonnell-Douglas* approach. Congress drew the line at 40 and it seems unnecessary judicial activism not to observe this as the dividing line between "older" and "younger" workers.

162. *Thorn*, 207 F.3d at 387.

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older Thorn for riffing. The company did, however, retain an employee in his thirties doing similar work even though the younger man was a "problem employee" who was "deficient in communication and interpersonal skills."[163] Based on the record, Posner concluded that a trial might well result in a finding of age discrimination against Thorn.[164] The other plaintiff, Curran, had a "much weaker" case that was also marred by his attempt to change his deposition testimony.[165]

As a whole, the *Thorn* opinion shows Posner working hard to examine the record and render considered decisions without exhibiting great hostility toward the ADEA statute. But neither is Posner enthusiastic about his partial finding for one plaintiff. In fact, Posner shows his greatest sensitivity to context in discussing the employer's motivations when making personnel decisions.

> It would be a foolish RIF that retained an employee who was likely to quit anyway in a few months while riffing one likely to perform well for the company over a period of years. High turnover of skilled workers can be very harmful to a company. The worker who leaves may take with him trade secrets valuable to a competitor or the benefits of specialized training that the employer had given him, at some expense, in the hope of recouping the expense in the worker's superior productivity now to be enjoyed by another employer. Since younger employees tend to be more mobile than older ones, there is no basis for an inference that employers interested in the long-term potential of an employee prefer young to old.[166]

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163. *Id.* at 387.

164. *Id.* at 388 ("In so ruling, we do not predict the outcome of the trial, and we remind the reader that our description of the facts was tilted as favorably to Thorn as the record permits, as of course we're required to do in considering a motion for summary judgment."). Even when finding for a discrimination plaintiff, Posner appears to go out of his way to suggest some resistance toward the antidiscrimination statutes. Any lawyer or judge reading the opinion would of course know that a reversal of summary judgment, standing alone, is only an opportunity for the plaintiff to prove his case at trial, not a finding against the employer. Although I have not searched with any seriousness, I have not seen Posner use similar cautionary language when reversing a plaintiff's ruling or decision and remanding to the trial court.

165. *Id.* "The contretemps over the altered deposition would not be enough to justify a verdict for Curran, and there is nothing else." *Id.* at 390.

166. *Id.* at 389.

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Hunt v. City of Markam[167] shows Posner taking on a civil rights case and providing considerable guidance for other judges and lawyers. In *Hunt*, four white police officers sued the City, alleging violations of 42 U.S.C. §1981 (which bars race nondiscrimination in contractual relations) and the ADEA. *Hunt* was a reverse discrimination case with a twist. Plaintiffs alleged that when the City came under black political control, it was payback time for the whites who had formerly held political power and government jobs.[168] Specifically, plaintiffs alleged a series of racist statements suggesting that the white officers were marked for dismissal or other mistreatment.[169] They also alleged and produced evidence of denial of raises and promotion as well as constructive discharge.[170]

The trial court granted summary judgment for the City, characterizing plaintiffs' proffered evidence of discrimination as simply offhand commentary insufficient to make a case. In reversing, Posner observed:

> [t]he district court overread language in a number of our cases to the effect that "stray remarks" of a derogatory character are not evidence of actionable discrimination. All that these cases hold -- all that they could hold and still make any sense -- is that the fact that someone who is not involved in the employment decision of which the plaintiff complains expressed discriminatory feelings is not evidence that the *decision* had a discriminatory motivation. That is simply common sense. It is different when the decision makers themselves, or those who provide input into the decision, express such feelings (1) around the time of, and (2) in reference to, the adverse employment action complaint of. For then it may be possible to infer that the decision makers were influenced by those feelings in making their decision. This is such a case.[171]

Posner's discussion is helpful in that too many courts have been too quick to dismiss discriminatory statements (which, if believed, constitute not just some evidence of racial animus but direct evidence of prejudice) as mere

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167. 219 F.3d 649 (7th Cir. 2000).

168. *Id.* at 652.

169. *Id.* The alleged statements were pretty blatantly racist, including talk of a need to "get rid of all the old white police officers" so that "we can bring these young black men up"; "you are the minority now; you lost, you might as well move out" and similar comments. *Id.*

170. *Id.* at 650.

171. *Id.* at 652-53 (emphasis in original) (citations omitted).

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"stray remarks." But by emphasizing the divide between statements by decision-makers versus others, Posner fails to note that statements by others should nonetheless be considered evidence of discrimination to the extent they indicate a hostile environment that was encouraged or condoned by management. He does not expressly make this point, suggesting that he is not willing to consider these "atmospheric" factors as sufficient evidence of discrimination. Although this position is consistent with the Seventh Circuit precedent cited by Posner in *Hunt*,[172] I doubt Posner would take this constricted a view if presented with the appropriate case of co-worker statements reflecting a hostile environment. But I'm not sure. Posner seems insensitive to the totality of circumstances in the workplace, which might be a very racist, sexist place because of the daily assault of language even if decision-makers themselves are never caught uttering a politically incorrect word. Posner recognizes this where the claim is one of sexual harassment (provided the atmosphere is sufficiently oppressive) but appears not to see it for other sorts of discrimination claims.

In *EEOC v. Humiston-Keeling, Inc.*,[173] Posner exhibits a similarly moderate approach to employee rights although the opinion perhaps suggests some unawareness of the modern marketplace of employment. In *Humiston-Keeling*, a complaining worker (Houser) "worked as a picker in a warehouse, where her duty was to carry pharmaceutical products from a shelf to a conveyor belt. The jobs required frequent lifting of as much as five pounds."[174] An accident at work led to an injured elbow that left her unable to lift more than five pounds, a condition the Court treated as a disability within the meaning of the ADA.[175]

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172. *See, e.g.*, Bellaver v. Quanex Corp., 200 F.3d 485, 493 (7th Cir. 2000); Cullen v. Olin Corp., 195 F.3d 317, 323 (7th Cir. 1999); Pitasi v. Gartner Group, Inc., 184 F.3d 709, 714-15 (7th Cir. 1999); Cianci v. Pettibone Corp., 152 F.3d 723, 727 (7th Cir. 1998); Bahl v. Royal Indem. Co., 115 F.3d 1283, 1293 (7th Cir. 1997); Cheek v. Peabody Coal Co., 97 F.3d 200, 203 (7th Cir. 1996); Rush v. McDonald's Corp., 966 F.2d 1104, 1116 (7th Cir. 1992); *see also* Vance v. Union Planters Corp., 209 F.3d 438, 442 (5th Cir. 2000); Stone v. Autolive ASP, Inc., 210 F.3d 1132, 1140 (10th Cir. 2000).

173. 227 F.3d 1024 (7th Cir. 2000).

174. *Id.* at 1028.

175. *Id.* at 1025. The court explained:

> We may assume without having to decide that this impairment was a sufficiently significant restriction on a major life activity to count as a disability within the meaning of the statue (although we have our doubts) thus placing on her employer, the defendant, the duty to find if possible,

As an attempt to accommodate Houser, the employer fire rigged an apron that was to help her carry items using only her good arm. The EEOC characterized the apron as not being a "meaningful" attempt to accommodate, but Posner rejected the EEOC view as "too strong," finding the apron to be a "failed experiment, undertaken in good faith so far as it appears and not obviously doomed to fail from the start."[176] Posner criticized the EEOC, stating the such experimentation should not be discouraged by deeming failed accommodation attempts as unreasonable "with the wisdom of hindsight," something Posner thought "seems to be the Commission's view."[177]

The Seventh Circuit then addressed the question of other accommodations. Houser was given a "light job as a greeter" at a company construction site but the job disappeared when the construction finished. The issue in the case then became Houser's ADA right to "several vacant clerical positions for which Houser was qualified in the sense of having at least the minimum qualifications for the position. She applied for these positions but in each case was turned down in favor of another applicant, and as a result was eventually let go by the company."[178] Posner found that giving the clerical positions to the other applicants did not violate the ADA because "[t]he EEOC does not deny that in every case the applicant chosen for the job was better than Houser in the sense of likely to be more productive."[179]

According to Posner, there was no dispute that the company had a policy of "giving a vacant job to the best applicant rather than the first qualified one" and that none of the clerical jobs "involved a degree of lifting that [Houser's] disability would have interfered with her performing." Further, Posner found that the EEOC had not "suggested that the defendant harbors any animus toward disabled workers."[180] Under these premises, Posner rejected the EEOC argument that the ADA requires that disabled workers be accommodated by assigning them another open job in the company if they are

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> a 'reasonable accommodation' of Houser's disability that would enable her to remain in the company's employ.

Id. (citations omitted). *See* 42 U.S.C. §§ 12101-12114 (defining disability and prohibiting discrimination against disabled, requiring reasonable accommodations of disabled workers).

176. *Humiston-Keeling, Inc.*, 227 F.3d at 1025.

177. *Id.*

178. *Id.* at 1026-27.

179. *Id.* at 1027.

180. *Id.*

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minimally qualified for the position unless the employer can demonstrate "undue hardship."[181]

In addition to raising burdens on employers, Posner suggested that the EEOC position would create difficult conflicts in antidiscrimination law. What if, for example, one of Houser's competitors for a clerical position is black and another Hispanic. Would the EEOC then not be advocating that the disabled have more protection against discrimination than ethnic or racial minorities, or women (which could have been an issue if Houser were male)?[182] Posner emphasized that the ADA "does not command affirmative action in hiring or firing."[183]

> [T]here is a difference, one of principle and not merely cost, between requiring employers to clear away obstacles to hiring the best applicant for a job, who might be a disabled person or a member of some other statutorily protected group, and requiring employers to hire inferior (albeit minimally qualified) applicants merely because they are members of such a group. That is affirmative action with a vengeance. This is giving a job to someone solely on the basis of his status as a member of a statutorily protected group. It goes well beyond enabling the disabled applicant to compete in the workplace, or requiring the employer to rectify a situation (such as lack of wheelchair access) that is of his own doing.[184]

The court added that the ADA does not require an employer to promote an employee as a reasonable accommodation. Although the EEOC had not advocated promotion as accommodation, Posner could not resist driving a stake through the heart of any such argument and in trying to use the EEOC's moderation on this point against it concerning the clerical positions, which were initially assumed to be a "lateral move" rather than a promotion. "Promotions are a subset of reassignments. A promotion is merely a reassignment to a better job -- and so the Commission's concession shows that

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181. *Id.*

182. *Id.*

183. *Id.* at 1028 (citing Matthews v. Commonwealth Edison Co., 128 F.3d 1194, 1196 (7th Cir. 1997)).

184. *Id.* at 1028-29.

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even the Commission does not interpret the duty of reassignment literally."[185]

Posner then opined on the relative desirability of clerical jobs-vs.-warehouse jobs, neither of which he appears to have ever done.

> Economists since Adam Smith have taught that part of a wage is compensation for whatever disamenities the job involves. . . . No doubt some people prefer the more strenuous job, perhaps to control their weight, perhaps because they find desk jobs insufferably boring; but it seems a fair generalization that most desk jobs are "better" in the sense we're using than factory or other physically demanding jobs that pay no more, other things being equal.[186]

Tempted to make the "ADA does not require promotion" conclusion a holding, Posner refrained because it might be argued that the warehouse job was nonetheless "better" because of the possibility of overtime work and pay. This uncertainty operated to

> make us prefer to rest decision on the alternative ground that the ADA does not require an employer to reassign a disabled employee to a job for which there is a better applicant, provided it's the employer's consistent and honest policy to hire the best applicant for the particular job in question rather than the first qualified applicant.[187]

In *Humiston-Keeling*, Posner's decision is certainly defensible (the ADA was designed to level the playing field but not give disabled workers preferred status) but appears to stack the decisional deck, perhaps simply because the EEOC permitted it. Posner suggests both that Houser is less qualified than the other candidates and that such qualifications can be known with considerable certainty and accuracy. His vision of personnel management is one in which the applicants for a vacant clerical position can be rank-ordered with precision, the human equivalent of interval data in social science.

Although this type of "scientific" applicant ranking may be possible according to some dimensions (e.g., Candidate A may type 75 words per minute while Candidate B types 45 words per minute), Posner's view sets forth something of a false precision about evaluating workers -- false

185. *Id.* at 1029.
186. *Id.* (citation omitted).
187. *Id.*

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precision used to defeat the EEOC and Houser. When the question is framed as whether the ADA requires a company to shift a disabled worker to an open job at the expense of refusing to hire a clearly "more qualified" person, the EEOC and the statute are made to look foolish, with the Commission trying to make the ADA affirmative action on steroids.

If one views the actual, empirical world of hiring more like I do and less like Posner, the EEOC position in *Humiston-Keeling* becomes considerably less radical. Rather than interpreting the ADA to force employers to hire the weakest workers just because of disability, the statute then looks more like something of a "super tie-breaker" that requires reassignment of an open job to the formerly productive disabled worker even if other applicants arguably have "better" qualifications. Perhaps Posner is right and Houser in the clerical position will not approach the productivity of the "best" candidate in practice. But perhaps I am right and Houser in practice will be roughly as good as the other leading applicants because of her experience, knowledge of the company, relations with other workers, and loyalty to the organization, even if her typing is a little slower.

Under this scenario, it is arguably not at all radical at all to interpret the ADA as requiring that Houser get a shot at an open clerical position (she would not be bumping another worker from the position; if there were no open positions, the ADA would not require the employer to fire someone else to make room for Houser) when she is unable to work at her warehouse job because of disability. In addition, the EEOC position takes into account something Posner appears not to appreciate. Even though Houser might be roughly as good as the "best" competing job applicant, employers may find disabled employees irritating and discomforting, making the employer too quick to find ways of removing the disabled worker. The ADA was passed in large part to engage law in forcing employers (and governments) to overcome this (often unconscious) bias and to go the extra yard for such workers, even if not the extra mile.

On the facts of Houser, this argument of mine is not particularly compelling. Houser is not badly disabled and the employer appears to have acted in good faith. Five pounds is not a lot to lift (although it could be over the course of a day) and Posner might suspect she is malingering. But his suspicions are the stuff of jury consideration, not judicial pretrial decisionmaking. In addition, what if Houser were in a wheelchair or were hideously disfigured as part of her disability? In such a case, prejudice against the disabled might well be a factor in the employer preferring to hire

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a "better" applicant for the secretarial post. In that sort of case, the EEOC position looks more reasonable and Posner's view of the ADA too limiting.

These are fact-based disagreements of course. My point simply is that Posner's approach in *Humiston-Keeling* suggests some of the historical Posner insensitivity toward the realities of the workplace. It also suggests resistance to a remedial statutory scheme. Posner is exerting himself a bit to keep the ADA from receiving an expansive interpretation even though the agency charged with implementing and enforcing the statute is urging such an interpretation. One would ordinarily expect more judicial deference to the EEOC -- unless the judge just doesn't like the statute or government intrusion on employer prerogatives.

Thus far in employment discrimination cases, we see a centrist Posner offering useful analysis but reflecting restraint to the point of lack of enthusiasm in enforcing antidiscrimination laws. When he talks at all about workplace context, it tends to be from the perspective of the employer, as if he were seeking to persuade the reader that employers are not generally unreasonable and that one should not be too quick to find discrimination in adverse employment actions. Prior to the 1990s, Posner had expressed the view that many job discrimination actions were brought by workers who were merely disgruntled rather than victimized.[188] But these decisions and their rhetoric are defensible, despite falling short of the neutrality and insight Posner tends to display in his insurance opinions. *DeClue v. Central Illinois Light Co.*,[189] however, suggests that the thoroughly modern Posner still fails to "get it" regarding job discrimination.

In *DeClue*, plaintiff was an apprentice lineman for the utility. She alleged numerous acts of discrimination taking place prior to filing her suit, but Posner (joined by Judge Bauer) found for the defendant. First, Posner ruled many of the most egregious incidents out of consideration as occurring prior to the 300-day time limit for bringing a discrimination claim.[190] Second, Posner found that the continuing alleged discrimination (failure to provide restroom facilities for her) did not raise a triable claim of a hostile work environment or disparate treatment.[191]

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188. *See* Richard A. Posner, *Coping With the Caseload: A Comment on Magistrates and Masters*, 137 U. PA. L. REV. 2215, 2216 (1989). Posner also took the view that the increase in discrimination was a substantial part of a perceived court congestion problem. *Id.*

189. 223 F.3d 434 (7th Cir. 2000).

190. *Id.* at 436.

191. *Id.*

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This history of harassment was deemed nonactionable by Posner on statute of limitations grounds. In addition, he seems to have accorded the incidents no evidentiary value. Because of the interests in leaving the past behind embodied in a statute of limitation, a court may be required not to hold someone liable for past acts too far in the past -- but certainly those incidents should have some bearing upon how a reasonable fact-finder might construe a current failure to provide toilet facilities to the one woman worker on the crew.

As to the continuing toilet denial, Posner found as a matter of law that this could not be gender discrimination. Once again, Posner's sensitivity antennae tilt toward employer rather than employee as he views the context as one of logistical difficulty or economic efficiency rather than the worker's actual work context.

> Linemen work where the lines are, and that is often far from any public restroom; nor do the linemen's trucks have bathroom facilities. Male linemen have never felt any inhibitions about urinating in the open, as it were. They do not interrupt their work to go in search of a public restroom. Women are more reticent about urinating in public than men. So while the defendant's male linemen were untroubled by the absence of bathroom facilities at the job sight, the plaintiff was very troubled.[192]

But, according to Posner this was not sexual harassment or a hostile work environment. It might be qualify as disparate impact gender discrimination because a facially neutral policy (no port-a-potties traveling with the line crew) impacts more negatively on women. "But this case has not been litigated as a disparate impact case."[193] In other words, DeClue must lose as a matter of law because of the demands of the adversary system and Posner's formalistic characterization of the claim.

> By failing to present her case as one of disparate impact, the plaintiff prevented the defendant from trying to show that it would be infeasible or unduly burdensome to equip its linemen's trucks with toilet facilities sufficiently private to meet the plaintiff's needs. She waived what may have been a perfectly good claim of sex discrimination.[194]

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192. *Id.*
193. *Id.* at 437.
194. *Id.*

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In contrast to the insurance cases, where Posner displays even-handed contextualism, in employment cases Posner's sensitivity runs toward the employer. It might have been annoying to remand the case and reopen discovery or to allow a jury to address the hostile work environment case that perhaps should have been framed as a disparate impact case, but this surely could have been done to resolve the issue, particularly when there is such an aroma of harassment surrounding DeClue's tenure on the line crew. However, Posner's highest priority appears to be avoiding "unfairness" to the employer and undermining the "you live with your tactical decisions" ethos of the adversary system.

Posner also elevates a formalist devotion to doctrine above service to the norms embodied in the statutes and the reality of the workplace.

> [I]t might be possible to argue that an employer who fails to correct a work condition that he knows or should know has a disparate impact on some class of his employees is perpetuating a working environment that is hostile to that class. But if this argument were accepted, it would make disparate impact synonymous with hostile work environment.[195]

Contrast Posner's approach in *DeClue* with his insurance law opinions discussed above. In the insurance cases, Posner is not looking to decide policy coverage and the like according to counsel's possibly erroneous framing of the question; he is looking to make the right determination by allowing appropriate reference to the overall purpose of the policy and context of the risk-bearing taken on by the parties. He is even willing to do some heavy lifting legal research (or at least keep his law clerks under the lash) to flesh out contract doctrines such as "mend the hold"[196] or to explain in some detail the nature of the Insurance Services Office.[197] But in a gender discrimination case, Posner is happy to boot the claim out of court because it was in his view improperly framed.

Judge Illana Diamond Rovner's dissent properly rejected both Posner's formalism and his curious detachment from workplace reality in her dissent in *DeClue*. Her dissent deserves quotation at length.

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195. *Id.*

196. *See supra* notes 61-87 and accompanying text (discussing Posner's opinion in *Harbor Insurance Co. v. Continental Bank Corp.*, 922 F.2d 357 (7th Cir. 1990)).

197. *See supra* notes 33, 41 (discussing *Great Central Insurance Co. v. Insurance Services Office, Inc.*, 74 F.3d 778 (1996)).

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> Women know that this disparity [of restroom facilities], which strikes many men to be of secondary, if not trivial, importance, can affect their ability to do their job in concrete and material ways. As recently as the 1990s, for example, women elected to the nation's Congress -- which had banned gender discrimination in the workplace some 30 years earlier -- found that without careful planning, they risked missing the vote on a bill by heeding the call of nature, because there was no restroom for women convenient to the Senate or the House chamber.
>
> . . . .
>
> The fact is, biology has given men less to do in the restroom and made it much easier for them to do it. If men are less reluctant to urinate outdoors, it is in significant part because they need only unzip and take aim. And although public urination is potentially a crime whether committed by a man or a woman, the risk of being caught in the act is arguably greater for women, for whom it is a more cumbersome, awkward, and time-consuming proposition. [Therefore, the lack of facilities for women workers] can support a disparate-impact claim for female employees.
>
> But there are respects in which the refusals to provide female employees with restrooms can be understood as creating a hostile work environment as well. . . . [W]hen, in the face of complaints, an employer fails to correct a work condition that it knows or should know has a disparate impact on its female employee -- that reasonable women would find intolerable -- it is arguably fostering a work environment that is hostile to women, just as surely as it does when it fails to put a stop to the more familiar types of sexual harassment. Indeed, the cases teach us that some employers not only maintain, but deliberately play up, the lack of restroom facilities and similarly inhospitable work conditions as a way to keep women out of the workplace.
>
> The evidence in this case supports a hostile environment claim. . . . I dare say that if the tables were turned, and all but one of the employees in this environment were women, a reasonable man would be equally reticent to drop his trousers

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> in order to relieve himself. . . . The defendant's failure to remedy the problem in turn could be viewed as a negligent response that subjects it to liability for a hostile work environment.
>
> *Discrimination in the real world many times does not fit neatly into the legal models we have constructed. . . . Because prejudice and ignorance have way of defying formulaic constructs, the lines with which we attempt to divide the various categories of discrimination cannot be rigid.* DeClue's complaint, insofar as it concerns the lack of restroom facilities, may fit more naturally into the disparate-impact framework that my colleagues discuss, but it also overlaps with the hostile environment framework into which she has placed it. It should be allowed to proceed within that framework.[198]

Rovner's treatment of the issue -- contextual, comprehensive, pragmatic, empirical (not statistics and graphs but an appreciation of the real world), and sensitive -- reminds me of Posner's insurance opinions. If only Posner's discrimination opinions reminded me of his insurance opinions.

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198. *DeClue*, 223 F.3d at 436-38 (citations omitted) (emphasis added). Judge Rovner aptly noted that the disparate impact theory itself was not drawn from the language of the statute or the express intent of the enacting Congress but was a wise judicial response to recognition that facially neutral rules could in application be discriminatory. *Id.* at 439-40. She also noted one famous instance where the Supreme Court embarrassed itself with excessive formalism when the Court in *General Electric Co. v. Gilbert*, 429 U.S. 125 (1976), held that pregnancy discrimination was not covered by Title VII because the employer-provided health insurance plan under attack differentiated only according to pregnancy rather than gender, ignoring that only women become pregnant. Congress swiftly acted to amend the statute to overrule the *Gilbert* decision. *Id.* at 440 n.4. *See also* Vicki Schultz, *Telling Stories About Women and Work: Judicial Interpretations of Sex Segregation in the Workplace in Title VII Cases Raising the Lack of Interest Argument*, 103 HARV. L. REV. 1749 (1990) (*cited in* 223 F.3d at 439) (Rovner, J., dissenting) (arguing that much male behavior in workplace is designed to exclude women or make them sufficiently uncomfortable so that they will leave or at least accept subservient status).

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III. POSNER AT THE INTERSECTION OF INSURANCE, EMPLOYMENT, AND CIVIL RIGHTS: *DOE V. MUTUAL OF OMAHA INSURANCE CO.* AS MICROCOSM

In *Doe v. Mutual of Omaha*,[199] the Seventh Circuit per Judge Posner ruled that a health insurance policy's exclusion of or cap on AIDS-related medical expenses does not violate the Americans with Disabilities Act (ADA) and that the McCarran-Ferguson Act also precludes an employee insured's challenge to the exclusion. The reconciliation of the ADA with the contract-based framework of insurance law presents difficult questions similar to those faced by courts in ruling on conflicts between discrimination statutes and insurance or pension plans.

Mutual of Omaha provides a reasoned and defensible analytic path in finding no ADA bar to the coverage exclusions at issue but, as reflected in the dissent in the case and commentary such as the note in this issue of the *Connecticut Insurance Law Journal*,[200] many disagree with Posner's view. The decision has a bit of the offhand, dispassionate tone that makes Posner's "pure" insurance opinions so good but can seem like lack of empathy toward or even scorn for the plight of the less fortunate worker or policyholder. But there is much less of this in *Mutual of Omaha* than one can find in earlier Posner discrimination opinions, just as there is much less of this in Posner's more recent discrimination and employment law opinions that do not touch upon insurance.[201]

Mutual of Omaha is a confluence of important insurance, discrimination, and jurisprudential forces, including the interpretation of two major statutes (the ADA and the McCarran-Ferguson Act). Initially reading the case, I was

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199. 179 F.3d 557 (7th Cir. 1999), *rehearing en banc denied*, 1999 U.S. App. LEXIS 18360 (Aug. 3, 1999), *cert. denied*, 528 U.S. 1106 (2000).

200. *See* Lori Bloch Izzo, Note, *Doe v. Mutual of Omaha Insurance Company: The ADA Does Not Regulate the Content of Insurance Policies, But What Have Cameras, Braille Books, or Wheelchairs Got to Do With It?*, 7 CONN. INS. L.J. 263 (2000).

201. *See* McGinley & Stempel, *supra* note 16, at 245-59 (contending that Posner is frequently dismissive of discrimination claimants and often resistant to discrimination law claims). Despite the critical posture of much of this article, it should not be overlooked that Posner deserves credit for some positive evolution in this realm. In *Mutual of Omaha Insurance Co.*, Posner can perhaps be faulted for insufficient appreciation of the practical realities facing the average worker in need of health insurance protection but *Mutual of Omaha Insurance Co.* does not reflect the "let them eat cake" tone of some of his employment opinions like *DeClue* and *Troupe*.

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unhappy with the bottom line result of reduced insurance security for the AIDS-afflicted but persuaded by Posner's analysis of the ADA-Insurance conflict. So viewed, *Mutual of Omaha* can be seen as an example of Posner's cool logic saving a court from the excessive pull of empathy for the disabled. But upon further examination of the decision, I have come to see *Mutual of Omaha* as incorrectly decided and once again revealing the "soft spots" in Posner's legal philosophy in application, at least where remedial statutes and antidiscrimination are concerned. *Mutual of Omaha* was more discrimination case than insurance case and Posner's resulting opinion is consequently more unsatisfactory than satisfactory.

The ADA states that "no individual shall be discriminated against on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation" by the owner of the operation. The sale of an insurance policy can be said to be the sale of a good or service. However, Posner found that the ADA language at issue had a "core meaning" of prohibiting a business from refusing to deal with the disabled. According to the panel majority, the ADA does not prevent a business from differentiating its products in a way that may impact upon the disabled.

> [A] dentist cannot refuse to fill a cavity of a person with AIDS unless he demonstrates a direct threat to safety or health, and an insurance company cannot (at least without pleading a special defense [of actuarial need discussed later in the opinion and this article]) refuse to sell an insurance policy to a person with AIDS. Mutual of Omaha does not refuse to sell insurance policies to such persons -- it was happy to sell health insurance policies to the two plaintiffs. But because of the AIDS caps, the policies have less value to persons with AIDS than they would have to persons with other, equally expensive diseases or disabilities. This does not make the offer to sell illusory, for people with AIDS have medical needs unrelated to AIDS, and the policies give such people as much coverage for those needs as the policies give people who don't have AIDS.[202]

202. *Mut. of Omaha Ins. Co.*, 179 F.3d at 559 (citations omitted).

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The court continued:

> The common sense of the [ADA] statute is that the content of the goods or services offered by a place of public accommodation is not regulated. A camera store may not refuse to sell cameras to a disabled person, but it is not required to stock cameras specially designed for such persons. Had Congress proposed to impose so enormous a burden on the retail sector of the economy and so vast a supervisory responsibility on the federal courts, we think it would have made its intention clearer and would at least have imposed some standards. It is hardly a feasible judicial function to decide . . . how many Braille books the Borders or Barnes and Noble bookstore chains should stock in each of their stores.[203]

Posner concluded that prohibiting AIDS caps for insurers willing to write health policies would make little sense when insurers retained the right to refuse to cover any pre-existing conditions related to AIDS or HIV-positive status, where "the insurer can in effect cap his AIDS-related coverage at $0."[204] Consequently, Posner did not regard it as counter to the ADA for the insurer to attach some limits on AIDS-related coverage since the insurer has substantial power to refuse to insure HIV-positive applicants altogether.

In making this argument, however, Posner failed to expressly note what I regard as a rather significant distinction: a refusal to cover pre-existing conditions does not preclude coverage for that condition per se -- even expensive coverage -- should the condition develop after the policy is in effect. Thus, Posner permits insurers to not only refuse to write coverage for persons that already have AIDS but also allows insurers to limit or exclude coverage should the originally HIV-free policyholder develop AIDS complications at some later date. As a practical matter, the distinction may mean a large difference in the number of ultimately covered persons and benefit dollars ultimately provided.

In addition, a health insurer's ability to preclude coverage of AIDS on pre-existing condition grounds is limited by practical considerations. Most health insurance is sold in group policies where the group is underwritten as a whole with minimal or no investigation of individual insureds. Of a pool of insureds, a certain percent may already have HIV-positive blood but it will

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203. *Id.* at 560.
204. *Id.* at 559.

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not be possible to know this with certainty years later when these insureds begin developing symptoms requiring physician treatment. This suggests that what Mutual of Omaha did (capping AIDS benefits) is indeed more dramatically adverse to the insured than the standard insurer practice of excluding the pre-existing condition. Although one can defend insurers on this point because they can be victimized by adverse selection, countervailing factors help the insurer. First, because group health insurance usually comes through a job, there are practical limits on adverse selection (people are not as likely to change jobs just to get insurance as they are to simply apply for insurance knowing they are in a high risk group). Second, employer-provided health insurance is subject to ERISA, which can make for deferential review of adverse coverage decisions.[205]

Posner buttressed his view by noting that other appellate cases had given similar construction to the ADA, even though several district court cases, including the trial court in *Mutual of Omaha*, had found disparate AIDS caps to violate the ADA.[206] These appellate cases essentially state that disparate benefit structures do not violate the ADA merely because they fall more adversely upon disabled persons so long as the disparate benefit schedule is not directed at disabilities per se.

In addition to assessing the ADA, Posner concluded that even if his interpretation of the ADA "is wrong, the [*Doe*] suit must fail anyway, because it is barred by the McCarran-Ferguson Act."[207]

> That Act [McCarran-Ferguson], so far as bears on this case, forbids construing a federal statute to "impair any law enacted by any State for the purpose of regulating the business of insurance . . . unless such Act specifically relates to the business of insurance." . . . Direct conflict with state law is not required to trigger this prohibition; it is enough if the interpretation would "interfere with a State's administrative regime." The interpretation of section 302(a) of the Americans with Disabilities Act for which the Plaintiffs contend would do this. State regulation of

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205. *See* supra notes 125-35 and accompanying text (discussing the *Herschenberger* case).

206. *See, e.g., Ford v. Schering-Plough Corp.*, 145 F.3d 601, 612-14 (3d Cir. 1998); *Parker v. Metro. Life Ins. Co.*, 121 F.3d 1006, 1010-14 (6th Cir. 1997) (en banc); *Vaughn v. Sullivan*, 83 F.3d 907, 912-13 (7th Cir. 1996).

207. *Mut. of Omaha Ins. Co.*, 179 F.3d at 563.

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> insurance is comprehensive and includes rate and coverage issues, so if federal courts are now to determine whether caps on disabling conditions (by no means limited to AIDS) are actuarially sound and consistent with principles of state law they will be stepping on the toes of state insurance commissioners.[208]

Both the majority and dissenting opinion set forth thoughtful and strong arguments. Not surprisingly, the unsuccessful plaintiff policyholders petitioned for rehearing before the entire Seventh Circuit. It is perhaps similarly unsurprising that the full circuit court of 12 judges split 7 to 5 on the issue of whether to grant a rehearing of the *Mutual of Omaha* case before the full Court.[209]

Although the majority of other cases on the issue, particularly appellate opinions, accord with the *Mutual of Omaha* majority rather than with the dissent, there is sharp division on the issue among federal judges.[210] For example, the Seventh Circuit was closely divided on the issue. The more "conservative" members of the Court supported the Posner opinion while the more "liberal" members of the Court voted to grant rehearing, but the judicial split on this issue is not uniformly ideological, either in the Seventh Circuit or other courts. To date, however, the Supreme Court has avoided the matter, denying certiorari in *Mutual of Omaha* and similar cases.[211]

Mutual of Omaha is the type of difficult case that makes me happy not to be a judge. Historical, practical, and textual information points in both directions on the issues in the case.[212] Posner's McCarran-Ferguson analysis seems more persuasive than his ADA analysis: If the ADA is to have this much impact on insurance, traditionally a subject of state regulation, would one not have expected more indication from Congress? The ADA provides that it

> shall not be construed to prohibit or restrict --
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> (1) an insurer, hospital or medical service company, health maintenance organization, or any agent, or entity that administers benefit plans, or similar organizations from

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208. *Id.* at 563-64 (citations omitted).
209. Doe v. Mut. of Omaha, No. 98-4112, 1999 U.S. App. LEXIS 18360 (7th Cir. 1999).
210. *See* Izzo, *supra* note 200, at 267-71 (summarizing case law).
211. Doe v. Mut. of Omaha Ins. Co., 528 U.S. 1106 (2000) (denying certiorari).
212. For a description of the ADA and its operation, *see generally* Izzo, *supra* note 200.

> underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with State law; or
>
> (2) a person or organization covered by this chapter from establishing, sponsoring, observing, or administering the terms of a bona fide benefit plan that are based on underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with State law; or
>
> (3) a person or organization covered by this chapter from establishing, sponsoring, observing, or administering the terms of a bona fide benefit plan that is subject to State laws that regulate insurance.
>
> Paragraphs (1), (2), and (3) shall not be used as a subterfuge to evade the purposes of subchapter I and III of this chapter.[213]

In drafting the ADA, Congress went out of its way to state that insurers were not in violation of the Act if their insurance policies were supported by valid and nonpretextual actuarial reasons for a coverage restriction that adversely affected the disabled.[214] Why would a rational legislature take the time to do this if the content of insurance policies was not subject to the Act? Posner has no good answer to this query. His failure to adequately explain away the "safe harbor" provisions of the law is ultimately the strongest reason suggesting that his *Mutual of Omaha* opinion is wrong on this point.

It is also the strongest reason for thinking that his McCarran-Ferguson analysis is also mistaken. The "safe harbor" language expressly states that the actuarial administration of the insurance policies offered must be "based on or not inconsistent with State law" in order to dock at the "safe harbor". In other words, the Act suggests that insurer behavior under the ADA must comport with the state regulatory scheme governing the policy in questions. This suggests that Congress has spoken with the requisite clarity to overcome the McCarran-Ferguson Act's general presumption against federal law inadvertently displacing or overriding state insurance regulation.

Although not presented for decision in the *Mutual of Omaha* case, the ADA "safe harbor" language also suggests that if the ADA's antidiscrimination edict is in conflict with state law, the insurer is protected from this aspect of the ADA so long as the alleged discriminatory risk

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213. 42 U.S.C. § 12201(c)(1)-(3) (2001); *see also* Izzo, *supra* note 200, at 288-300 (discussing "safe harbor" provision).

214. 42 U.S.C. § 12201(c)(1) (2001).

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classification is shown to be "based on" state law. Thus, if insurers can persuade state regulators to mandate or expressly permit differential coverage to the disabled, the insurance policies would not be rewritten by federal courts applying the ADA nor would insurers be subject to liability. Frankly, as a liberal, I'm not sure I like what this part of the statutory scheme is saying. Insurers have historically proven quite adept at getting what they want from state regulators (something that Posner, as a pragmatist and economist familiar with public choice literature must surely appreciate). To the extent insurers are successful lobbyists with regulators on matters of differential coverage for the disabled, the ADA does not appear to prohibit this, although in blatant cases, courts may deem such state regulation urged by industry to be a subterfuge violating the statute. Nonetheless, state regulators, who are responsive to the insurance industry but also responsible to state politics, may be the best source of final decision on these issues.

Of course, the abstract existence of the ADA "safe harbor" without concrete state regulatory pronouncements on matters of AIDS coverage does not suggest the broad-based immunity found by Posner in *Mutual of Omaha*. It does not follow that the ADA may not be applied to insurers simply because under the ADA and McCarran-Ferguson, state regulation might permit insurers to discriminate because they "have to" to maintain the financial integrity of their risk pools. As Judge Evans stated in dissent in *Mutual of Omaha*, the defendant insurer's stipulation that the "safe harbor" was not at issue removed this defense from the case. Without this defense, the ADA appears applicable by its terms and the state regulation is not at issue, meaning McCarran-Ferguson is not at issue.

Judge Posner's best point is suggesting that the ADA "dog" did not "bark" loudly enough to indicate that Congress really wanted to intrude on traditional state regulation through the ADA.[215] Certainly, greater clarity on

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215. In statutory interpretation matters, a number of scholars and Justices Stevens and Rehnquist have stated that they find it significant when Congress is silent when one would have expected express Congressional commentary on issues of significant change in the law. For example, if Congress in a new statute stated only that "no law should treat Americans differently because of their wealth", few would interpret this as a legislative abolition of the income tax or the estate tax, substantial changes in the law for which one would expect Congress to make noise, "bark" if you will. The analogy comes from the A. Conan Doyle Sherlock Holmes story *Silver Blaze*, in which the racehorse named in the title is quietly stolen from the stables without the family watchdog barking. Holmes correctly concludes the dog's failure to bark meant that the thief was someone familiar to the dog who did not arouse suspicion. A. CONAN DOYLE, THE COMPLETE SHERLOCK HOLMES 35, 349 (1927) (reprinting

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this point would be appreciated. But we are talking about legislation, which emerges in a muddle of compromise and expediency. Despite this, the ADA pretty clearly states that nondiscrimination is the rule in insurance[216] unless insurers can, consistent with their state law regulatory regimes, demonstrate that they need to discriminate in order to maintain solvency. The dog is not howling, but it is probably barking loudly enough for anyone willing to listen.

Instead of listening with a judicially open mind, Posner strains to characterize this portion of the actuarial "safe harbor" as the insurance industry's extraction of exculpatory language from Congress in case the ADA is "given just the expansive interpretation that the district court gave it in this case."[217] To Posner, the "safe harbor" provision, because it is "obviously intended for the benefit of insurance companies,"[218] must not auger for the *Mutual of Omaha* plaintiffs. But here Posner is just plain illogical. Of course the "safe harbor" was intended to protect insurers where their business requires disability discrimination to maintain solvency. But that's got to be because the Act otherwise governs their policies. If it did not, there would be no reason for the "safe harbor."

If, as Posner suggests, the "safe harbor" were added to the statute just to buttress the non-applicability of the statute to insurance policies, it would not read as it does (requiring a showing of actuarial need consistent with state regulation) but would simply say "this Act does not require insurers or employers to offer insurance coverage that does not adversely impact disabled policyholders" or similarly broad language. The insurance industry failed to obtain such super-exculpatory language and got only the "safe harbor" language, which requires insurers to demonstrate the actuarial need for disability discrimination. Mutual of Omaha stipulated away the right to

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story); *see, e.g.*, Chisom v. Roemer, 501 U.S. 380, 396 n.23 (1991) (using analogy); Church of Scientology v. IRS, 484 U.S. 9, 17-18 (1987) (Rehnquist, J.); *see also* WILLIAM N. ESKRIDGE, JR. & PHILIP A. FRICKEY, LEGISLATION: STATUTES AND THE CREATION OF PUBLIC POLICY 757, 834 (2d ed. 1995).

216. 42 U.S.C. § 12182(a) (2001). The "general rule" is that "[n]o individual shall be discriminated against on the basis of disability in the *full and equal enjoyment* of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation by any person who . . . operates a place of public accommodation." *Id.* (emphasis added). 42 U.S.C § 12181(7)(F) (2001) defines insurance offices as public accommodations.

217. Doe v. Mut. of Omaha Ins. Co., 179 F.3d 557, 562 (7th Cir. 1999).

218. *Id.*

make this argument, which means they stipulated away the right to use this defense. Judge Evans appreciates this; Judge Posner fails to appreciate it.

The ADA clearly defines an "insurance office" as a "public accommodation" subject to the Act[219] which means that insurance sales and service are clearly subject to the Act. This subjection leaves open the issue of whether the products sold by the insurer in the public accommodation insurance office must be nondiscriminatory. However, coupled with the "safe harbor" provision, which allows insurers product differentiation based on actuarial need, the inevitable conclusion is that the ADA does indeed require that the products offered at a public accommodation not be discriminatory.[220] In addition, the statute's language strongly suggests that the statute was designed to do more than simply allow disabled persons to enter businesses through the front door, stating that

> [i]t shall be discriminatory to afford an individual or class of individuals, on the basis of a disability . . . directly, or through contractual, licensing, or other arrangements with the opportunity to participate in or benefit from a [good or service] that is not equal to that afforded to other [nondisabled] individuals.[221]

Posner's opinion, while purporting to be grounded on a reading of statutory language, gives insufficient attention to this part of the statute[222] as well as failing to appreciate the significance of the "safe harbor" provision.

In addition, legislative history surrounding the ADA appears to favor the *Doe v. Mutual of Omaha* plaintiffs. A Senate Report on the bill stated that under the law, "a person with a disability cannot be denied insurance or be subject to different terms or conditions of insurance based on disability alone, if the disability does not pose increased risks."[223] The only exception to this discussed in the House or Senate Reports on the Act is the "safe harbor" for insurers who can demonstrate that "the refusal, limitation, or rate differential [adversely affecting disabled persons] is based on sound actuarial principles

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219. 42 U.S.C. § 12181(7)(F) (2001).

220. *See* Izzo, *supra* note 200, at 288-300.

221. 42 U.S.C. § 12182(b)(1)(A)(ii) (2001).

222. *See* Izzo, *supra* note 200, at 287 (discussing this language and Posner's incorrect focus on some statutory text to the exclusion of statutory text as a whole).

223. S. Rep. No. 106-16 at 84 (1989). The *Mutual of Omaha Insurance Co.* district court found this history significant. Doe v. Mut. of Omaha Ins. Co., 999 F. Supp. 1188, 1193-94 (N.D. Ill. 1998).

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or is related to actual or reasonably anticipated experience."[224] Against this evidence of statutory meaning, there appears to be no legislative history stating that the content of insurance policies is outside the ADA.

In addition, as noted by the trial court, Department of Justice interpretative guidelines favored the *Mutual of Omaha* plaintiffs.[225] The Department had in fact filed an amicus brief supporting the plaintiffs with the Seventh Circuit.[226] Posner accorded the Department *Chevron* deference, but not much of it.[227] One wonders whether he would have been so grudging if the Environmental Protection Agency were construing a law or regulation as exempting a business from the need to install expensive anti-pollution equipment. But, by the same token, Posner has a very good point in limiting his deference to the Department where the proffered interpretation comes internally and through amicus brief rather than from the "more deliberative, public and systematic procedure" of rulemaking[228] (or, for that matter, government-commenced litigation).[229]

Posner's *Mutual of Omaha* opinion also falters in other ways because of its lack of sensitivity to context. The policy in question capped benefits for health care expenses stemming from conditions related to AIDS --but the policy did not define this with any clarity. After *Mutual of Omaha*, a health insurer is not only permitted to cap benefits to disabled policyholders based on their disability but also is in a position to construe any doubtful expenses in its favor and give the disability discrimination excessive bite. For example, if an HIV-positive policyholder gets pneumonia or receives other treatment for flu, fatigue, arthritis, or other maladies, an insurer will be tempted to deny coverage on all of these, contending that the diseases are AIDS-related. But people without AIDS get the flu, pneumonia, arthritis, fatigue, and other maladies. Although the question of insurance policy construction was not directly before the Court, its broad holding of ADA immunity for insurers drafting policies surely will lead insurers to continue

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224. H.R. Rep. No. 101-485, pt. 2, at 136-37 (1990), *reprinted in* 1990 U.S.C.C.A.N. 303, 419-20, *cited with approval in* Doe v. Mut. of Omaha Ins. Co., 999 F. Supp. at 1193.

225. *Mut. of Omaha Ins. Co.*, 999 F. Supp. at 1194. *See* Izzo, *supra* note 200, at 275.

226. Izzo, *supra* note 200, at 281.

227. Under *Chevron, U.S.A., Inc. v. Natural Resources Defense Council*, 467 U.S. 837, 844 (1984), courts are to grant considerable deference to the reasonable interpretation of a statute proffered by the agency responsible for the statute's administration.

228. Doe v. Mut. of Omaha Ins. Co., 179 F.3d 557, 562-63 (7th Cir. 1999).

229. Izzo, however, has a strong response to this aspect of Posner's *Mutual of Omaha Insurance Co.* opinion. *See* Izzo, *supra* note 200, at 293-95.

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using similarly vague policy language and to resolve cases in their favor at the expense of disabled policyholders. Judge Evans's dissent expressly recognized that the practical effect of allowing a cap on coverage for "AIDS-related conditions" is to give the insurer carte blanche discretion to deny claims made by insureds with AIDS. In *Mutual of Omaha*, Posner opens the door to the type of opportunistic insurer misbehavior he generally does not permit when deciding insurance coverage cases.

Posner also is guilty of suggesting greater government interference in the market than would ultimately result if the *Mutual of Omaha* plaintiffs prevail. He suggests that a victory for plaintiffs would threaten to require providers of goods and services to offer a product line catering to every manner of disability.[230] But this seems to be a bit too much *reductio ad absurdum*, even for judicial rhetoric. As one commentator suggests, "the real issue, however, concerns the *intentional* placement of a clause in an insurance contract that singles out individuals with a recognized disability for differential treatment where the insurer cannot defend its disparate treatment based on actuarially- or historically-based justifications."[231] Insurance is a product of sorts, but one with special aspects that require special judicial consideration.[232]

Where disability discrimination in an insurance policy (or other product or service contract for that matter) is express, a better reading of the ADA suggests that such discrimination violates the statute. Where a generically offered good or service is truly only incidentally less valuable to the disabled, courts can easily find this not to violate the ADA. In such cases, Posner's discussion of bookstores, shoes stores, and the like makes sense. For example, a person without legs cannot with a straight face allege that a shoestore discriminates because it sells pairs of shoes without leg-replacing prosthetic devices or that it charges extra for artificial legs that go along with shoes. Similarly, a one-leg amputee cannot complain that he must buy a pair of shoes at regular price rather than insisting on one shoe at half-price. But if a vendor expressly designs products to give them less value or greater cost for the disabled, both the text and the purpose of the ADA would seem

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230. *Mut. of Omaha Ins. Co.*, 179 F.3d at 562. Izzo suggests that Posner was unduly influenced by the doomsday predictions of the defendant in the litigation, which asserted in its briefs that the plaintiffs' position would "effect a sea change in the provision of every good and service throughout the American economy" and require that goods and services be tailored for every disability. *See* Izzo, *supra* note 200, at 291.

231. Izzo, *supra* note 200, at 291.

232. *Id.* at 301.

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applicable. A victory for the insureds in *Mutual of Omaha* would probably increase disputing costs at the margin because there will be greater need for adjudication of the vendor's motive and the application of the ADA's "safe harbor" provision. But this is an acceptable price to pay for enforcing the statute, not the drastic one suggested by Posner.

Further, Posner fails to appreciate practical realities of health insurance that would prevent a plaintiffs' victory in *Mutual of Omaha* from unraveling risk pools and the insurance system. *Mutual of Omaha* stipulated away the "safe harbor" defense of actuarial need, but this does not mean that it "cannot defend its disparate treatment based on actuarially- or historically-based justifications" as suggested by the otherwise excellent and persuasive Note in this issue of the Journal.[233] A stipulation is just that, a concession for purposes of the instant litigation. Stipulating may mean that the facts are inarguable or it may mean that the litigant seeks only a pure legal ruling. Mutual of Omaha may simply have sought a circuit court decision of no ADA applicability without the need to develop facts supporting its policy provisions. If it had lost before the Seventh Circuit, it would not have been precluded from developing an actuarial "safe harbor" defense in subsequent policyholder litigation. I suspect that insurers, if forced to litigate on "safe harbor" grounds, will generally do pretty well.[234] AIDS is a tragic disease that raises medical costs and may well require disparate treatment by health insurers by way of policy exclusions, benefit caps, or higher premiums. Posner and others may regard "safe harbor" adjudication as a recipe for wasteful litigation expense, but it is no justification for an unduly crabbed reading of the ADA or an unduly expansive reading of the McCarran-Ferguson Act.

Despite the difficulty presented in *Mutual of Omaha*, it appears that the decision is one where Posner's resistance to corrective legislation and government protection of the less powerful trumped his normally keen appreciation of the totality of the circumstances for insurance matters. Notwithstanding all his progressive evolution as a pragmatist judge, Posner is ultimately continuing to decide the close cases based on a personal philosophical preference for private sector prerogatives and an aversion to

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233. *Id.* at 287.

234. *See* Alan I. Widiss, *To Insure or Not to Insure Persons Infected with the Virus that Causes AIDS*, 77 IOWA L. REV. 1617 (1992) (explaining that persons with AIDS are often uninsurable or insurable only with exceptions or high premiums); Izzo, *supra* note 200, at 296-97.

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government legislation. As one commentator noted, Posner did not consider the sweeping nature of the statute.[235] In this regard, Arthur Leff's earlier criticism of Posner, that he respects human endeavor that amasses commercial wealth but not human endeavor that operates governments, continues to ring true.[236]

CONCLUSION

In the insurance context, Posner opinions consistently reflect such neutrality and nonpartisanship. As a political-psychological matter, he seems indifferent to policyholder-vs.-insurer, primary-vs.-excess, liability carrier-vs.-boiler-insurer, reinsurer-vs.-retrocessionaire. His employment opinions are less satisfying because of their occasional tone of preference for employers with corresponding insensitivity to workers alleging discrimination, injury, or intolerable conditions.

Although one perhaps cannot undo the subtle effects of Realism in judging, at least one can study it. Posner arguably falls short of the ideal in judging in some instances where he is faced with gritty types of workplace related claims or claims of workers he subconsciously appears to regard as lackluster, malingering, or unduly sensitive. In discrimination cases, he continues to have bouts of elitism, unreality, and insensitivity to the plight of worker complainants. In statutory interpretation matters, Posner is often excellent but also on many occasions tends toward a restricted scope of the statute in question, particularly statutes like the antidiscrimination laws in which the government overrides operation of the labor market or other business operations in pursuit of other social goals. His occasional "insensitivity" to workers and remedial legislation contrasts markedly with his consistent sensitivity to the operation of insurance, contracting, and commercial relations.

Why the contradiction? Or is it a contradiction? In assessing the pre-judicial Posner, Arthur Leff observed this inconsistency in the first edition of *Economic Analysis of Law*. Posner venerated the market but either did not realize or did not concede that this was a value choice. And, of course, by embracing the private sector and market as superior to a world shaped by legislation and enforcement, Posner implicitly embraced the status quo.

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235. Izzo, *supra* note 200, at 287.

236. Leff, *supra* note 2, at 480-81.

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> What this all means is that Posner has not played fair with the question of power, or inequalities thereof. He has made a very common move: *after* something of value has been distributed he has defined *taking* as illicit and *keeping* (except when paid) as in tune with the expressed wishes of the universe. . . . [B]y and large, the government is to have no role in even annoying those who choose to exclude others from what they already have. Keepers, keepers, so to speak.
>
> But why is that? Let us say I am naturally superior to a rich man in taking things, either by my own strength or by organizing aggregations of others (call them governments) to do my will. I am not much of a trader, but I'm one hell of a grabber. That's just the way things are.
>
> . . . .
>
> In brief, there seems to be some normative content in Posner's neo-Panglossianism after all. Only some kinds of inequality are to be accepted as unquestionable *grundnorm* upon which to base efficiency analysis. The transfers that come about against a background of wealth inequality are fine; any that come about against a background of inequality in strength, or the power to organize and apply strength, are unjustifiable. Some inequalities are more equal than others -- and all without reference to any apparent normative criterion at all.[237]

Even if one concedes for argument the inefficiency of antidiscrimination laws,[238] in particular the ADA, these laws appear to be clear instances where Congress and the vast majority of the public wanted nondiscrimination more

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237. Leff, *supra* note 2, at 480-81 (footnotes omitted) (emphasis in original).

238. There is, of course, debate within the legal academic community on this point. *Compare* RICHARD EPSTEIN, FORBIDDEN GROUNDS: THE CASE AGAINST EMPLOYMENT DISCRIMINATION LAW (1992); POSNER, *supra* note 98, at 336-340; Richard A. Posner, *An Economic Analysis of Sex Discrimination Laws*, 56 U. CHI. L. REV. 1311 (1989); Richard A. Posner, *The Efficiency and the Efficacy of Title VII*, 136 U. PA. L. REV. 513 (1987) (arguing that Title VII is inefficient) *with* John J. Donohue III, *Prohibiting Sex Discrimination in the Workplace: An Economic Perspective*, 56 U. CHI. L. REV. 1337 (1989); John J. Donohue III, *Further Thoughts on Employment Discrimination Legislation: A Reply to Judge Posner*, 136 U. PA. L. REV. 523 (1987); John J. Donohue III, *Is Title VII Efficient?*, 134 U. PA. L. REV. 1411 (1986) (arguing that Title VII is efficient).

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than it wanted market efficiency, in effect saying "you lose" to business objections. In addition, both Posner and Leff give short shrift to an important point: markets do not arise in a state of nature; they need government provided law and its enforcement to protect the wealth-creating exchange Posner so values. Without government, wealth is possible only if one is pretty good at maintaining a private army to conquer and occupy (and can pay one's mercenaries in the absence of effective legal tender). Under these circumstances, hostility or even resistance toward government-enacted statutes is unwarranted so long as the statutes are passed through good faith operation of the political process (e.g., not the result of bribery or other corruption).

Without doubt, Posner has emerged as a judge of note regarding insurance matters. Unfortunately, resistance to remedial legislation and overzealous econominalism continue to make Posner's work less admirable in other contexts.

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POSNER AND MORAL HAZARD

*Eric D. Beal**

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INTRODUCTION

Insurance is everywhere.[1] Americans "lead the world in per capita consumption of liability insurance," spending more than $75 billion per year, an amount equal to approximately 2% of the gross domestic product.[2] The presence of insurance, however, may cause insureds to be less concerned with avoiding a loss. In other words, if the insurer, not the insured, is on the hook for a loss, then the insured may invest less in care, e.g., driving less or more

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* For Lillian. The author is a graduate of the University of Connecticut School of Law, Class of 2000, and is currently a judicial clerk to the Honorable Justices Francis M. McDonald and Peter T. Zarella of the Connecticut Supreme Court. This paper originally was written for Professor Peter Siegelman's course on the economics of insurance, and I am grateful for his comments on an earlier draft.

1. Kent D. Syverud, *The Logic of Liability Insurance Purchases: On the Demand for Liability Insurance*, 72 TEX. L. REV. 1629 (1994). According to Syverud, "liability insurance pervades economic life in the United States." *Id.*

2. *Id.*

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slowly, installing smoke detectors, or eating a low fat diet. This is the problem of moral hazard.[3]

Practically all of the literature on moral hazard focuses on insureds' incentives and behavior. This Comment suggests that insurance organizations are also subject to the effects of moral hazard. The theory of moral hazard, in addition to providing insight into the behavior and incentives of insureds, also may explain, in part, insurers' actions. First, this Comment analyzes the operation of moral hazard in non-insurance contracts in two judicial opinions: *Outboard Marine Corp. v. Babcock Industries*[4] and *Harley-Davidson v. Minstar*.[5] Then, that analysis is applied to contracts between insurers and insureds in *Charter Oak Fire Insurance Co. v. Color Converting Industries Co.*[6] Finally, this Comment concludes that viewing insurers' incentives through the optic of moral hazard may enhance the traditional analysis of how moral hazard effects operate within the insurer-insured relationship.

Insurance has a close relationship with law; after all, in many instances, the legal system will be asked to force the responsible party to pay for a loss.[7] Despite its prevalence, insurance has received relatively little attention from legal scholars.[8] Richard Posner, a former law professor at the University of Chicago, and current Chief Judge of the United States Court of Appeals for the Seventh Circuit, recognizes the importance of insurance -- not just the business of insurance -- but also the ability of the insurance concept to explain a wide range of behavior.[9]

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3. "Moral hazard refers . . . to the tendency of insurance protection to alter an individual's motive to prevent loss." Steven Shavell, *On Moral Hazard and Insurance*, 93 Q.J. ECON. 541 (1979).

4. 106 F.3d 182 (7th Cir. 1997).

5. 41 F.3d 341 (7th Cir. 1994).

6. 45 F.3d 1170 (7th Cir. 1995).

7. Syverud, *supra* note 1, at 1633-34.

8. As Judge Posner has said, "I think it is a very fine idea for academic lawyers to pay more attention to insurance law, an understudied field . . . ." Letter from Richard Posner, to Tom Baker, Professor, University of Connecticut School of Law (Sept. 8, 1999) (on file with author).

9. Judge Posner has written over 300 opinions that mention the word "insurance." Many of these cases involve market insurance policies, *see, e.g.*, Chapter v. Montfort, Inc., 20 F.3d 286 (7th Cir. 1994) (exclusion under "criminal acts" provision) -- but many do not, and are instead concerned with contracts, welfare benefits, or torts, e.g., products liability. *E.g.*, Sutton v. A.O. Smith Co., 165 F.3d 561 (7th Cir. 1999) (contracts); Jenkins v. Bowling, 691 F.2d 1225 (7th Cir. 1982) (unemployment compensation); Clark Equipment Co. v. Dial Corp., 25 F.3d 1384 (7th Cir. 1994) (products liability). Posner's opinions have been widely influential; they are very often cited as precedent in other jurisdictions. Gordon Crovitz, *Winds of Change*

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Posner is one of the leading proponents of the law and economics perspective,[10] a perspective that seeks to explain the underpinnings and development of the common law in terms of economic efficiency.[11] Posner prolifically writes on the economics of law in academic journals, judicial opinions, books and other media.[12] According to some, Posner promotes the economics of law with zeal unbecoming of a federal appeals court judge,[13] and as a result he has alienated people on both ends of the political spectrum.[14] Indeed, Posner's refusal to sacrifice legal and theoretical integrity to political will may have cost him an appointment to the United States Supreme Court.[15] Posner has been successful in his efforts to put law and economics at the forefront of American jurisprudence, particularly in the areas of antitrust, securities, and the law of corporations.[16]

This Comment will discuss and expand upon Posner's use of the notion of moral hazard. Part I provides a brief history of moral hazard and the economic explanation for moral hazard. Part II discusses the insurance function of contracts. Part III will examine the Posner opinions that apply the moral hazard concept. This section applies Posner's and others' theories about risk and insurance to three Posner opinions that concern moral hazard effects. The implications of the idea that insurers also have moral hazard incentives are explored through one of Posner's insurance contract cases. That analysis suggests that the dynamic between insurer and insured may

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on the Bench, WALL ST. J., Mar. 15, 1985, § 1, at 24. (After only three years on the bench, Posner was cited as precedent in almost 1,000 decisions.)

10. *E.g.*, Stephen Wermiel, *Is Analysis Out of Touch? Scholars Blend Law, Economics*, WALL ST. J., Dec. 18, 1984, § 1, at 64.

11. RICHARD A. POSNER, ECONOMIC ANALYSIS OF LAW 23-24 (4th ed. 1992).

12. Crovitz, *supra* note 9.

13. Wermiel, *supra* note 10, § 2, at 64 ("[F]ew have carried [law and economics] as far as Judge Posner."). Judge Robert Bork has lamented that, "I tend to think [Judge Posner] overdoes the relevance of economics to everything." *Id. See also* 2 ALMANAC OF THE FEDERAL JUDICIARY 1999 [hereinafter ALMANAC].

14. ALMANAC, *supra* note 13, at 6 (quoting American Lawyer (1991)).

15. *Id.* ("[Posner] wins praise for intellectual honesty . . . but is considered flaky and unreliable by result-oriented conservatives and thus an unlikely Bush nominee. [He has a] paper trail full of provocative proposals like eliminating adoption agencies and selling babies on the open market, which would give liberal screamers a field day.").

16. Paul M. Barrett, *Influential Ideas: A Movement Called 'Law and Economics' Sways Legal Circles*, WALL ST. J., Aug. 4, 1986, § 1, at 1 ("Law and Economics has become the premier topic in legal academic circles, and it has dramatically changed teaching practices at major law schools.").

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usefully be understood in terms of moral hazards on both sides of the insurance contract.

I. MORAL HAZARD

In its infancy, the word "hazard" referred to a game of dice that survives today in a simplified version: craps.[17] Early insurers identified two kinds of hazards -- those that caused a loss, e.g., fires, and those that affected the likelihood or amount of a loss.[18] Later, in an attempt to avoid underwriting poor risks, insurers used the phrase 'moral hazard' as shorthand to describe the undesirable traits in an insured that might increase the probability of a loss.[19] These traits were not limited to a predisposition to commit fraud or arson, for example, but also included "bad character or habits, financial embarrassment, poor business practices, and over insurance."[20] Insurers also recognized that even people without any of these bad characteristics might be "tempted" into "carelessness and roguery."[21]

Economists' ideas about moral hazard focus on the same problem -- that insurance may reduce care or induce fraud -- but the "moral" aspect of good and evil is absent.[22] There is no god in economics. Economists speak in terms of incentives, not of moral character.[23] Before getting too far into

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17. Tom Baker, *On the Genealogy of Moral Hazard*, 75 TEX. L. REV. 237, 244 (1996).

18. *Id.* at 248.

19. *Id.* at 248-49.

20. *Id.* at 249. The 1867 edition of the Aetna Guide to Fire Insurance provided guidance to agents as how to spot moral hazard:

> What is the general character borne by the applicant? Are his habits good? Is he an old resident, or a stranger and an itinerant? Is he effecting insurance hastily, or for the first time? Have threats been uttered against him? Is he . . . popular or disliked? Is his business profitable or otherwise? . . . Is the stock reasonably fresh and new, or old, shopworn, and unsalable?

Id. at 250.

21. *Id.* at 251.

22. *E.g.*, Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. L. REV. 941 (1963); Richard Zeckhauser, *Medical Insurance: A Case Study of the Tradeoff Between Risk Spreading and Appropriate Incentives*, 2 J. ECON. THEORY 10 (1970); Isaac Ehrlich & Gary S. Becker, *Market Insurance, Self-Insurance and Self-Protection*, 80 J. POL. ECON. 623 (1972); Mark V. Pauly, *Overinsurance and Public Provision of Insurance: The Roles of Moral Hazard and Adverse Selection*, 88 Q.J. ECON. 44 (1974); John M. Marshall, *Moral Hazard*, 66 AM. ECON. REV. 880 (1976).

23. *E.g.*, Mark V. Pauly, *The Economics of Moral Hazard*, 58 AM. ECON. REV. 531 (1968). *But see* Kenneth J. Arrow, *The Economics of Moral Hazard: Further Comment*, 58 AM.

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moral hazard, it first would be helpful to briefly describe what may be meant by the term "insurance."

In its very broadest sense, insurance includes any circumstance that spreads risk.[24] Risks are spread through the law of averages and diversification.[25] This definition encompasses more than the relationship between an insurance company and a policyholder; it also includes other kinds of contracts, social welfare entitlements, and networks of community members or families.[26] Under this definition, "insurance," or risk spreading, is a malleable concept that may be applied to widely different situations. But to the extent that insurance alters the incentives of those who are able to displace the risk of loss onto someone else (usually an insurance company), if insurance is everywhere, then moral hazard is everywhere, too.[27]

As both insurers and economists recognize, moral hazard may take many forms: (1) the insured may intentionally cause a loss ("Type I"); (2) the insured may take less care to avoid a loss (which sounds like negligence) ("Type II"); (3) the insured may intentionally increase the amount of the loss ("Type III"); and (4) the insured may not take precautions to lessen the amount of a loss ("Type IV").

ECON. REV. 537, 538 (1968) ("Mr. Pauly's wording suggests that 'rational economic behavior' and 'moral perfidy' are mutually exclusive categories. No doubt Judas Iscariot turned a tidy profit from one of his transactions, but the usual judgment of his behavior is not necessarily wrong.").

This is not to say, however, that non-pecuniary incentives never motivate us. Social norms, peer pressure, guilt and love are all wonderful means of shaping behavior and law. *E.g.*, Cass R. Sunstein, *Social Norms and Social Roles*, 96 COLUM. L. REV. 903 (1996). And economists' notion of "utility" is broad enough to encompass the satisfaction one gets from meeting social expectations or feeling loved.

24. SAUL B. ACKERMAN, INSURANCE, A PRACTICAL GUIDE 3 (3d ed. 1948); JAMES L. ATHEARN, RISK & INSURANCE 25 (1977).

25. ROBERT COOTER & THOMAS ULEN, LAW AND ECONOMICS 49 (Bruce Kaplan ed., 2d ed. 1997).

26. Posner discusses the insurance function of contracts in ECONOMIC ANALYSIS OF LAW, *supra* note 11, at 102-07. Another example of insurance is in Carol Stack's ALL OUR KIN (1975). Stack documents how poor black residents of East St. Louis created elaborate social networks to distribute and share windfalls as well as losses. And the family example is easy: a friend of mine wrecked her car -- her parents paid for another one (a Volvo).

27. Joseph E. Stiglitz, *Risk, Incentives and Insurance: The Pure Theory of Moral Hazard*, 8 GENEVA PAPERS ON RISK AND INS. 4, 6 (1983) ("The more and better insurance that is provided against some contingency, the less incentive individuals have to avoid the insured event, because the less they bear the full consequences of their actions.").

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Type I includes arson, paying someone to steal your car or kill your spouse, etc. Type II, by contrast, would involve, e.g., not repairing faulty wiring of which you had knowledge (or would have had if fire insurance was unavailable), not locking the car doors, or neglecting to call emergency services when your spouse complains of chest pains and passes out. Type III includes "puffing" of loss amounts. For example, claiming that when thieves robbed your house they stole your CD collection, when in fact they did not (probably because of your taste in music), or, following an injury, claiming additional injuries which you had not suffered (malingering). Finally, not taking precautions to lessen the amount of a loss (Type IV) might include, for instance, leaving your valuable jewelry collection spread out on the coffee table over a weekend away from home during which your house is burglarized. This differs from taking less care in that the probability of the loss (the burglary) presumably would have been the same whether or not the jewelry was left out, but the lack of care increased the *amount* of the loss.[28]

Insurers, of course, want insureds to take as much care as they would if the insured incurred the loss. Insurance contracts therefore leave some of the risk on the insured through deductibles, co-payments, exclusions, and experience rating.[29] Deductibles specify that the insured will pay for the first dollars of loss.[30] Co-payments, which are common in health insurance, make the insured pay for a percentage of the cost of care, or a per-visit fee, e.g., $10.00 per visit and $3.00 per prescription.[31] Because services cost the insured far less than the insurer, the insured uses more services than they would if they had to pay out of pocket.[32] Co-payments discourage the over-use of services. Exclusions serve to narrow the types of risks that are covered by a policy,[33] e.g., most (if not all) policies exclude losses that result from

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28. One could look at the jewelry on the table as increasing the probability of the loss of the jewelry, rather than increasing the chances of the house being burglarized.

29. *E.g.*, Pauly, *supra* note 23, at 535-36.

30. ACKERMAN, *supra* note 24, at 6-7.

31. EMPLOYMENT & HEALTH BENEFITS: A CONNECTION AT RISK 336 (Marilyn J. Field & Harold T. Shapiro eds., 1993).

32. *Id.* at 535.

33. *E.g.*, Continental Cas. Co. v. Anderson Excavating & Wrecking Co., 189 F.3d 512 (7th Cir. 1999). Anderson's insurance contract contained an "Inchmaree Clause," a standard exclusion in marine insurance. *Id.* at 519-20. The clause stated that Anderson was insured against losses "'of 'accidents in loading . . . cargo' provided, however, that the loss 'has not resulted from want of due diligence by the . . . owners or managers of the vessel.'" *Id.* at 520. Anderson, unable to find suitable heavy-duty barges, had damaged light-duty barges by dropping huge chunks of concrete on them, and sought coverage for his liability to the barge

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intentional acts of the insured. Finally, an experience rating is the insureds' "track record;" greater losses result in higher premiums.[34] Through these mechanisms, insurers seek to minimize moral hazard effects.

II. CONTRACTS AS INSURANCE AND THE SUPERIOR RISK BEARER

All contracts contain an element of insurance, whether the parties intend it or not.[35] In the absence of the parties' intent about allocation of risk, the risk of non-performance should, according to Posner, fall on the "Superior Risk Bearer."[36] The Superior Risk Bearer is "the party that is the more efficient bearer of the particular risk in question, in the particular circumstances of the transaction."[37] If the parties expressly assign risk, however, the Superior Risk Bearer analysis "is merely an aid to interpretation."[38]

A party may be the superior risk bearer if: (1) "he may be in a better position to prevent the risk from materializing;" or (2) he is the least cost insurance provider.[39] For example, if performance is stymied because one party fails to order the proper supplies, then that party should bear the risk because they are in the better position to avoid that risk.[40] Determining which party is the least cost insurance provider involves two factors: (a) which party is in the better position to estimate the probability of the risk occurring and the magnitude of the loss resulting from the risk if it happens;

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owners. *Id.* Posner concluded that "[t]he exclusion in the Inchmaree Clause for losses caused by 'want of due diligence' . . . fits this case to a T. The damage to the barges resulted from . . . a conspicuous lack of diligence . . . So clear is this that no purpose would be served by remanding the case for better findings by the district court." *Id.*

34. EMPLOYMENT & HEALTH BENEFITS: A CONNECTION AT RISK, *supra* note 31, at 337.

35. "Ordinary commercial contracts also shift risks, and thus provide a form of insurance. The risk-shifting or insurance function of contracts is related to the fact that a contract . . . by its nature commits the parties to a future course of action; and the future is uncertain." POSNER, *supra* note 11, at 104. *See also* Richard A. Posner & Andrew M. Rosenfield, *Impossibility and Related Doctrines in Contract Law: An Economic Analysis*, 6 J. LEGAL STUDIES 83 (1977).

36. Posner & Rosenfield, *supra* note 35, at 90.

37. *Id.*

38. *Id.*

39. *Id.*

40. In this example, even assuming that the non-ordering party could have avoided the risk, they would likely incur greater monitoring costs than the ordering party, and therefore would not be the least cost risk avoider. As Posner points out, this vein of analysis parallels tort law's assignment of liability based on standards of care. *Id.*

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and (b) which party could self-insure, i.e., the party who could better spread the risk of loss.[41]

Posner's allocative rule that "the superior risk bearer is the party that is the more efficient bearer of the particular risk in question, in the particular circumstances of the transaction," is a "default rule."[42] "Default rules fill in the gaps in incomplete contracts; they govern unless the parties contract around them."[43] Posner advocates that courts should set default terms that the parties would have wanted had they contracted for the terms ex ante.[44]

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41. This is because self-insurance is often cheaper than market insurance. *Id.* at 92. Self-insurance, like market insurance (insurance through an insurance company) is accomplished through diversification and the law of large numbers.

Posner applies this analysis in Sutton v. A.O. Smith Co., 165 F.3d 561, 562-63 (7th Cir. 1999), as interpretive guidance and explanation for the common law rule in Wisconsin that contractual indemnity provisions, unless they appear in an insurance contract, are presumed not to cover claims arising from the negligence of the party seeking indemnity. Sutton worked as a truck driver for Q-1, which was hired to transport goods for A.O. Smith. *Id.* at 562. After Sutton was injured on A.O. Smith's property by an employee of A.O. Smith, he sued A.O. Smith (which settled for $17,000), and A.O. Smith impleaded Q-1, claiming that Q-1 must indemnify A.O. Smith pursuant to their contract. *Id.*

Posner reasons that the Wisconsin rule "is based on a belief that a contracting party is unlikely either to have good information about the propensity of the other party to behave negligently, or to be in a position to prevent such behavior, and so is unlikely to have agreed to insure the other party against the consequences of that party's negligence." *Id.* at 563.

Posner notes that the presumption that negligence is not covered under an indemnity agreement

> falls away if the party sought to be held as an insurer is an insurance company, whose business it is to insure people against liability . . . . Insurance companies are specialists in risk assessment and risk spreading; truck companies are not, though a diversified company, or even an undiversified company but one organized as a corporation and whose shareholders hold diversified portfolios, might be able to spread risk as well as an insurance company.

Id.

42. *E.g.*, Ian Ayres & Robert Gertner, *Filling Gaps in Incomplete Contracts: An Economic Theory of Default Rules*, 99 YALE L.J. 87 (1989).

43. *Id.* Since it would be very expensive to contract for every contingency, there will almost always be gaps.

44. POSNER, *supra* note 11, at 354 (Default rules "should economize on transaction costs by supplying standard contract terms that the parties would otherwise have to adopt by express agreement."). *Cf.* RESTATEMENT (SECOND) OF CONTRACTS § 204 (1981) (default rules should be "reasonable in the circumstances"); Charles Goetz & Robert Scott, *The Mitigation Principle: Toward a General Theory of Contractual Obligation*, 69 VA. L. REV. 967, 971 (1983) (what arrangements would most bargainers prefer?).

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Default rules may, however, promote moral hazards (bad incentives) such as opportunism[45] and rent-seeking.[46] The default rules create these hazards by providing incentives to withhold information. Posner's "least cost insurer" default rule could promote these bad incentives to withhold information. Specifically, his rule might motivate parties to withhold information both about their ability to estimate the probability and magnitude of risks and their ability to self-insure against the risk. At the margin, these incentives may motivate parties who otherwise would have been the superior risk bearer to not only purposely avoid contracting around risks that they do perceive, but to also close their eyes to other risks for fear of being considered "better able to estimate risks." For these and other reasons, Ayres and Gertner advocate, in some cases, default rules that are *not what the parties would have wanted* to motivate parties to divulge information and to contract around risks.[47] However, forcing the parties to reveal information will undermine parties' incentives to obtain unfavorable information.[48] Ayres and Gertner therefore conclude that penalty defaults that have a "net effect of reducing the amount of socially useful information" should not be imposed.[49]

According to Posner, the moral hazard problem arises when a party is "insured" against a risk "that he could have prevented at a reasonable cost."[50] But this analysis of moral hazard might go one step further: If party X, through legal action, is able to externalize its risk (the loss it faces if the risk occurs) onto party Y, then party X rationally would conclude that it could spend less on preventing the risk from materializing (even though it is the least cost risk avoider). In other words, undesirable incentives are created if a party that could have done something to avoid or minimize the loss is let off the hook by a court. Thus, when courts employ default rules to allocate risk among parties to a contract, the court is in a sense "writing insurance" ex

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45. Ayres & Gertner, *supra* note 42, at 98. For example, if one party is deemed the least cost insurer with respect to a certain risk, similarly situated bargainers to the "insured" (non-insuring) party will have incentives to make similar contracts to put the risk on the "superior risk bearer." *See also* Juliet P. Kostrisky, *Bargaining with Uncertainty, Moral Hazard, and Sunk Costs: A Rule for Precontractual Negotiations*, 44 HASTINGS L.J. 621 (1993).

46. Ayres & Gertner, *supra* note 42, at 100. A party may withhold information relating to their ability to insure against a risk, thereby maintaining rents against uninformed parties who end up bearing that risk.

47. *Id.* at 106-07 ("[W]hen individual parties have private incentives to withhold information, it may be desirable for the law to give them a nudge.").

48. *Id.* at 107.

49. *Id.*

50. Posner & Rosenfeld, *supra* note 35, at 91.

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post. One implication of this is that courts, acting as an arbiter of risk by construing a contract, must be wary of creating conditions for moral hazard.[51]

III. POSNER'S USE OF MORAL HAZARD FROM THE BENCH

Consistent with his desire to propagate a law and economics perspective, Posner has analyzed everything from petitions for a temporary injunction to religious freedom under the First Amendment using economic analysis.[52] Posner often injects some economic analysis in his opinions with didactic flourish,[53] and Posner also is one of the few judges who gives insurance issues their due. This section will focus on three case cases that contain an analysis of insurance and moral hazard.

A. Outboard Marine Corp. v. Babcock Industries.

Much has been written about how insurance, and therefore moral hazard, affects investments in care under a tort analysis.[54] Much less attention has been paid, however, to moral hazard problems in non-insurance contracts. The importance of *Outboard Marine* is that it highlights the insurance aspect of work-a-day contracts, drawing on analogies between contract and tort doctrines.

Outboard Marine, a manufacturer of boat engines, brought a breach of warranty action against ACCO (formerly Babcock Industries), a supplier of cables for its engines.[55] Outboard Marine alleged that the cables that ACCO supplied for Outboard's new type of engine were faulty and had caused a high

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51. This is true also when courts interpret insurance contracts between an insurer and the insured under the "doctrine of reasonable expectations." The doctrine holds that, if there is ambiguity in an insurance contract, the ambiguity will be resolved in favor of the insured. *See generally* JEFFERY W. STEMPEL, INTERPRETATION OF INSURANCE CONTRACTS § 11.1 (1994). Were it the other way, insurers incentives to deny coverage would be greater. *But see* Michael B. Rappaport, *The Ambiguity Rule and Insurance Law: Why Insurance Contracts Should Not Be Construed Against the Drafter*, 30 GA. L. REV. 171 (1995).

52. Wermiel, *supra* note 10 (religious freedom); Am. Hosp. Supply Corp. v. Hosp. Prods., 780 F.2d 589 (7th Cir. 1986) (preliminary injunction should be granted "if but only if P x Hp > (1-P) x Hd.").

53. Posner's analysis is rigorous, often considering arguments that were not raised by the parties (but perhaps should have been) as well as policy considerations that predictably draw from economic theories.

54. *E.g.*, STEVEN SHAVELL, ECONOMIC ANALYSIS OF TORT LAW (1987).

55. Outboard Marine Corp. v. Babcock Indus., 106 F.3d 182, 183 (7th Cir. 1997).

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(and expensive) failure rate of that engine.[56] Outboard Marine sought $19.13 million in damages, but instead received a jury award of $4.4 million.[57]

On appeal, Outboard argued that the jury's award was unreasonable, and that the trial judge either should have entered a judgment of $12.38 million for Outboard or granted a new trial on damages. During the trial there was evidence that the cables supplied by ACCO did not conform to Outboard's specifications.[58] But there also was evidence that the engines contained defects caused by Outboard that had nothing to do with ACCO's cables, and which would have caused many of the engine failures even if the cables had been made properly.[59]

Outboard Marine claimed a $19.13 million loss, which assumed that all of the engine failures and resulting recalls and replacements were caused by ACCO's faulty cables.[60] ACCO countered that the engine failures were due to Outboard's own design defects, so Outboard should receive only $303,000, the cost of the defective cables.[61] "In calculating the damages award between $303,000 and $12.38 million," Posner wrote, "the jury was on its own."[62]

Posner summarily disposed of Outboard's argument for a directed judgment,[63] but gave greater consideration to Outboard's argument for a new trial on the issue of damages. ACCO argued on appeal that, because there were three causes of the engine failures, and two of them were Outboard's fault, the jury properly "assigned two-thirds of the liability to Outboard Marine."[64] Outboard Marine countered, arguing that, if the jury apportioned damages, then it wrongly applied tort-type comparative fault to a contract case, effectively making comparative negligence a defense in a contract case.[65]

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56. *Id.*

57. *Id.* The trial judge denied Outboard Marine's motion to enter judgment for $12.38 million, or to grant a new trail on damages. *Id.*

58. *Id.*

59. *Id.*

60. *Id.*

61. *Id.* The $12.38 million figure came from ACCO, which argued that, even if all of the engine failures were because of the bad cables, as Outboard claimed, Outboard would be out-of-pocket $12.38 million, not $19.13 million as originally calculated by Outboard. *Id.* at 183-84.

62. *Id.* at 183.

63. Outboard's argument relied on a misunderstanding of ACCO's position regarding damages. *Id.* at 183-84.

64. *Id.* at 184.

65. *Id.*

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Posner agreed with Outboard that "there is no contract doctrine of contributory or comparative negligence."[66] On the way to this conclusion, Posner discussed the relationship between contract and tort law, pointing out that both try to minimize harm after the breach.[67] For example, Posner wrote that "[m]itigation of damages in contract law . . . corresponds to avoidable consequences in tort law."[68]

Whereas mitigation of damages and avoidable consequences concern harm occurring ex post, contributory and comparative negligence relate to behavior that would have prevented the accident from occurring in the first place.[69] Posner suggests that a doctrine of contributory or comparative negligence in contract cases makes no sense. Although he does not say it directly, what he seems to be getting at is that parties to a contract can bargain with each other ex ante, while an injurer and victim do not have the chance to bargain before an accident.

Moreover, because parties to a contract can bargain, they can allocate the risks (and therefore the care required to avoid a risk) among themselves before a loss occurs.[70] Here is the nexus of tort, contract and insurance:

> Often a promisee wants and contracts for protection against his own mistakes. Contracts have an insurance function. People insure themselves against the consequences of their own negligence. *Of course, when they do this, there is what is called the "moral hazard" problem; being insured, they don't have as much incentive to be careful.*[71]

Specifically, there are two moral hazards. One is taking less care to *prevent* a loss event, the other is taking less care to minimize losses after the event has happened.[72]

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66. *Id.*
67. *Id.*
68. *Id.*
69. *Id.*
70. Posner writes: "[A] promisor can always condition his promise on the observance by the promisee of precautions designed to head off disaster if the promise is broken -- can, that is, impose a duty of care on the promisee beyond what is implicit in the doctrine of conditions." *Id.* at 185.
71. *Id.* (emphasis added).
72. Recall the discussion *supra* Part I. of the four "types" of moral hazard. Two involve increasing the probability of a loss, the other two relate to increasing the amount of a loss resulting from an event.

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According to Posner, moral hazard "is controlled in the contract setting by the doctrine of mitigation of damages."[73] But mitigation of damages will control only harms that occur after the breach. No principle of comparative fault for purely contractual warranty cases existed under the controlling substantive law in *Outboard Marine* which would presumably spell out a standard of care that must be met *before* a breach of warranty occurs.[74]

Nevertheless, Posner concludes that: "The promisor who breaks his promise is liable only for the harm that he causes, which is to say the harm that would have been avoided had he not broken his promise. He is therefore not liable for the harm that occurred solely as a result of the plaintiff's acts."[75] Applying this principle to the case at hand, Posner writes:

> Because [] Outboard Marine's own design defects, some of its new engines would have failed . . . even if the cables had been manufactured to the contractual specifications, which is to say that some of the harm that Outboard Marine suffered as a result of the engine failures would have occurred even if there had been no breach of warranty.[76]

Under Posner's superior risk bearer default rule, the outcome in *Outboard Marine* makes sense in that ACCO was in the best position to avoid risks related to its faulty cables, and Outboard Marine could best avoid the risks related to the design of its engine. Presumably, if the parties had contracted on this issue, they would have chosen the allocation of risks that Posner did -- each bearing the costs that resulted from their own mistakes.

Outboard Marine shows how courts, through "interpreting" contracts and applying default rules, may (although Posner wisely declined to do so here) write into contracts indemnity or warranty provisions that might promote moral hazard effects. If ACCO was held liable for the full cost of the engine failures, $12.38 million, then they would be "insuring" Outboard Marine, through the warranty contract, against the risk of Outboard's own mistakes. Likewise, if Outboard Marine received only $303,000, then they would be insuring ACCO, and ACCO would not have the proper incentives to make the cables correctly.

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73. *Outboard Marine Corp.*, 106 F.3d at 185.
74. *Id.* at 183. Because this was a diversity case, Illinois law controlled.
75. *Id.* (citations omitted).
76. *Id.*

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B. Harley-Davidson v. Minstar

The issue in *Harley-Davidson* was whether indemnification agreements are allowed under the Comprehensive Environmental Response, Compensation and Liability Act ("CERCLA") (a.k.a. "Superfund").[77] It is noteworthy for the court's analysis of this issue, and provides another example of Posner's application of the moral hazard idea to a non-insurance contract.

A predecessor company of Harley-Davidson bought a manufacturing plant from a predecessor of Minstar and AMF.[78] The buyer, Harley-Davidson, agreed to indemnify the seller, Minstar, "against all liabilities relating to the division of the seller...that owned the plant."[79] The land that the plant was on was contaminated, and Harley-Davidson incurred remediation costs.[80] Harley-Davidson sought contribution from Minstar and others under CERCLA, which entitles the owner of contaminated land to contributions from other persons who are responsible, in whole or in part, for the contamination.[81] Minstar claimed the indemnity agreement as a defense, but the district court judge held that CERCLA prohibits indemnity agreements, so Minstar would have to contribute.[82] The Seventh Circuit accepted the issue on an interlocutory appeal.[83]

The legal issue in *Harley-Davidson* was one of statutory interpretation. The disputed language in CERCLA states:

> No indemnification, hold harmless, or similar agreement or conveyance shall be effective to transfer from . . . any person who may be liable . . . under this section, to any

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77. Harley-Davidson, Inc. v. Minstar, Inc., 41 F.3d 341, 342 (7th Cir. 1994).

78. *Id.*

79. *Id.* Thus, neither Harley-Davidson nor Minstar/AMF in their form at the time of this case were a party to the indemnification agreement. The agreement stated that:

> [Harley-Davidson] shall . . . indemnify AMF INCORPORATED against all debts, liabilities, and obligations, without any limitation, relating to [AMF's] York division, its operations and products, whether known or unknown, . . . and whether existing on the date of this agreement or coming into existence hereafter.

Id. at 344.

80. *Id.* at 342.

81. *Id.* Nothing in the opinion suggests that Minstar or AMF denied responsibility for the contamination.

82. *Id.*

83. *Id.*

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> other person the liability imposed under this section. Nothing in this subsection shall bar any agreement to insure, hold harmless, or indemnify a party to such agreement for any liability under this section.[84]

Harley-Davidson argued that if indemnification is allowed, would-be polluters will have less incentive to avoid CERCLA liability since they can be "insured" against liability through indemnification.[85] Since Harley-Davidson had indemnified Minstar, if CERCLA allows indemnity agreements, then Harley-Davidson would bear all of the costs of the contaminated land that it purchased from Minstar. Harley-Davidson in essence argued that the court should undo the indemnity provision it had agreed to with Minstar.

"[I]nsurance," wrote Posner, "is just a form of indemnification,"[86] and he correctly framed Harley-Davidson's argument as relying on moral hazard. Posner concluded that Harley-Davidson "misses the mark" on interpreting the language of CERCLA. Posner noted that sometimes insurance *is* unavailable, for intentional acts,[87] or for other conduct which for public policy reasons is deemed uninsurable. Here, Posner concluded that although CERCLA forbids shifting *liability*, it allows sharing the *cost* of liability with other responsible parties.[88] Thus, Harley-Davidson's agreement to indemnify Minstar, which assigned to Harley-Davidson all risks related to the land it purchased from Minstar, is not prohibited by CERCLA.

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84. *Id.* (quoting Comprehensive Environmental Response, Compensation, and Liability Act § 107(e)(1), 42 U.S.C. § 9607(e)(1994) [hereinafter CERCLA].

85. *Id.* at 343.

86. *Id.*

87. *E.g.*, Chapter v. Montfort, Inc., 20 F.3d 286 (7th Cir. 1994). In *Montfort*, the plan participant's wife sustained $250,000 worth of injuries from a car accident she caused by driving drunk. *Id.* at 287. The plan participant (the husband) sued his health insurer, arguing that they must cover the cost of his wife's injuries. *Id.* The plan contended that the injuries were excluded under the "intentional acts" exclusion. *Id.* Posner, writing for the court, held that: "Mrs. Chapter, not her husband, was the plan participant who incurred the medical expenses for the injuries she sustained in the accident, and she, and therefore her husband as well, is barred from reimbursement for those expenses by her participation in criminal activities." *Id.* at 288. Were this not so, "she would benefit indirectly if her husband were allowed to circumvent an exclusion designed for just such a case as this." *Id.* *See also* Fuller v. CBT, 905 F.2d 1055, 1057 (7th Cir. 1990) (Policy "excludes from coverage treatment of any condition resulting from an intentional self-inflicted injury.'" This common exclusion "reflect[s] concern with the 'moral hazard' . . . that is created when a person buys insurance against the consequences of his deliberate behavior.").

88. *Harley-Davidson*, 41 F.3d at 343.

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Harley-Davidson "misses" for another reason as well. There is another moral hazard problem lurking here: if Harley-Davidson received contribution, it will have been rewarded for not getting more information from the seller. This is somewhat the story that Ayres and Gerter tell. By giving the buyer what they do not want (no contribution), buyers will be motivated to seek more information about possible pollution from sellers *before* buying and agreeing to indemnify the seller.[89] Here, Posner interpreted the CERCLA language to allow, even encourage, parties to contract around pollution clean-up costs, including indemnity agreements.

It might be argued that since the seller will usually have more information about whether their land is polluted, then they should disclose that information. Sellers, however, have no reason to do so unless the buyer asks (or they are required to by statute). Sellers will not disclose that land is polluted unless the buyer writes a penalty into the contract for sellers' withholding information. And if the buyer is dissatisfied with the seller's information, then they can contract around the issue, perhaps leaving some of the liability to the seller (like a deductible). But it all starts with the buyer taking the initiative, which apparently Harley-Davidson did not. At the least, Harley-Davidson might have agreed to a narrower indemnification agreement with Minstar, again, making Minstar responsible for some risks, like pollution, that neither party knew about at the time of the transaction.[90]

C. Charter Oak Fire Insurance Co. v. Color Converting Industries Inc.

Color Converting involves a "traditional" insurance contract -- a contract between a consumer and an insurance company. Moral hazard is an insurance

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89. This outcome also has the effect of getting information regarding contamination sooner rather than later. To the extent having this information is useful, e.g., less costly clean-up, avoiding building on polluted land, it is a social good to have early disclosure of the information.

90. *Cf.* Clark Equip. Co. v. Dial Corp., 25 F.3d 1384 (7th Cir. 1994). *Clark* was concerned with an indemnification agreement between the seller and buyer of a crane business. *Id.* at 1385. "The evident intent of the indemnification provision was, quite sensibly, to make sure that neither the buyer nor the seller was responsible for the conduct of the other. Clark would not be responsible for defects in the old cranes, or Dial for defects in the new ones (that is, ones manufactured or sold after the sale of the business to Clark)." *Id.* at 1389.

If CERCLA applies retroactively, it may be that the seller, Minstar's predecessor, had no idea that the site could result in liability because the transfer occurred before CERCLA was enacted. In that case, there is no moral hazard problem because there was no known risk of CERCLA liability to be ducked and unloaded on an unwary buyer.

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concept that has been exported to other contexts, e.g., contracts as in *Outboard Marine* and *Harley-Davidson*. One of the purposes of the moral hazard analysis in this section is to apply the insights of the previous sections to the multi-faceted nature of moral hazard to insurance contracts. Of course, insurance contracts are subject to a range of law, such as the tort of "bad faith" and the "doctrine of reasonable expectations," which is unique to the insured-insurer relationship.[91] This section suggests that "bad faith" law and the "doctrine of reasonable expectations" addresses another incarnation of moral hazard: the incentives that insurance companies have to deny coverage or otherwise act in their interest at the insured's expense.[92] *Color Converting* will be used to illustrate this kind of "moral hazard."

Color Converting involved self-insurance of sorts. Color Converting, an ink manufacturer, told its biggest customer, American National, that it could use a certain type of ink on some of its packaging.[93] During the fall of 1990, American National used the ink, which did not work. American National demanded $235,000 in compensation.[94] Shortly thereafter, Color Converting

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91. Bad faith claims include: denial of benefits, quality of defense of insured, and failure to settle or failure to refuse a settlement that unnecessarily exposes the insured to liability. *E.g.*, Alan O. Sykes, *Judicial Limitations on the Discretion of Liability Insurers to Settle or Litigate: An Economic Critique*, 72 TEX. L. REV. 1345 (1994). The doctrine of reasonable expectations is a doctrine of contract interpretation, under which a court may interpret an ambiguous insurance agreement to comport with the insured's "reasonable expectations" that certain losses were covered. *See generally* Symposium on the Doctrine of Reasonable Expectations, 5 CONN. INS. L.J. 1, 72 (1999).

92. A moral hazard analysis has been applied to the insurance industry, *see* James G. Bohn & Brian J. Hall, *The Moral Hazard of Insuring the Insurers*, working paper 5911, National Bureau of Economic Research (1997); Elijah Brewer et al., *The Role of Monitoring in Reducing the Moral Hazard Problem Associated with Government Guarantees: Evidence from the Life Insurance Industry*, 64 J. RISK & INS. 301 (1997) (concluding that risk taking by life insurers is higher in states with guaranty funds that are underwritten by ratepayers); as well as to the banking industry, *see* Harris Weinstein, *Moral Hazard Deposit Insurance and Banking Regulation*, 77 CORNELL L. REV. 1099 (1992); and the Pension Benefit Guaranty Fund, Daniel Keating, *Pension Insurance, Bankruptcy and Moral Hazard*, 1991 WIS. L. REV. 65 (1991). The tendency of health insurers and employers to join to reduce health care costs by limiting access to care, e.g., by providing incentives for physicians to deny care has been called "reverse moral hazard." 149 N.J. L.J. p. 26 (Sept. 1, 1997) (editorial). Bohn and Hall's study suggests that financially shaky insurers may write risky, long-tail policies to increase short-term cash flow, leaving the guaranty fund to pick up the pieces when the insurer becomes insolvent. *Id.* at 140, 164.

93. Charter Oak Fire Ins. Co. v. Color Converting Indus. Co., 45 F.3d 1170, 1171 (7th Cir. 1995).

94. *Id.*

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notified its agent of the loss, and in June, 1991, Color Converting had a meeting with American National during which American National agreed to reduce its claim to $200,000.[95] In July, 1991, Color Converting told its agent that the claim was $200,000, and Travelers assigned claims handlers to the case, almost a year after the loss.[96]

In November, Travelers decided that the ink accident was covered, but it wanted more information to determine the amount of liability.[97] Specifically, Travelers wanted to know if American National was also at fault (which would mitigate Color Converting's liability), and also wanted proof from American National that it actually had sustained a $200,000 loss.[98]

American National was asking only for the cost of its ruined output, not the "rack rate" (the cost of production plus profit).[99] But since it was asking for the cost of production, Travelers wanted documentation that the ruined output indeed cost $200,000.[100] American National refused, claiming that the information sought by Travelers was proprietary.[101]

Instead of providing the requested information, Color Converting provided Travelers with industry cost averages to show that American National's demand was reasonable, and within the industry norm.[102] Travelers refused to accept this information "on the ground that American National's costs might well be below the average for its industry," since American National was a very successful firm.[103] "Color Converting argues that Travelers was being overcautious; and for purposes of this appeal we accept the argument."[104]

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95. *Id.*
96. *Id.*
97. *Id.*
98. *Id.*
99. *Id.* at 1171-72.
100. *Id.*
101. *Id.* at 1172. American National's refusal to divulge to Travelers this information seems reasonable, even in light of Traveler's promise to keep it confidential. The information could be used by American National's competitors to smear its reputation, and by customers to bargain down on prices. Travelers might not have the right incentives to protect this information, which if sold or leaked, could jeopardize American National's goodwill. It seems unlikely that, if the information did get out, American National could be made whole by a legal action against Travelers for the breach of confidence.
102. *Id.*
103. *Id.*
104. *Id.*

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Almost two years after the accident, American National gave an ultimatum to Color Converting: pay $200,000 or lose our patronage.[105] Color Converting told Travelers about the demand, and Travelers refused to make any settlement offer.[106] To preserve its business relationship with American National (which was presumably worth much more than $200,000 over the long haul), Color Converting paid the amount demanded.[107] Travelers refused to reimburse Color Converting, invoking the voluntary-payments clause.[108]

Posner characterized Travelers' refusal to make any settlement offer as a moral hazard issue.[109] The story here would be that, without more information, it would be easy for two companies to agree to concoct a loss, or inflate the amount of an actual loss, and get the insurance company to pay.[110]

But there is another moral hazard story here: Color Converting ended up "self-insuring" against the loss to a third party which resulted from Color Converting's product. As between Color Converting and Travelers, one must pay the loss. Therefore, Travelers' incentives might be distorted, believing that if they dragged their feet long enough, their potential liability to American National would be covered by Color Converting. By insuring itself against the risk of Travelers denying coverage, Color Converting also in a metaphorical sense "insured" Travelers against the risk of having to pay on the claim. And being "insured," the insurer may succumb to moral hazard by: (1) increasing the cost to color Converting (deny claim); or (2) taking less care by negligently handling the claim. To the extent that it exists, "insurer

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105. *Id.*

106. *Id.*

107. *Id.*

108. *Id.* A voluntary payments clause provides that a policyholder who voluntarily makes a payment may not then expect his insurer to reimburse him for that payment. Richard W. Fields & Elin P. Swanson, *The Voluntary Payment Clause: The Insurer's New Bogeyman*, 5 ENVTL. CLAIMS J. 57, 58 (1992). The primary purpose of the voluntary payments clause in a CGL policy is to protect the insurer from the risks of collusive settlements between the policyholder and an injured third party. *Id.*

109. *Id.* at 1174 ("Insurance companies are reluctant to insure against risks that the insured controls. Such insurance would give the insured an incentive to increase risk, since he would have shifted the cost of the increased risk to the insurance company. This problem goes by the name of 'moral hazard.'").

110. *See id.* ("If the insurance company has an implied duty to cooperate with its insured to the extent necessary to avoid offending powerful customers, the opening for collusive and exaggerating claims of products liability will be immense.").

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moral hazard" is kept in check by the threat of bad faith litigation, which focuses, among other things, on the conflicts of interest that come up when insurance companies have control over whether, and for how much, to settle a claim on behalf of an insured.[111]

Ultimately, Posner concludes that "[t]he only risk Travelers was creating [by refusing to settle] was the risk that Color Converting might lose a customer. That is not a risk against which Travelers agreed to insure Color Converting."[112] But he recognizes that if "Travelers, believing the settlement to be reasonable -- having no doubts -- stalled in the hope that Color Converting would trip over the voluntary-payments clause," then Travelers would be estopped from using the voluntary-payments defense.[113] Posner writes that, at worst, "Travelers was overly cautious, overly suspicious, in its handling of American National's claim against its insured," and its conduct

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111. *See* Crisci v. Security Ins., 426 P.2d 173 (Cal. 1967); Sykes, *supra* note 91. Since bad faith litigation and the doctrine of reasonable expectations curb insurance companies "moral hazards," one might think of these doctrines as the equivalent of exclusions, co-payments, and deductibles on the insured's side, i.e., the threat of losing a bad faith claim leaves some of the risk of denying coverage on the insurer. For example, if the insurer believes it should deny coverage for a $100,000 loss, but also thinks the insured has 5% chance of winning a bad faith action, the insurance company retains $5,000 (100,000 x .05) of the risk of denying coverage. If not for bad faith claims, insurers would not face this "deductible," and therefore their moral hazard of tending to want to deny coverage or otherwise act in its own best interests would go unchecked.

112. *Color Converting,* 45 F.3d at 1177. Posner here is drawing a distinction between losses that are usually insured, or "firm specific" losses, and "market" or "systemic" losses. The difference is that specific losses affect one entity, for example when a store is burglarized, while systemic losses affect the whole industry, for example the demand for the store's wears declines. Both affect the store's bottom line, but the market risks can not be as easily insured because they would be harder to diversify away, i.e., the store's market risks would likely not be independent of other stores losses. Another reason insurers will not write market risks is that they can not be accurately predicted, whereas other risks, like car accidents and even natural disasters, are "known" risks about which one can find actuarial data.

In *Movitz v. First National Bank of Chicago*, 148 F.3d 760, 761-62 (7th Cir. 1998), the plaintiff, an investor, claimed that the defendant's real estate investments were too speculative (the investment's value plummeted during the Houston real estate crash of 1983), and therefore the plaintiff should be compensated for his loss. Posner concluded that "[t]o hold the defendant liable for the loss would produce overdeterrence by making him an insurer against conditions outside his control. . . . The legal system is busy enough without shouldering the burden of providing insurance against business risks." *Id.* at 763.

113. *Color Converting*, 45 F.3d at 1176.

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was not "a deliberate, opportunistic breach of the contractual duty to defend."[114]

At bottom, Posner seems to think that Travelers' tip-toeing was not unreasonable. But there is evidence to the contrary. First, American National was entitled to the market value of the ruined output and not just the cost of production. Certainly Travelers could have found out what the retail cost of the lost units was, and if it was more than $200,000, count itself as lucky. Second, it may be wrong to assume that because American National is very successful, then they may have a lower cost of production than the industry averages which Color Converting submitted to support the $200,000 demand. Indeed, American National may have higher than average production costs, resulting in high quality products which contribute to American National's success -- products that may command higher than average retail prices.

Posner is probably right that Travelers' foot-dragging did not amount to a bad faith refusal to settle, but it is a close case. Part of the problem is that liability is presented as either all or nothing. Either Travelers pays, or Color Converting does (through paying for American's ruined output or loss of its business). Some sort of split liability between the insurance company and the insured might derail the moral hazards on both sides to dump the liability on the other.[115] Otherwise, insures will be rewarded for unreasonably or negligently stalling in settle negotiations -- just as insureds would be tempted to collude with third parties to make up or inflate losses if the insurance company felt it could not refuse to pay. A partial-liability judgment would also let the insurer know that losses incurred by a special third party must be handled with greater care.[116] This is consistent with Aryes and Gertner's suggestion that sometimes parties must be denied what they want to motivate them to provide information.[117]

Finally, *Color Converting* again illustrates the role of the court as an arbiter of risk. Not the risk of loss due to physical damage, but the risk of insurers denying coverage, or of an insured's scheme to inflate the amount of loss. Judge Posner clearly is aware of the possible moral hazards on both

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114. *Id.* at 1176-77.

115. For an example of split liability, see *Outboard Marine Corp v. Babcock Industries*, 106 F.3d 182, 186 (7th Cir. 1997).

116. *Color Converting*, 45 F.3d at 1177. (Posner cites Hadley v. Baxendale, 9 Ex. 341 (1854) for this proposition.) In the present case, of course, it is Color Converting that would need to alert its insurer to the consequences of mishandling a claim made by an important client.

117. Ayres & Gertner, *supra* note 42, at 91, 97.

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sides of a contract -- including insurance contracts -- and of courts' responsibility to assign risk so that moral hazard effects are minimized.

CONCLUSION

This comment has shown that moral hazard is a malleable concept which should be applied to both sides of an agreement and that allocates the risks of uncertain future events. Such forms of insurance are ubiquitous, occurring in contracts, welfare entitlements, and elsewhere but most notably in insurance contracts. Posner's decisions are laudable for giving thoughtful and thorough treatment of insurance and moral hazard issues.

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AN ANALYSIS OF THE HONORABLE RICHARD A. POSNER'S SOCIAL SECURITY LAW

*Barbara A. Sheehy**

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INTRODUCTION

The social security disability system annually affects more than seven million people and provides more than sixty billion dollars in cash benefits per year.[1] "[The] applicants include a diverse cross-section of Americans: the parents of judges, the children of the rich and famous, and the otherwise faceless poor."[2] It represents an arm of the modern welfare state that touches most Americans at some stage in their lifetime.[3] The Social Security Act ("Act") as initially proposed and implemented did not include disability insurance. Over several congressional sessions, however, the push to include disability insurance triumphed, and now the Act's disability program comprises a massive system in its own right. The exponential growth of the system since its modest inception in 1935 has not gone unnoticed. "The Social Security Administration operates the largest system of administrative adjudication in the Western world."[4]

As the system has grown, so too have the rules and regulations that govern the dispensing of benefits. Despite efforts to establish a relatively straightforward, non-adversarial system, where the average applicant easily understands the process and procedures, it has become one of the least user-friendly bureaucracies known to the administrative state. Indeed, an applicant must wade through and digest no fewer than two thousand three hundred pages of statutory text and the accompanying regulations. The system of mass justice teeters on collapse under its own weight, and proposals and pleas to repair it have become increasingly frequent.

This Article, however, does not offer any proposals or particular critiques of the system; instead, it examines the role of the circuit court of appeals in the disability program. As the system currently stands, the judicial system plays an essential role in the administration of benefits. Dissatisfied claimants can appeal administrative decisions to the district court and ultimately to the circuit court of appeals. Individuals can challenge various processes, procedures, and regulations in federal courts as violative of protected rights.

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1. LINDA G. MILLS, A PENCHANT FOR PREJUDICE: UNRAVELING BIAS IN JUDICIAL DECISION MAKING 2 (1999) (citing 1997 GAO figures).

2. *Id.*

3. JERRY L. MASHAW, BUREAUCRATIC JUSTICE: MANAGING SOCIAL SECURITY DISABILITY CLAIMS 18 (1983).

4. *Id.*

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Given the statistical likelihood that the United States Supreme Court will pass on hearing a social security claimant's appeal, the circuit court represents the final arbiter of the dispute. As the likely forum with the final say, one cannot overstate the importance of the circuit court in the process. This importance notwithstanding, a recent Federal Courts Study Committee Report suggests that federal jurists view social security appeals as trivial or unworthy of serious attention.[5] This conclusion should startle even the most passive individual. Although one social security claimant may be viewed as insignificant in the overall scheme of mass justice, one must not forget that disability benefits may constitute the sole source of revenue for that claimant. Moreover, "[disability awards] often exceed [] the money damages awarded in civil court (one disability pension can amount to $500,000 over a person's lifetime) . . ."[6] Mindful of this report, this Article surveys social security decisions authored by Judge Richard A. Posner during his tenure on the Seventh Circuit Court of Appeals.[7]

Part I contains a very general discussion of social security in an attempt to provide the necessary background to understand the case law. The discussion briefly describes the provisions of the Act, requirements for eligibility, and evaluation of disability. It concludes with a discussion of the process itself, beginning at the administrative level and ultimately terminating in the federal courts. Part II comprises the analysis section with discussions of selected social security decisions. The topics range from standing to eligibility, and from substantive disability issues to judicial review. The author selected each case for a different reason,

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5. CAROLYN KUBITSCHEK, SOCIAL SECURITY DISABILITY: LAW AND PROCEDURE IN FEDERAL COURT, § 6.44, at 402 (3d ed. 1994); *infra* note 260.

6. MILLS, *supra* note 1; *see also* MASHAW, *supra* note 3, at 18 ("[t]he average, present, discounted value of the stream of income from a successful disability application is over $30,000. Disability claims, on the average, thus have a value three times that required by statute for the pursuit of many civil actions in federal district courts.").

7. President Reagan appointed Judge Posner to the Seventh Circuit in 1981. He is currently the Chief Judge for the United States Court of Appeals for the Seventh Circuit and Senior Lecturer at the University of Chicago Law School. His profound influence on the law is unquestionable. There are certainly those that criticize and disagree with his economic approach to law, but his formidable intellect and powerful reasoning remain beyond reproach. This Article is a mere survey of Judge Posner's social security decisions, not an exhaustive compilation. Putting aside the obvious, that a complete survey of his decisions would itself be a daunting task, not every social security decision warrants discussion. The author, therefore, attempted to select cases that raised important and interesting issues relevant to social security.

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resulting in varying discussion formats and content. Some cases raised compelling issues, while other cases raised less interesting issues, but seemed particularly "Posner-esque." As a result, some discussions may focus more upon the law, whereas others may focus more upon the factors and characteristics that communicate a Posner-penned decision. Each case, however, aptly illustrates the author's conclusion that, despite Judge Posner's unveiled criticisms of the social security system, if the Federal Courts Study Committee's report describes the typical federal judge, Judge Posner is undoubtedly the exception.

I. THE SOCIAL SECURITY ACT

A. General Provisions

Before surveying social security decisions written by Judge Posner during his years on the circuit bench, a brief introduction to the administrative social security process is necessary to understand the court's role as disability claims mature into lawsuits. Congress originally enacted the Social Security Act in 1935.[8] The Act initially provided limited coverage for employees and old-age insurance.[9] Congress has since amended the Act numerous times and broadened the scope of coverage to include old age and disability benefits for most employed and self-employed workers, as well as for their dependents and survivors.[10]

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8. Social Security Act, ch. 531, 49 Stat. 620 (1935) (codified as amended at 42 U.S.C. §§ 301-1397f (1994)). When Franklin Delano Roosevelt signed the Act in 1935, "he envisioned, with the Congress, that Pub.L. 74-271 created a new version of an insurance plan – not welfare. . . . [T]he program expected to be self-financing . . . and was not to remake American social philosophy; it merely presented a workmanlike solution to a discrete problem." Phyllis E. Bernard, *Social Security and Medicare Adjudications at HHS: Two Approaches to Administrative Justice in an Ever-Expanding Bureaucracy*, 3 HEALTH MATRIX 339, 362-63 (1993).

9. ARTHUR ABRAHAM & DAVID L. KOPELMAN, FEDERAL SOCIAL SECURITY 3 (1979).

10. *Id.* at 3-4. In 1939, Congress expanded both coverage and benefits, providing insurance benefits for retired workers, for the wives and children of retired workers, and for the survivors of deceased workers. *Id.* at 3. In 1950, coverage was extended to self-employed persons. *Id.* In 1954, the Act allowed for partial protection for disabled workers. *Id.* at 4. Two years later, provisions were adopted for disability-based benefits. *Id.* In 1958, benefits were extended to dependents of disabled workers. *See* Social Security Amendments of 1958, Pub. L. No. 85-840, 72 Stat. 1013. In 1965, provisions for hospital and supplementary medical insurance benefits were enacted. ABRAHAM & KOPELMAN, *supra* note 9, at 4. In 1974, the current SSI program was established, supplanting state-

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The Act authorizes two major federal cash benefit programs that the Social Security Administration ("SSA") supervises: the Old Age Survivors and Disability Insurance ("OASDI") program[11] and the Supplemental Security Income ("SSI") program.[12] The former, OASDI, is essentially an insurance program that replaces income lost due to death, retirement, or disability and protects workers whose disability occurred after having made social security contributions.[13] The latter, SSI, is "a means-based welfare program for elderly and disabled persons"[14] that offers cash assistance and, often, medical coverage to Americans who become disabled irrespective of their work history. Each of these programs comprises an essential element of the American welfare state, constituting the safety net for the rich and the poor should they become too sick to work.[15]

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operated welfare and disability programs. 42 U.S.C. §§ 1381-1383c (1994). In 1977, several amendments were adopted that provided "a prompt study of the program with a view to providing universal coverage, that is, coverage of all employees, including those not covered by Social Security." ABRAHAM & KOPELMAN, *supra* note 9, at 4.

11. 42 U.S.C. §§ 401-433 (1994). OASDI is Title II of the Social Security Act and is also called the Retirement, Survivors, Disability and Health Insurance ("RSDHI"), but for purposes of consistency the author will use OASDI to refer to Title II of the Act.

12. *Id.* §§ 1381-1383. "The existence of two disability programs has required that the Social Security Administration . . . create the largest system of administrative adjudication in the western world. The system handles millions of claims filed each decade." Larry M. Gropman, *Social Security*, 1994 DET. C. L. REV. 871, 872. Programs under the Act cover a broader range than disability claims. These programs include retirement benefits, survivors' benefits, Aid to Families with Dependent Children, Medicaid, and Medicare. This Article, however, only considers the disability claims within the Act's coverage.

13. Jon C. Dubin, *Social Security Law*, 26 TEX. TECH. L. REV. 763, 763 (1995). Contributions take the form of premiums called Federal Insurance Contribution Act ("FICA") taxes that are automatically withheld from a worker's paycheck. *Id.* These withholdings allow workers and their families to receive monthly benefits in the event of retirement, death, or disability. *Id.*

14. *Id.*

15. MILLS, *supra* note 1, at 2. "The bulk of applicants . . . are working people, people who, after years of on-the-job physical and emotional strain, become incapable of meeting the demands of full-time employment." *Id.* Moreover, these two programs "annually provide seven million people with a total of more than $60 billion in cash benefits (GAO 1997). In 1996, approximately 2.5 million Americans applied for disability benefits (GAO 1997)...." *Id.*

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B. Financial and Medical Requirements for Eligibility

OASDI and SSI each have a financial and medical eligibility requirement, both of which a claimant must satisfy before being eligible for benefits under either program. The medical criteria, discussed below, are identical, but the financial eligibility tests vary from program to program. As noted above, the OASDI is an insurance program whereby a person secures coverage by working in employment covered by the Act. The financial standards generally "require forty quarters (ten years) of work in covered employment at any time during the worker's life, twenty of which must be earned within the forty-quarter period immediately prior to disability."[16] SSI, to the contrary, is not an insurance program so there is no "quarters of coverage" requirement. Indeed, the claimant need not have ever worked. The determination of SSI financial eligibility, therefore, hinges on level of need, considering income and resources.

As stated above, both OASDI and SSI similarly define disability. According to both programs, disability is "the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve months."[17] As a threshold matter, therefore, a claimant must have a medical problem. "[A] physical or mental impairment is an impairment that results from anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques."[18] A claimant must also be incapable of performing any substantial gainful activity. Substantial work activity is defined as "activity that involves doing significant physical or mental activities . . . even if it is done on a part-time basis."[19] Gainful work activity is "work activity that you do for pay or profit."[20] "Work activity

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16. Charles H. Koch, Jr. & David A. Koplow, *The Fourth Bite at the Apple: A Study of the Operation and Utility of the Social Security Administration's Appeals Council*, 17 FLA. ST. U. L. REV. 199, 208 (1990). A worker can therefore lose disability coverage if he voluntarily abandons covered employment for a significant period of time before the onset of a disabling impairment. *Id.*

17. 42 U.S.C. §§ 423(d)(1)(A) (OASDI program), 1382c(a)(3)(A) (SSI program) (1994).

18. *Id.* §§ 423(d)(3), 1382c(a)(3)(C).

19. 20 C.F.R. §§ 404.1572(a), 416.972(a) (2000).

20. *Id.* §§ 404.1572(b), 416.972(b).

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is gainful if it is the kind of work usually done for pay or profit, whether or not a profit is realized."[21] The duration requirement unilaterally excludes any claimant from the benefits of the program whose condition lasts fewer than twelve months, regardless of the level of incapacitation.[22] Furthermore, the Act provides that:

> [a]n individual shall be determined to be under a disability only if his physical or mental impairment or impairments are of such severity that he is not only unable to do his previous work but cannot, considering his age, education, and work experience, engage in any other kind of substantial gainful work which exists in the national economy, regardless of whether such work exists in the immediate area in which he lives, or whether a specific job vacancy exists for him, or whether he would be hired if he applied for work.[23]

C. Sequential Evaluation Process

In 1978, the SSA promulgated a "sequential evaluation process," a five-step method replacing the individual assessment of each claimant with a categorized approach. "In order to allay misunderstanding and to encourage a more uniform application of [SSA] policy, every step of the sequential evaluation process is governed by detailed regulations."[24] A finding of disabled or not disabled at any point in the review process is conclusive and terminates the analysis.[25]

First, the SSA must determine whether the claimant is currently engaged in "substantial gainful activity," or more simply, whether the claimant is working.[26] An affirmative answer to this inquiry precludes

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21. *Id.*

22. *Id.* §§ 404.1509, 416.909. The individual need not wait, however, to apply for benefits until her disability has lasted twelve consecutive months. The law merely refers to an impairment as one which "has lasted or *must be expected* to last for a continuous period of not less than twelve months." *Id.* (emphasis added).

23. 42 U.S.C. §§ 423(d)(2)(A), 1382c(a)(3)(B) (1994).

24. Carolyn A. Kubitschek, *Disability Standards and Concepts, in* SOCIAL SECURITY AND SSI DISABILITY 43, 49-50 (2000).

25. 20 C.F.R. §§ 404.1520(a), 416.920(a).

26. *Id.* §§ 404.1520(b), 416.920(b). For a discussion of SSA considerations in reaching a determination of "substantial gainful employment" see Kubitschek, *supra* note 24, at 50-57.

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eligibility for benefits. If, however, the SSA makes a negative determination, it will proceed to step two.

Second, the claimant must demonstrate a medically severe impairment that restricts his or her ability to work. Satisfaction of the severity requirement necessitates that the impairment or combination of impairments "significantly limit[] [one's] physical or mental ability to do basic work activities," without considering age, education, or work experience.[27]

Third, the SSA must determine whether the claimant's illness or injury is identical or equivalent to one of the medical conditions defined and listed in the regulations as presumptively disabling.[28] If the claimant's condition matches or is equivalent to one of the impairments in the "Listing of Impairments," and meets the duration requirement, her ability to work becomes irrelevant. The SSA will award benefits without any further inquiry into the effects of the impairment on her life.[29]

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27. *Id.* §§ 404.1520(c), 416.920(c). Basic work activities include walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, seeing, hearing, speaking, understanding and carrying out simple instructions, using judgment, responding adequately to supervision and co-workers, and adjusting to changes in a routine work setting. *Id.* §§ 404.1521, 416.921. Several circuit courts had invalidated the use of the severity step, holding that it "was facially inconsistent with the Social Security Act or that the SSA had regularly misapplied it by transforming a de minimis preliminary screening process into a much more powerful barrier justifying peremptory denials of large numbers of substantial cases." Koch & Koplow, *supra* note 16, at 211. The Supreme Court upheld the severity requirement, finding it consistent with the enabling statute. *See* Bowen v. Yuckert, 482 U.S. 137, 154 (1987). The SSA, however, issued a ruling on severity and noted that it should only preclude the weakest cases. Koch & Koplow, *supra* note 16, at 212. "An impairment or combination of impairments is found 'not severe' . . . when medical evidence establishes only a *slight abnormality or a combination of slight abnormalities* which would have no more than a *minimal effect* on an individual's ability to work . . ." S.S.R. 85-28 (1985) (emphasis added). This paper briefly explores one of the problems associated with establishing a severe impairment. *See infra* notes 79-108 and accompanying text.

28. 20 C.F.R. pt. 404, subpt. P app. 1 (2000). The "Listing of Impairments" enumerates more than 100 defined medical conditions, organized into fifteen categories of body systems. Koch & Koplow, *supra* note 16, at 212. The fifteen categories include: growth impairments, musculoskeletal system, special senses and speech, respiratory system, cardiovascular system, digestive system, genito-urinary system, hemic and lymphatic system, skin, endocrine system, multiple body systems, neurological disorders, mental disorders, neoplastic diseases, and immune system. 20 C.F.R. pt. 404, subpt. P app. 1 (2000). "Approximately three-quarters of disability awards are based on these listings." Koch & Koplow, *supra* note 16, at 212-13.

29. 20 C.F.R. §§ 404.1520(d), 416.920(d).

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Fourth, if the claimant's impairment is not equivalent or identical to any in the Listing, the SSA will examine the claimant's ability to do past relevant work. If the SSA determines that the claimant's "residual functional capacity"[30] enables the claimant to perform past relevant work, then the claimant is not disabled.[31]

Fifth, if the claimant cannot resume her former job, the SSA will proceed to the final step. During the last step of the sequential evaluation process, the SSA will again consider the claimant's "residual functional capacity." At this stage, however, the focus shifts from past relevant work to whether there are other jobs in the national economy that the claimant can perform.[32] The burden shifts to the SSA to establish that a significant number of jobs are available in the national economy that the claimant can perform. Essentially, the question becomes whether the claimant can perform *other* substantial gainful activity despite her impairments. The SSA answers this question using a set of tables known as the "Medical-Vocational Guidelines" [33] or "grids," which are a "series of charts designed to consider four key variables affecting ability to work."[34] The four variables include residual functional capacity,[35] age,[36] education,[37] and previous work experience and transferability of acquired skills.[38] "The grids combine all variables into eighty-two 'rules,' each deemed

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30. *Id.* §§ 404.1545, 416.945. "Your residual functional capacity is what you can still do despite your limitations. . . . [It] is an assessment based upon all the relevant evidence." *Id.* §§ 404.1545(a), 416.945(a).

31. *Id.* §§ 404.1520(e), 416.920(e).

32. *Id.* §§ 404.1566, 416.966. "We consider that work exists in the national economy when it exists in significant numbers either in the region where you live or in several other regions of the country." *Id.*

33. *Id.* pt. 404, subpt. P app. 2.

34. Koch & Koplow, *supra* note 16, at 214.

35. 20 C.F.R. §§ 404.1545, 416.945.

36. *Id.* §§ 404.1563, 416.963. Age is separated into three categories: advanced age (55 and over), approaching advanced age (50-54), and younger (under 50). *Id.* The SSA generally considers that a younger person's age does not seriously affect the ability to work. Persons approaching advanced age *may* be affected by age and those of advanced age are presumed to be significantly affected. *Id.*

37. *Id.* §§ 404.1564, 416.964. The Act contains several education categories: unable to communicate in English, illiterate, completion of sixth grade or less (marginal), completion of seventh through eleventh grade (limited), and high school and above. *Id.*

38. *Id.* §§ 404.1568, 416.968. The SSA will classify previous work experience as unskilled, semi-skilled, and skilled and skills as transferable or nontransferable. *Id.*

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'disabled' or 'not disabled.' If a claimant's medical vocational coordinates fall squarely on a grid rule, then that outcome determines the case."[39] The SSA will award benefits at the fifth step of the process if the claimant cannot perform other work, as determined by use of the grids.

The SSA will consider all medical evidence, including signs, symptoms and laboratory findings in making a determination of disability. The Act defines signs as those anatomical, physiological, or psychological abnormalities observed by trained professionals using medically acceptable clinical diagnostic techniques.[40] Trained professionals typically include three types of physicians: treating, examining, and non-examining.[41] The SSA accords varying degrees of weight to each physician's opinion and reports.[42] "Generally, we give more weight to opinions from [the claimant's] treating sources . . . ."[43] Symptoms are the claimant's description of any physical or mental impairment.[44]

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39. Koch & Koplow, *supra* note 16, at 214-15. These authors provide a useful illustration of how the grids operate.

> For example, a person (a) with the residual functional capacity for light work, (b) . . . approaching advanced age, (c) of limited or less education, and (d) who is skilled or semi-skilled with skills not transferable, would be found not disabled ... If the person is of advanced age, however, with all the other variables unchanged, a finding of "disabled" would be made ...

Id. at 214 n.81.

40. 20 C.F.R. §§ 404.1528, 416.928.

41. Kubitschek, *supra* note 24, at 75. A treating physician has treated the claimant long term and normally provides the most information on the claimant's condition. *Id.* at 75-77. An examining physician is one "who do[es] not actually provide treatment to the claimant over a period of time. Instead [she] examine[s] the claimant once, sometimes at the request of the [SSA]." *Id.* at 77. Non-examining physicians generally include either a review physician, "[a] physician[] hired by the agency to review the claimant's medical records and determine whether the claimant is disabled under [the] Social Security rules [, or a] physician[] called to testify as [an] advisor[] at hearings." *Id.* at 78.

42. *Id.* at 75.

43. 20 C.F.R. §§ 404.1527(d)(2), 416.927(d)(2). The SSA will give controlling weight to a treating physician's opinion if it is "well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in [the] case record." *Id.* If the SSA does not accord the treating physician's opinion controlling weight, it will apply a series of factors to determine the appropriate weight. *Id.* §§ 404.1527(d)(3)-(6), 416.927(d)(3)-(6).

44. *Id.* §§ 404.1528(a), 416.928(a).

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Laboratory findings are determined by x-rays, blood tests, and other similar medical tests.[45]

D. Award of Benefits

The SSA calculates the amount of disability benefits using a highly intricate formula. "In general, consistent with the insurance plan nature of [OASDI], the higher the claimant's prior covered earnings, the higher the payments the claimant receives. An SSI monthly disability check is designed to bring the claimant's income up to the established federal support level."[46]

E. Filing for Benefits and the Administrative Process

To obtain any benefits, a person must first file a claim form provided by the SSA at any district office.[47] As noted previously, the office will first investigate the claimant's financial eligibility for OASDI, SSI, or both. The district office will deny the application if it finds the claimant financially ineligible and will then send a notice of denial. If, however, the district office does not reject the claim at this preliminary stage, it will forward the file to the state Disability Determination Service ("DDS"), a second office under contract to the SSA, for a determination of disability.[48] The DDS solicits the claimant's hospital records and other medical evidence and may order consultative evaluations.[49] Once the DDS has fully developed the medical file, a DDS medical consultant and a disability examiner make the disability decision.[50]

The Act entitles a claimant to a "three-stage administrative review process" if the DDS denies the claim. The first step in the process is

45. *Id.* §§ 404.1528(c), 416.928(c).

46. Koch & Koplow, *supra* note 16, at 217; *see also* ABRAHAM & KOPELMAN, *supra* note 9, at 61-68; Kathryn L. Moore, *Redistribution Under a Partially Privatized Social Security System*, 64 BROOK. L. REV. 969, 971 n.13 (1998) (explaining the complex formula).

47. 20 C.F.R. §§ 404.614, 416.325; *see also* ABRAHAM & KOPELMAN, *supra* note 9, at 105.

48. 42 U.S.C. §§ 421(a), 1383b(a) (1994); 20 C.F.R. §§ 404.1503, 416.903.

49. 20 C.F.R. §§ 404.1513, 416.913. *Id.* § 404.1519a(b)(1-5) for those situations necessitating a consultative examination.

50. Koch & Koplow, *supra* note 16, at 219-20 n.116 for a description of these officials' roles in the decision-making process.

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reconsideration.[51] If after the reconsideration determination the applicant is still dissatisfied, she may request a hearing before a federal administrative law judge ("ALJ").[52] The third and final administrative remedy entails a review of the ALJ's decision by an SSA entity called the Appeals Council.[53] The SSA created the Appeals Council in an effort to establish some final central agency review and to ensure consistency with overall agency policy among the hundreds of ALJ decisions throughout the country. Review by the Appeals Council is purely discretionary, and the Council may, therefore, deny or dismiss a request for review.[54] If the Council grants review, it will consider all the evidence in the ALJ hearing record as well as any new and material evidence submitted.[55]

The Appeals Council's decision, either after review or following denial of review, becomes the final and appealable decision of the

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51. 20 C.F.R. §§ 404.907, 416.1407. Reconsideration is a de novo review of the application. Different personnel at the district office will review the financial eligibility decision or a new two-person team at the DDS will review the eligibility determination. Koch & Koplow, *supra* note 16, at 219. The personnel rely on the evidence in the original file and any additional evidence the claimant submits concerning the reconsideration. *Id.*

52. 42 U.S.C. §§ 405(b)(1), 1383(c)(1)(A); 20 C.F.R. §§ 404.929, 416.1429. The hearing is de novo and constitutes the first opportunity for the claimant to be represented by counsel. The ALJ may order additional examinations, solicit additional expert testimony, and question the claimant and all other witnesses. "The claimant (or a representative) may submit additional medical records and a brief, deliver opening and closing remarks, and question all witnesses. Hearings are non-adversarial, and the level of formality varies." Koch & Koplow, *supra* note 16, at 223; *see also* ABRAHAM & KOPELMAN, *supra* note 9, at 118-20.

53. 20 C.F.R. §§ 404.967, 416.1467; *see also* Koch & Koplow, *supra* note 16, at 231-65 (detailing the Appeals Council's role and function). A final decision by the Council shall be the final decision of the Secretary of Health, Education, and Welfare for purposes of judicial review and exhausts a claimant's administrative remedies. 20 C.F.R. §§ 404.981, 416.1481.

54. 20 C.F.R. §§ 404.967, 416.1467. The Appeals Council will only review those cases where the ALJ abused his discretion, there is an error of law, the decision is unsupported by substantial evidence, or the case implicates a broad policy or procedural issue. *Id.* §§ 404.970, 416.1470.

55. *Id.* §§ 404.976, 416.1476. It is unlikely that the claimant will appear before the Council to present oral argument. The regulations limit this procedure to those cases raising an important question of law or policy where reaching a proper decision necessitates oral argument. *See id.* §§ 404.976(c), 416.1476(c); *see also* Robert S. Haberman & Linda B. Kalet, *Oral Argument Before the Appeals Council*, 40 FED. B. NEWS & J. 512 (1993).

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Secretary.[56] A claimant must complete this three-stage process before appealing to the federal court system.

F. In the Federal Courts

The Act permits a claimant to bring a civil action, filed within sixty days, to review the Secretary's final decision.[57] Once at the district court level, the Act provides that the findings of the Secretary concerning any fact supported by substantial evidence shall be conclusive.[58]

> In other words, if the findings and conclusions drawn by the Secretary are reasonable under the circumstances, the court is not free to review the record and draw its own inferences and conclusions from it. The resolution of conflicting evidence is for the Secretary, not for the court, to decide.
>
> . . . The court, of course, determines issues of law, and the court is not in any way bound by the Secretary's interpretations, except insofar as his interpretations are entitled to weight because they are rendered by an administrative expert in this particular field.[59]

The United States district court has the power to enter "a judgment affirming, modifying, or reversing the decision of the Commissioner of Social Security, with or without remanding the cause for a rehearing."[60] The court may reverse if substantial evidence does not support the claim or may remand for a new hearing or new decision if the Secretary predicated his decision on an improper legal standard, adopted an inappropriate procedure, or based the decision on an incomplete record. The claimant may appeal the final judgment, like any other judgment in civil actions, to the court of appeals, and ultimately to the United States Supreme Court.

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56. 20 C.F.R. §§ 404.981, 416.1481.

57. 42 U.S.C. § 405(g).

58. *Id.* According to the Supreme Court, substantial evidence is "more than a scintilla. It is such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." Richardson v. Perales, 402 U.S. 389, 401 (1971).

59. ABRAHAM & KOPELMAN, *supra* note 9, at 124-25.

60. 42 U.S.C. § 405(g).

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II. ANALYSIS OF CASES

The sheer number of individuals that the Act affects should be enough in itself to persuade federal judges that as the final arbiters of social security appeals, there is an immeasurable value in the time and energy that they invest in a thoughtful consideration and fair decision of a claimant's appeal. According to the conclusion of the Federal Courts Study Committee Report,[61] however, the enormous scope of affected individuals has proven unpersuasive to many of those jurists. Those judges who remain unconvinced need only consider the number of issues that social security cases present. Without a doubt, social security cases seem unappealing because they are overly technical or unduly complex[62] and involve an unbelievable bureaucratic maze. No one should maintain, however, that only sexy or high-profile cases are worthy of a federal judge's intellectual exercise. Once one moves beyond the initial complexities presented by social security law, these cases involve claims that run the gamut of any law school curriculum and satisfy the appetite of even the pickiest legal mind; from civil procedure to constitutional law, from statutory construction to evidence.

Although the Report suggests that certain federal judges view social security cases as a waste of their time, no one could accuse Judge Posner of such a mindset. He is clearly not a proponent of the current system and its appellate scheme,[63] but his opposition is born not from a superiority complex, but, rather, from an overall dissatisfaction with the system's efficiency. His opposition manifests itself, therefore, not in the judicial arena by way of a summary disposition of a case, but in academia, by way of a scholarly discussion of the federal courts. The reader should remain mindful of the Report's findings as he or she reads through the following case studies, all the while inquiring whether any case hints that Judge Posner gave the social security claimant less attention than he would have given Microsoft if he had presided over that antitrust action.

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61. KUBITSCHEK, *supra* note 5; *infra* note 260 and accompanying text.
62. KUBITSCHEK, *infra* note 260 and accompanying text.
63. POSNER, *infra* note 132 and accompanying text.

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A. Standing: D'Amico v. Schweiker[64]

In *D'Amico*, seven ALJs sought an injunction against an instruction issued by the SSA. The instruction involved the announcement of a new policy, that of "retroactive cessation," cessation prior to the sending of notice that the SSA is terminating benefits.[65] The new policy mandated the point at which the SSA would begin recouping improperly paid benefits and, therefore, eliminated this determination from the ALJ's discretion.[66] On appeal to the Seventh Circuit, the court dismissed the cause of action for want of jurisdiction, finding that the ALJs lacked standing.[67]

The decision in *D'Amico* is consistent with the principles of standing. The judges could not demonstrate an injury that conferred standing. The policy did not affect their pay, benefits, or job conditions. Judge Posner also distinguished *D'Amico* from a case where the Second Circuit granted standing to an ALJ to seek an injunction against "an allegedly authorized regime of monitoring, evaluation and control" that directly affected an ALJ's decisional independence.[68] By contrast, however, *D'Amico* did not implicate decisional independence to any significant degree, as the

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64. 698 F.2d 903 (7th Cir. 1983).

65. *Id.* at 904-05.

66. *Id.* at 905. The new policy required that "the month in which the beneficiary receives notice that his benefits are being terminated – that is, there will be no retroactive cessation – except in specified circumstances, such as when the 'cessation was based on work activity.'" *Id.* (quoting instruction issued by the SSA). Previously the ALJ determined as a matter of fact the date of cessation by weighing the evidence. *Id.* The new policy "removed the date from the realm of fact." *Id.*

67. *Id.* at 907.

68. *Id.* at 906-07 (quoting Nash v. Califano, 613 F.2d 10, 11 (2d Cir. 1980)). *Nash* involved:

> "mandatory instructions concerning the proper length of hearings and opinions, the amount of evidence required in specific cases, and the proper use of expert witnesses"; the establishment of "an arbitrary monthly production quota" for administrative law judges; and an attempt to "control the number of decisions denying Social Security Benefits" by specifying 50 percent as the acceptable rate of reversal of administrative law judges' decisions and "counsel[ing] and admonish[ing] . . . those who deviate from the mean . . . to bring their rates in line with" this figure.

Id. at 907 (alterations in original) (quoting *Nash*, 613 F.2d at 13).

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directives at issue were non-substantive.[69] Judge Posner also expressed concern for allowing a suit where the ALJ would take sides in a controversy where he is the umpire, the impartial adjudicator.[70] The recipients, not the judges, constituted the appropriate parties to challenge the directives.

The decision is also fully consistent with Judge Posner's economic analysis of the federal judicial system. He has argued that the increased caseload in the federal courts is a simple matter of supply and demand.[71] The causes of demand are several. For instance, the fact that the minimum $10,000 amount in controversy requirement for diversity actions has not changed since 1958, and that inflation has eroded that amount by more than two-thirds, has increased demand in diversity cases.[72] Furthermore, Judge Posner notes that the "progressive relaxation of the elements of the justiciability requirement of Article III, notably mootness and *standing*"[73] has also led to increased demand. These increased demands have compromised the quality of the judicial process.[74] "The fall in price of that input -- from prohibitive to zero -- for a large class of federal litigants is the economic equivalent of a dramatic drop in the price of the services themselves."[75]

In response to these rising demands and the corresponding decline in service, Judge Posner proposed increasing the price of the services to limit the demand.[76] Since Judge Posner has identified standing as a factor

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69. 698 F.2d at 907. "The withdrawal, as in this case, of one issue from the factfinding power of the administrative law judges does not significantly impair 'decisional independence.'" *Id.*

70. *Id.* at 906-07.

71. RICHARD A. POSNER, THE FEDERAL COURTS: CRISIS AND REFORM 77 (1985) (viewing "federal judicial services as a product whose output, like that of other products, is governed by the laws of demand and supply"). *Id.*

72. *Id.* at 78-79. "Thus, many diversity claimants who would have been priced out of the federal judicial services market by the $10,000 minimum in 1960 can today, when $10,000 is worth less than a third as much, litigate their modest claims in federal court." *Id.* at 79.

73. Ian Shapiro, *Richard Posner's Praxis*, 48 OHIO ST. L.J. 999, 1009 (1987) (emphasis added) (citing POSNER, *supra* note 71, at 79)).

74. *See id.* at 1010-11.

75. POSNER, *supra* note 71, at 79.

76. His methods for limiting demand include raising the price of the service – increased filing fees, higher minimum amount-in-controversy in diversity cases,

adding to the explosive increase in the demand for judicial services, he was understandably reluctant to confer standing on the ALJs in *D'Amico*. A decision recognizing that the ALJs had standing would further broaden the justiciability requirements and exacerbate the federal court crisis.

The economic imagery Judge Posner invokes in deciding that the judges lacked a sufficient beneficial interest in the matter to have standing to sue is also noteworthy. In the decision, Judge Posner remarks that "[d]iscretion is a power, a commodity that judges, like other people, prize. A reduction in discretion is a reduction in an important though nonpecuniary form of compensation for a judge."[77] This comment prompted one commentator to note that "[Judge Posner] all but agreed that the judges had been injured."[78] A writer uses figurative diction in those portions of his texts where he wishes to produce a particular effect, such as a train of intellectual associations. For Judge Posner, those intellectual associations are often economic references. The imagery in this case illustrates his propensity to view legal matters through an economic lens. It is this unique method of analyzing legal issues that permitted him to concede that, to some degree, although not enough for purposes of standing, the ALJs had suffered an injury. Only through this economic rubric could one begin to reach the conclusion that the judges had demonstrated a legally cognizable injury. The economic imagery also reveals the thoughtful approach that Judge Posner adopted in deciding the case. One could easily imagine a cursory conclusion that the ALJs were not injured, but Judge Posner selected the more difficult path. He concedes that on a certain level the new policy had injured the ALJs, but that injury is not one that the courts can remedy.

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reinstatement of a minimum amount in other cases, and a requirement that losing litigants in civil litigation pay the winners' attorneys fees. *See id.* at 95-97.

77. *D'Amico*, 698 F.2d at 905.

78. James Wilson, *Constraints of Power: The Constitutional Opinions of Judges Scalia, Bork, Posner, Easterbrook and Winter*, 40 U. MIAMI L. REV. 1171, 1224 (1986).

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B. Substantive Issues Affecting Disability Evaluations

1. Medical Severity Threshold Standard: *Wallschlaeger v. Schweiker*[79]

The claimant in this case, Margaret Wallschlaeger, appealed to the Seventh Circuit to set aside a district court decision affirming the denial of a claim for social security disability. In 1957, Wallschlaeger underwent an operation to remove her thyroid gland that partially paralyzed her vocal cords.[80] Although her speech remained relatively unaffected, the operation restricted the airway in her throat and rendered her breathing difficult. She continued to work intermittently after her surgery until 1965, doing light factory assembly work. In 1977, she applied for disability benefits, which the SSA denied. The ALJ found that "the testimony of the claimant and the medical evidence of record also indicate that the claimant's breathing problem is not severe enough to preclude substantial gainful work activity of a sedentary classification such as the claimant has previously performed or for which she would have some transferable skills."[81] The magistrate upheld the finding of the ALJ, but remanded the case to the SSA to determine if she suffered from psychological impairments.[82] After another hearing and a review of the evidence, the ALJ found that she was not disabled, a finding that the magistrate and district court judge upheld.[83]

On appeal to the Seventh Circuit, Judge Posner affirmed the denial of benefits. He first noted that the court's review of a finding of non-disability was highly deferential – asking only if there was substantial evidence to support that finding.[84] "The only serious issue is whether the breathing problem caused by the 1957 thyroidectomy is disabling."[85] The opinions of doctors and evidence concerning her condition conflicted. Several doctors concluded that she was unable to perform any activity that would require physical exertion. Another doctor did not report any

79. 705 F.2d 191 (7th Cir. 1983).
80. *Id.* at 194.
81. *Id.*
82. *Id.*
83. *Id.*
84. *Id.*
85. *Id.* at 195.

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disabling impairment. An examining psychiatrist stated that she did not exhibit any difficulty in breathing and that she was "largely malingering."[86] Judge Posner recognized that only actual observation of the claimant would reveal the extent of her breathing disability, not objective testing.[87] "The opportunity to observe her is one of the inestimable advantages that the first administrative law judge in this case had over us."[88]

The ALJs considered that Wallschlaeger had successfully functioned as a wife and mother for twenty years, giving birth three times, while suffering from her breathing impairment. She had done light factory work as late as 1965, and there was no evidence that her breathing worsened since then. "If she was able to do light work then, she should be able to do it now."[89]

The court then considered the necessity of a vocational expert to determine whether there were jobs similar in their skill and exertion requirements to the light factory work that she performed until 1965. The claimant argued that the ALJ should have rated her work experience as

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86. *Id.*

87. *Id.*

88. *Id.*

89. *Id.* Posner also cited portions of the report of the psychiatrist who interviewed her.

> This patient's typical day consisted of the following: On the Sunday prior to the interview, she claimed that she walked around and waited on people in a flea market for a friend. At this job she takes money and plays a record player. She said that she sold junk dishes, candy, fudge, brownie[s] which she makes at home. She said that she can fix meals, read the paper, make beds and is quite proud of making her own clothes, by sewing. She also claimed to make quilts. She also goes to the C.I.O. Hall to help with bingo games, where she sells popcorn and makes sandwiches, claiming that she gets $6.00 and is allowed to play bingo. She said that she goes grocery shopping with a sister, goes to relief office, the food stamp place, and also belongs to the Eagles' Club. At the club she said that she [waits? – transcript is illegible] tables when they have an affair. She also claimed to have gone to a Christmas Party last week and had a good time. She said that she also belongs to the Baltic Club and goes to meetings occasionally. She said that she attends several club meetings at least once a month.

Id. (alteration in original).

zero since it took place more than fifteen yeas ago[90] and that this rating, coupled with the other factors in the grid matrix, suggested a finding of disabled. Judge Posner rejected her argument because it failed to proceed sequentially through the determination of disability. The regulations provide for a sequential determination, and, therefore, the applicant must first demonstrate a medically severe impairment before getting on the grid.[91] It was at this threshold level, the demonstration of a medically severe impairment, that Wallschlaeger had failed. Only after one establishes a severe impairment (step two) will the SSA or court consider the residual functional capacity and the physical and mental demands of previous work (step four).

After having dismissed the plausibility of this claim, Judge Posner concluded that substantial evidence supported the ALJ's findings. He considered the two methods for establishing an impairment, and determined that Wallschlaeger could not avail herself of either method. First, neither her impairment nor an equivalent was listed. Second, the evidence did not support a limit, either physical or mental, to performing basic work activities. The SSA must have flexibility in deciding whether an applicant can do basic work activities even if she is unable to perform all activities listed in the regulation. "[W]e doubt [the regulation] could be read to make the lifting of heavy objects or any other strenuous physical exertion an indispensable element of basic work activities."[92]

Judge Posner criticized the ALJ for even considering whether Wallschlaeger could perform her prior work or other jobs. This analysis, according to Posner, was a technical error under the regulations.

> The administrative law judge should have stopped with the passage quoted above ["the claimant's impairments are not severe enough, singly or in combination, to warrant a finding of disability based on medical considerations alone"]. Only a "medically determinable . . . impairment" is within the purview of the statute. . . .

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90. The regulations define previous work experience as experience acquired in a job held within the last 15 years. 20 C.F.R. § 416.965(a) (1998).

91. *Wallschlaeger*, 705 F.2d at 196. In deciding the case on these grounds, Judge Posner was able to pass on the issue of whether the application for disability benefits tolls the running of the 15-year period. Recall, Wallschlaeger worked until 1965, and applied for benefits in 1977. Her appeals process continued, however, into the early 1980s.

92. *Id.* at 197.

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> The administrative law judge had found that Mrs. Wallschlaeger did not have a severe medically determinable impairment; that finding barred her claim under the statute and regulations.[93]

A failure at the second step to demonstrate a severe medically determinable impairment precludes an ALJ from proceeding in the sequential evaluation and, therefore, the ALJ should never have concerned himself with Wallschlaeger's ability to perform prior work.

The opinion evokes a relatively unsympathetic tone and concludes that "[t]he statute does not seek to foster a type of welfare dependency that consists of, in the psychiatrist's description of Mrs. Wallschlaeger, 'using and exaggerating physical symptoms in the pursuit of a goal recognizable by the patient for financial compensation and [to] avoid some work.'"[94] Despite this tone, however, one federal judge followed Judge Posner's reasoning to *relieve* a claimant of some of the arduous burden of the social security process. In *Hundrieser v. Heckler*,[95] the plaintiff challenged the facial validity of the regulation defining "severe impairment." The plaintiff was fifty-eight years old with an eighth-grade education and two years of vocational training. He worked as a maintenance mechanic until extensive knee problems caused him to discontinue working and to undergo a tibial osteotomy.[96] He did not return to work after the operation, and his knee condition continued to limit his ability to stand, walk, climb, and kneel.[97] The ALJ implicitly concluded that the plaintiff could not return to his past work, but determined that the plaintiff's impairments were not severe because they did not significantly limit his ability to perform basic work-related functions. The plaintiff was, therefore, denied benefits at the second stage of the five-step sequential evaluation. "The interesting aspect of this case stems from the fact that the

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93. *Id.* (citation omitted).

94. *Id.* at 197-98.

95. 582 F. Supp. 1231 (N.D. Ill. 1984). An Idaho district court conducted a similar analysis as the one set forth for *Hundrieser*. Stout v. Heckler, 579 F. Supp. 237, 239 (D. Idaho 1984) (noting that an inability to do past relevant work is at least an indication of a severe impairment and using Judge Posner's decision in *Wallschlaeger* as support for this rule).

96. The record also reflected that the claimant had been diagnosed with hypertension, degenerative disc disease, and bilateral carpal tunnel syndrome. *Hundrieser*, 582 F. Supp. at 1234.

97. *Id.*

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record as it now stands provides strong support for a finding that plaintiff is disabled, had the ALJ continued his review through all five steps."[98] The plaintiff argued that he would satisfy the definition of disabled under step five, and as such, the regulations contained a fatal inconsistency between severe impairment and the definition of disability in the underlying statute.[99]

The district court reviewed the statutory language, legislative history, history of the regulation, and burdens of proof under the statute, and determined that the court should narrowly interpret the regulation concerning "severe impairment." A narrow interpretation would not require a claimant, who was unable to do his previous work, to prove at the threshold level that he suffers from a "severe impairment."[100] The district court's interpretation of "severe impairment," therefore, required the Secretary to show that the claimant's impairments were presumptively non-disabling. The claimant may then rebut the presumption by showing that his impairments prevent him from doing his past work.[101] "In other words, by making out a prima facie case of disability through showing an inability to do past work due to 'an impairment' the claimant necessarily satisfies the 'severe impairment' requirement of 20 C.F.R. § 404.1520(c)."[102] The district court determined that this interpretation protected claimants from a statutorily unwarranted increase in the burden of establishing a prima facie case of disability.

The district court cited *Wallschlaeger* as support for its interpretation. It emphasized that Judge Posner noted at several points that Wallschlaeger retained her ability to do her past work, and, as such, she failed to rebut the Secretary's showing of presumed non-disability and absence of a severe impairment.[103]

> Judge Posner's discussion of the relationship between the severe impairment requirement of § 404.1520(c) and the statutory definition of disability supports this court's view of the requirement as limited in scope and satisfied

98. *Id.* at 1235.

99. *Id.* at 1235-36.

100. *Id.* at 1240-41. A narrow construction of the regulation also allowed the district court to side-step striking it down and to keep the regulation intact.

101. *Id.* at 1242.

102. *Id.*

103. *Id.* at 1243.

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> by the claimant who makes out a prima facie case: "If you do not have a severe impairment [under the regulations] you are not disabled even if you have some slight impairment that disables you from performing any work which you have or are qualified to do. But in a practical sense an impairment that prevents an applicant from doing any work he is qualified to do is a severe impairment, for by hypothesis it is totally disabling, and the statute itself . . . defines 'severe' in just that practical way."[104]

The district court in *Hundrieser* remanded the case, which granted the plaintiff an opportunity to establish his inability to perform past work due to a medically demonstrable physical impairment. Once the plaintiff presents such a prima facie case, the burden then shifts to the Secretary to prove that the plaintiff was capable of filling jobs that exist in significant numbers in the national economy.[105]

This scheme, apparently supported by Judge Posner's decision in *Wallschlaeger*, certainly diminishes the burden on a claimant. It allows a claimant, whose inquiry would ordinarily halt at step two, a second chance to demonstrate a severe impairment. The process is sequential in nature and, therefore, at the moment the claimant fails to carry his or her burden of proof at a particular step, the process ends. This prima facie case and rebuttable presumption theory, endorsed by the district court and supported by Judge Posner, seems at odds with the sequential evaluation process. The severity requirement ignores age, education, and work experience, and focuses uniquely on significant limitations of one's physical or mental ability to perform basic work activities.[106] The analysis set forth in *Hundrieser* and supported by *Wallschlaeger*, however, indirectly injects these elements into the inquiry. It allows a claimant to stay in the game despite losing at step two if she can demonstrate an inability to perform her prior job (step four in the sequential evaluation process). The claimant skips to step four and forces the Secretary to proceed to step five -- whether there are other jobs in the national economy that the claimant can perform.

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104. *Id.* (quoting Wallschlaeger v. Schweiker, 705 F.2d 191, 197 (7th Cir. 1983)) (citations omitted).

105. *Id.*

106. 20 C.F.R. § 404.1520(c) (1998).

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Nearly every individual who has studied or had any contact with the Act has commented on its complexity. Indeed, the Act's intricacies and entanglements have led one commentator to label it "the Mount Everest of bureaucratic structures."[107] Judge Posner, in *Wallschlaeger*, similarly criticized "the byzantine labyrinth of the Social Security Administration's regulations."[108] Perhaps it is for this reason that the courts on occasion bend over backwards to ensure that an individual's claim does not fail at the preliminary stages of the process. Without a creative interpretation of the regulations in *Hundrieser* and supporting comments from a previous Posner opinion, the court would have determined that the SSA had appropriately denied the application at the initial stages of the process. Judge Posner and others have not been shy in their critical evaluations of the SSA's process, and perhaps that skepticism has led, on occasion, to some judicial ingenuity out of sympathy for claimants who must negotiate their way through the labyrinth.

2. Weight of Treating Physician Assessment: *Cummins v. Schweiker*[109]

The claimant, Duane Cummins, applied for social security disability benefits, which the ALJ denied after a hearing. He was forty-nine years old, of limited education, literate, and had been involved in lumberyard and farm labor jobs, all of which involved heavy manual labor.[110] Cummins had been blind in one eye for years and an automobile accident had left him with a permanent but mild weakness on the right side of his body. Moreover, he had arthritis in his knees and right shoulder.[111] The ALJ found that Cummins was capable of sedentary work, even though he had never engaged in such work.[112] As prescribed by statute, the ALJ invoked the mechanical approach to determine whether Cummins' characteristics established a finding of disabled or non-disabled. The applicable rule dictated that if the applicant, Cummins:

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107. Paul R. Verkuil, *The Self-Legitimating Bureaucracy*, 93 YALE L.J. 780, 781 (1984).

108. *Wallschlaeger*, 705 F.2d at 194.

109. 670 F.2d 81 (7th Cir. 1982).

110. *Id.* at 82.

111. *Id.*

112. *Id.*

> is 45-49 years of age, has limited or less education but is at least literate and able to communicate in English, has either no previous work experience or previous work experience limited to unskilled labor, and in his present condition is capable at most of sedentary labor . . . then he is not disabled.[113]

Cummins raised several issues on appeal, only one of which this section considers.[114] Cummins challenged the ALJ's finding that he had the exertional capability to perform sedentary work.[115] The ALJ discredited Cummins' own testimony and gave little or no weight to the testimony of Cummins' personal physician. The medical evidence conflicted and Cummins argued that the ALJ should have accorded more deference to his personal physician's judgments and opinions. Judge Posner rejected Cummins' argument and upheld the ALJ's finding. Judge Posner noted that "this physician had examined Cummins more extensively than anyone else; but as Cummins' personal physician he might have been leaning over backwards to support the application for disability benefits; therefore the fact that he had greater knowledge of Cummins' medical condition was not entitled to controlling weight."[116]

Judge Posner's decision in *Cummins* cast doubt on what had become the treating physician rule ("TPR").[117] The TPR is "a judicially created

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113. *Id.* at 83. "Where the findings of fact made with respect to a particular individual's vocational factors and residual functional capacity coincide with all of the criteria of a particular rule, the rule directs a conclusion as to whether the individual is or is not disabled." *Id.* at 82-83 (quoting 20 C.F.R. § 200.00 app. 2 (1998)).

114. Cummins challenged the "grid" approach as violative of the statute, which requires that the Secretary's denial of an application for benefits be supported by substantial evidence. *Id.* at 83-84. Judge Posner rejected this challenge and found the binding criteria of Appendix 2 valid, provided those criteria were reasonable. Judge Posner similarly rejected Cummins' claim that blindness in one eye had interfered with his previous work and would interfere with sedentary work. *Id.* at 84.

115. *Id.*

116. *Id.*

117. It should be noted that the SSA changed its regulations concerning the weight accorded to medical opinions in 1991. At the time *Cummins* was decided, however, the regulations contained only a cursory consideration of medical opinions. The extent of the regulation was as follows:

> We are responsible for determining whether you are disabled. Therefore, a statement by your physician that you are "disabled" or "unable to work" does not mean that we will determine that you are

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presumption designed to aid disabled Americans in proving disability to the SSA. In short, the TPR requires that when an applicant's own physician or psychologist . . . establishes that the claimant is disabled, that physician's decision binds SSA, unless contradicted by substantial evidence."[118] Neither the Act nor the constitution required the rule.

Judge Posner gave license to the ALJs to accord little or no weight to treating physicians when compared to opinions expressed by non-treating physicians and overruled what had been the law in the Seventh Circuit. *Cummins* abandoned the theory that "[o]nce it is determined that an impairment exists, the opinions of the treating physician are entitled to substantially greater weight than the impressions of a doctor who sees the claimant only once."[119]

The lower courts in the Seventh Circuit interpreted *Cummins* as a rejection of a per se rule that a treating physician's evidence is entitled to controlling weight.[120] District courts began recognizing "the real-world likelihood that a patient's regular treating physician 'might have been leaning over backwards to support the application for disability benefits.'"[121] Judge Posner's doubts concerning evidence offered by treating physicians spread beyond the Seventh Circuit. Indeed, judges in the Third, Sixth, and Ninth Circuits have referred to his "leaning over backwards" comment.[122]

The effect of allowing an ALJ to ignore the TPR generated much criticism. Critics believed that treating physicians should constitute the preferred source of evidence because of their substantial familiarity with

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> disabled. We have to review the medical findings and other evidence that support a physician's statement that you are "disabled."

20 C.F.R. § 404.1527 (1983). The changes in the regulations will be taken up shortly. *See infra* notes 134-137 and accompanying text.

118. George Szary, Note, *The Treating Physician Rule: Morgan Presumption in Social Security Disability Insurance and Supplemental Security Income Cases*, 17 N.Y.U. REV. L. & SOC. CHANGE 303, 304 (1989-1990).

119. Allen v. Weinberger, 552 F.2d 781, 786 (7th Cir. 1977) (quoting Selig v. Richardson, 379 F. Supp. 594, 601 (E.D.N.Y. 1974)).

120. Carter v. Schweiker, 535 F. Supp. 195, 203 (S.D. Ill. 1982).

121. Kindred v. Heckler, 595 F. Supp. 563, 566 (N.D. Ill. 1984) (quoting *Cummins*, 670 F.2d at 84).

122. Pysher v. Heckler, 640 F. Supp. 837, 840 (E.D. Pa. 1986); Blevins v. Secretary of Health & Human Servs., 831 F.2d 293 (6th Cir. 1987) (Wellford, J., dissenting) No. 86-3521, 1987 U.S. App. LEXIS 13132 (6th Cir. Oct. 5, 1987); Brownton v. Heckler, 571 F. Supp. 140, 143 (N.D. Cal. 1983).

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the claimant's abilities and limitations, a familiarity absolutely unavailable to a one-time treating physician.[123] "The opinion of the treating physician, because it is based on an ongoing relationship with the patient, has a direct bearing on the likelihood of disability and is therefore exceptionally probative in nature."[124] Moreover, Judge Posner's rejection of a deferential approach conflicted with the Act's unequivocally remedial nature and disregarded that its intent is "inclusion rather than exclusion" of claimants.[125]

In *Schisler v. Bowen*,[126] the Second Circuit rejected Judge Posner's view of a treating physician's testimony. According to the *Schisler* court, "[w]here [the] SSA finds that the opinion of a treating source regarding medical issues is inconsistent with other evidence in file, including opinions of other sources, the adjudicator must resolve the inconsistency, according to the [treating physician rule]."[127] No such mandate existed, however, in the Seventh Circuit. In fact, one could read the *Cummins* decision quite broadly so as not even to require the existence of conflicting medical evidence. In *Cummins*, Judge Posner noted that the medical evidence was disputed, but did not identify to what extent or how it was in dispute, nor did he couch his rejection of the rule in terms of a requirement that the medical evidence conflict. Instead, the opinion painted an objection to the rule with a broad brush and stated that courts and the ALJs may validly consider, without limitation, incentives when they resolve issues of credibility.

It is interesting that Judge Posner condoned, and arguably encouraged, skepticism of a treating physician's motives because that individual may be "leaning over backwards" to aid her patient in obtaining disability benefits. He offered no plausible motivation for a physician to collude with a claimant, offer fraudulent testimony and compromise his or her professional reputation. Rather than justify his position, he summarily stated his conclusion that doctors may bend over backwards to help their patients. "The relatively small amounts obtained by claimants preclude a

123. Szary, *supra* note 118, at 320.
124. *Id.* at 329.
125. Marcus v. Califano, 615 F.2d 23, 29 (2d Cir. 1979).
126. 851 F.2d 43 (2d Cir. 1988).
127. *Id.* at 47.

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financial windfall for doctors."[128] His sanctioning of this suspicion is also curious in that it wholly ignores the government's motivations. Desires to maintain SSA contracts may drive consulting examiners to offer conclusions in favor of the SSA. Whereas a doctor is unlikely to receive a windfall from one claimant's benefits, the same cannot be said of a doctor who secures a government contract. "Physicians were pressured [by the SSA] to reach 'conclusions' contrary to their own professional beliefs where they felt, at the very least, that additional evidence needed to be gathered."[129] "[S]kepticism can be counseled concerning the report of a physician employed and paid by the government solely for the purposes of defending against a disability claim."[130] Moreover, SSA examiners remain unencumbered by financial concerns since the government foots the bill. Those examiners can, therefore, generate more evidence and more tests that may lead an ALJ to conclude erroneously that the sheer weight of the government examiner's evidence establishes more reliability. "Even the most sympathetic fact-finder would not be remiss in assuming such evidence to be more probative and reliable. Poor claimants may be disadvantaged because the general practitioner's diagnosis and prognosis, although dependable, may be obscured by evidence generated by the SSA through its superior resources."[131]

Judge Posner has voiced his concern on a number of occasions for the overburdened federal caseload and the role social security appeals play in that congestion. This concern may explain his position in *Cummins*. A decision to the contrary would have eliminated certain ALJ discretion and left an ALJ's credibility determination vulnerable. Such a situation could lead to more appeals to the federal courts – an undesirable result in Judge Posner's eyes. In fact, he, along with several other commentators including Justices Rehnquist and Scalia, have suggested that federal

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128. Szary, *supra* note 118, at 338. Szary then notes that "[t]he amount of monthly disability benefits is based on a worker's lifetime average earnings covered by Social Security." *Id.* at 338 n.207. "The average monthly benefit for a worker early in 1989 is $529." *Id.* (quoting Social Security Administration, U.S. Dept. of Health and Human Services, Pub. No. 05-10029, Disability 14 (1989)). "The basic Federal SSI payment for an eligible person is $368 a month." *Id.* (quoting Social Security Administration, U.S. Department of Health and Human Services, Pub. No. 05-1000, SSI 10 (1989)).

129. *Id.* at 334 (quoting City of New York v. Heckler, 578 F. Supp. 1109 (E.D.N.Y. 1984), *aff'd*, 476 U.S. 476 (1986)).

130. Whitson v. Finch, 437 F.2d 728, 732 (6th Cir. 1971).

131. Szary, *supra* note 118, at 330.

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review of social security appeals (or at least one level of federal review) should be eliminated altogether.[132] It came, therefore, as little surprise that Judge Posner refused to reverse the ALJ's decision in *Cummins* because such reversal of SSA examiners would waste judicial time and resources.[133] Similarly unsurprising was the depth of Judge Posner's analysis. Notwithstanding his suggestion to eliminate federal review altogether, the *Cummins* decision does not betray Judge Posner's commitment to the legal system. Although the *Cummins* decision added several hurdles to a claimant's successful path to benefits, it does not suggest that Judge Posner treated the case in a non-serious or summary fashion.

As noted earlier, the Secretary expanded the regulations that govern the consideration and weight of medical opinions.[134] The Secretary changed the regulations, in large part, to address public concern and the conflict among the circuit courts. As of 1991, therefore, the regulations eliminated the judge-made TPR and standardized the level of deference accorded to a treating physician's evidence.[135] The regulations now enumerate detailed factors that the SSA must consider to determine the appropriate weight of medical opinions.[136] The promulgation of new regulations that govern the evaluation of medical evidence has largely

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132. RICHARD A. POSNER, THE FEDERAL COURTS 265-67 (1999).

133. Szary, *supra* note 118, at 337.

134. The regulations now declare that each medical opinion should be evaluated, regardless of its source.

> [B]ecause opinions always have a subjective component, because the effects of medical conditions on individuals vary so widely, and because no two cases are ever exactly alike, it is not possible to create rules that prescribe the weight to be given to each piece of evidence that (may be taken) into consideration in every case.

Evaluating Medical Opinions, 56 Fed. Reg. 36934-935 (1991) (to be codified at 20 C.F.R. § 404.1527(d)(2), § 416.927(d)(2)).

135. This statement may not be wholly accurate. It is questionable whether some courts have interpreted the Secretary's "treating source regulation" to supercede the TPR. *See* Rachel Schneider, Comment, *A Role for the Courts: Treating Physician Evidence in Social Security Disability Determinations*, 3 U. CHI. L. SCH. ROUNDTABLE 391, 402-05 (1996).

136. 20 C.F.R. § 404.1527(d)(2), § 416.927(d)(2); *see also supra* note 43; Thomas P. Smith & Patrick M. Fahey, *Some Points on Litigating Title II and Title XVI Social Security Disability Claims in United States District Court*, 14 QUINNIPIAC L. REV. 243, 256-59 (1994) (discussing the regulations); Schneider, *supra* note 135, at 400-02 (discussing the regulations).

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mooted much of the criticism of Judge Posner's opinion in *Cummins* because the regulations themselves now govern the level of deference. The *Cummins* decision appears to have sparked the abandonment in some circuits of "the long reign of the 'treating physician rule' in the courts."[137] The rule's abandonment in some circuits, but not in others, created a conflict in the circuits, which the new regulations sought to address. The new regulations essentially codify Judge Posner's skepticism of treating physician evidence.

3. Previous Work: *Strittmatter v. Schweiker*[138]

Dorothy Strittmatter applied for disability benefits. The ALJ denied her application based upon a finding that she was capable of doing the work she had done in the past. Strittmatter was fifty-nine years old and was last employed in 1973, operating a small machine to assemble parts.[139] She had numerous medical problems, including cataracts in both eyes and scoliosis, or curvature of the spine.[140] She experienced difficulty turning her neck and torso, incessant pain in her back, chest, and shoulder, and difficulty breathing. Moreover, her thick corrective lenses impaired her peripheral vision. One doctor stated that he believed she "could actually do a job, sitting down because her upper extremities are very functional."[141] On the basis of this opinion, the ALJ concluded that she could perform sedentary work. "The claimant's former work involved sedentary work activity. Accordingly, the undersigned concludes that the claimant would be able to return to her former job as a machine operator or other assembly jobs she had [that] were sedentary in nature."[142] Judge Posner noted that this statement constituted the "entire relevant portion" of the ALJ's decision.[143] The Seventh Circuit reversed and remanded the case for additional findings on whether Strittmatter was capable of doing her former work.[144]

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137. Smith & Fahey, *supra* note 136, at 257.
138. 729 F.2d 507 (7th Cir. 1984).
139. *Id.* at 508.
140. *Id.* at 508-09.
141. *Id.* at 509.
142. *Id.*
143. *Id.*
144. *Id.* at 509-10.

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The significance of this case lies in the interpretation of "previous work." According to one author, the courts of appeals are split as to the meaning of "previous work" under the statute's definition of disability.[145] One line of cases interprets "previous work" to mean an individual's "type" of work, while the other line interprets the phrase to mean "exact" work.[146] The "type" of work interpretation requires a claimant to establish an inability to perform his former type of work rather than a specific job.[147]

Judge Posner's decision in *Strittmatter* represents one of the "leading 'exact' work cases."[148] The "exact" work meaning requires the ALJ to "ascertain the demands of [the claimant's previous work] in relation to the claimant's present physical disabilities."[149] Under the "exact" work theory, an ALJ may not find a claimant capable of performing previous work merely because that claimant can perform a generic exertional category of work, into which category the past work falls.

As an illustration of this theory, consider Strittmatter. The ALJ first determined that she could perform generic sedentary work. Next, the ALJ found that her prior work was sedentary. In light of these two determinations, the ALJ concluded that Strittmatter could perform her prior work and denied her benefits. According to Judge Posner, however, this reasoning erroneously presumed all types of sedentary work were similar.[150] "The physical demands placed on a receptionist or a ticket seller are not the same as those placed on a factory worker operating machinery."[151]

Judge Posner's "exact" theory, rather than the "type" of work theory, allows for an individualized assessment and is thus more consistent with the Act's purpose.[152] It also simplifies appellate review and reduces the

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145. Wayne A. Kalkwarf, *Social Security Disability Determinations: Resolving the Conflict as to the Definition of 'Previous Work'*, 17 CAP. U.L. REV. 1, 6 (1987).

146. *Id.*

147. *See, e.g.*, Torres v. Calebrezze, 349 F.2d 342 (1st Cir. 1965).

148. Kalkwarf, *supra* note 145, at 6.

149. *Strittmatter*, 729 F.2d at 509.

150. The Seventh Circuit's analysis is the same as that in the Third, Fifth, Eighth, and District of Columbia Circuits. Podeworny v. Harris, 745 F.2d 210 (3d Cir. 1984); Epps v. Harris, 624 F.2d 1267 (5th Cir. 1980); Millbrook v. Heckler, 780 F.2d 1371 (8th Cir. 1985); Diabo v. Secretary of Health, Educ. and Welfare, 627 F.2d 278 (D.C. Cir. 1980).

151. *Strittmatter*, 729 F.2d at 509.

152. Kalkwarf, *supra* note 145, at 14.

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appellate inquiry to whether the record reveals that the Secretary compared the claimant's prior work and present capabilities, rather than the more difficult determination of whether the Secretary properly categorized the claimant's job.[153] Moreover, step five, whether a claimant can perform other work that exists in the economy, constitutes the more appropriate point to consider evidence of other jobs.

C. Judicial Review

1. Issue Exhaustion: *Johnson v. Apfel*[154]

Johnson v. Apfel specifically overruled Seventh Circuit authority requiring issue exhaustion in the adjudication of social security appeals. Prior case law demanded that a claimant raise an issue before the Appeals Council in order to preserve it for appeal to the federal court system.[155] The doctrine of issue exhaustion is judge-made, extending the general principle that "an appellate court does not give consideration to issues not raised below" to "administrative agencies entrusted with the responsibility of fact-finding."[156] "[It] reflects the extension to administrative law of this settled principle of formal judicial appellate procedure."[157] The vast majority of circuit courts recognize the doctrine.[158] In those circuits, "just as federal district court review requires that claimants' arguments be specifically and fully developed, briefed, and presented by counsel in order to preserve further appellate review, so too this formal 'judicialized' approach must now be followed in SSA administrative adjudication."[159]

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153. *Id.* at 15.

154. 189 F.3d 561 (7th Cir. 1999).

155. Banuelos v. Apfel, 165 F.3d 1166 (7th Cir. 1999); *see also Johnson*, 189 F.3d at 562-63 (listing the Seventh Circuit cases that extended issue exhaustion to the administrative arena).

156. Hormel v. Helvering, 312 U.S. 552, 556 (1941).

157. Jon C. Dubin, *Torquemada Meets Kafka: The Misapplication of the Issue Exhaustion Doctrine to Inquisitorial Administrative Proceedings*, 97 COLUM. L. REV. 1289, 1310 (1997).

158. Gonzalez-Ayala v. Sec'y of Health & Human Servs., 807 F.2d 255, 256 (1st Cir. 1986); Krystoforski v. Chater, 55 F.3d 857, 858, 860 (3d Cir. 1995); Cline v. Chater, No. 95-2076, 1996 WL 189021, at *4 (4th Cir. Apr. 19, 1996); Paul v. Shalala, 29 F.3d 208, 210-11 (5th Cir. 1994); Harper v. Sec'y of Health & Human Servs., 978 F.2d 260, 262, 265 (6th Cir. 1992); Miller v. Shalala, No. 93-56444, 1995 WL 299847, at *1 (9th Cir. May 10, 1995); James v. Chater, 96 F.3d 1341, 1343-44 (10th Cir. 1996).

159. Dubin, *supra* note 157, at 1318.

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Recently, however, several circuits, including the Seventh Circuit in *Johnson*, have begun to reject the doctrine. The split among the circuits precipitated review by the Supreme Court, which affirmed the position taken by the Seventh Circuit.[160]

In the face of strong support for issue exhaustion and a Seventh Circuit opinion issued just months before *Johnson* that reaffirmed the doctrine, Judge Posner authored an opinion that expressly rejected the concept in the context of social security. He determined that prior decisions requiring issue exhaustion could not "be squared with the regulations governing appeals to the Appeals Council."[161] The regulations allow for, but do not require, the filing of a brief with the Appeals Council.[162] The regulations merely require a dissatisfied claimant to complete a one-page form that provides three lines for the statement of the issues and grounds for appeal.[163] The regulations do not contemplate a waiver and the SSA "knows how to draft [a] waiver rule."[164] Since the SSA opted not to draft such a rule, a court cannot "compel disappointed applicants for disability benefits to bombard the Appeals Council with full briefs in order to preserve their right to judicial review" and do a disservice to the agency.[165] Issue exhaustion would threaten the informal inquisitory nature of the administrative process and replace it with a formal adversarial process.

Valid concerns exist for transforming a non-adversarial process, in which few claimants have the financial resources to secure an attorney, into a full-blown adversarial proceeding. The expectations of administrative agencies differ vastly from those of the federal courts and the expectations should, indeed, remain distinct. These concerns certainly affected the decision to reject the issue exhaustion requirement in disability appeals.

There was likely another concern that motivated the result in *Johnson*. Although Judge Posner suggests that fears of disservicing the agency counsel rejection of the issue exhaustion doctrine, his scholarly works suggest additional motives. Judge Posner has openly criticized the

160. Sims v. Apfel, 530 U.S. 103 (2000).
161. *Johnson*, 189 F.3d at 563.
162. *Id.* (citing 20 C.F.R. § 404.975 (1998)).
163. *Id.* (citing 20 C.F.R. § 422.205(a)).
164. *Id.*
165. *Id.*

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Appeals Council, calling it "an obscure body within the Social Security Administration."[166] "The opinions of the Appeals Council that I have read --- and I have read a great many -- are perfunctory, even when difficult questions are presented concerning the administrative law judge's decision."[167] Judge Posner is undoubtedly aware of the studies that suggest the inefficiencies and problems of the Council.[168] In light of his own views of the Council's deficiencies and the comprehensive studies that reveal a gravely flawed system, it comes as little surprise that Judge Posner disagreed that "issue exhaustion serve[d any] meaningful or legitimate prudential function."[169] Issue exhaustion would not likely enhance or assist judicial review given the "obscure" body's cursory development and superficial analysis of legal issues during its quick-paced

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166. POSNER, *supra* note 132, at 265.

167. *Id.*

168. For example, in 1987, Professors Charles Koch and David Koplow conducted a comprehensive study of the Council and concluded that "[t]he Appeals Council, as it now stands . . . . is buried in casefiles and unable to marshal its unique expertise or perspective." Koch & Koplow, *supra* note 16, at 319. They recommended that if the Council failed to implement fundamental alterations in its operation and function, it should be abolished. *Id.* at 298. They noted that "[v]alid reasons exist to support abolition. Appeals Council review is now largely superfluous. It changes the results in only 5% of the cases, a statistic that may constitute a prima facie case for abolition . . .." *Id.* at 297. Moreover, Carolyn Kubitschek has also discussed the Council's tremendous shortcomings.

> In reviewing a decision of an ALJ, the Appeals Council has several legal obligations. First, the Appeals Council must review all of the evidence. Second, the Appeals Council must review the tape of the hearing. The Appeals Council does not always fulfill these obligations. In 1983, for example, the Social Security Administration asked for remands in 2236 cases because the agency could not produce copies of the administrative record in court or because the tape of the hearing was blank or inaudible. In the vast majority of those cases, the administrative record became lost before it arrived at the Appeals Council building. Also, in virtually all cases in which the tape was inaudible, the problem occurred at the ALJ hearing. Therefore, when the record was misplaced or the tape was inaudible, the problem invariably existed at the Appeals Council as well as in federal court. The Appeals Council either failed to notice the problem – because its judges did not read the records or listen to the tape – or overlooked it. This callous disregard of . . . obligations . . . violates the rights of claimants.

KUBITSCHEK, *supra* note 5 at § 6.44, at 402.

169. Dubin, *supra* note 157, at 1326.

and perfunctory review.[170] It is also unlikely that Judge Posner believed that issue exhaustion promoted judicial economy because of his skepticism of the nature and manner of proceedings at the Appeals Council, which results in few cases actually being mooted.[171] "Although there is already appellate review within most agencies, the review function is often performed in so perfunctory and unconvincing a manner as to have deservedly little credibility with federal judges."[172] This case represents another example of Judge Posner's ability to afford a social security claimant's case the same attention as any other litigant's appeal, despite his criticism of the current system.

2. New Evidence: *Eads v. Secretary of the Department of Health and Human Services*[173]

In *Eads*, the Seventh Circuit addressed whether new evidence at the Appeals Council became part of the record reviewable by the federal courts if the Council refused to review the ALJ's decision. The claimant, Thomas Eads, applied for benefits because he needed to elevate his legs for several hours during every eight-hour period and, therefore, could not work.[174] Eads suffered from poorly controlled diabetes and extreme obesity, but offered no medical evidence to support his disability claim.[175] On appeal to the Council, Eads submitted a letter from his doctor that supported his claim.[176] The Council, however, refused to review the ALJ's decision despite the new evidence. The district court also refused to consider the letter as part of the record since it was not before the ALJ.[177] The Seventh Circuit affirmed the district court's decision.

Judge Posner's skepticism of the Appeals Council did not persuade him to accord less deference to the Agency's decision to refrain from

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170. *Id.* at 1330-31.

171. *Id.* at 1331-32; *see also* Dubin, *supra* note 157, at 1326-27 ("Most decisions receive boilerplate form denials of review and only five percent of cases review produce changes in result.").

172. POSNER, *supra* note 132, at 265.

173. 983 F.2d 815 (7th Cir. 1993).

174. *Id.* at 816.

175. *Id.*

176. *Id.* The letter stated that Eads could not sit for more than 30 minutes at a time, but must be "supine periodically in order to keep his legs elevated." *Id.*

177. *Id.*

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considering new evidence. In the opinion, he notes that if the Council refuses review and exercises its certiorari-type jurisdiction, the decision that the federal courts review is that of the ALJ.[178] As such, "[t]he correctness of that decision depends on the evidence that was before him. He cannot be faulted for having failed to weigh evidence never presented to him, such as the doctor's letter in this case."[179] If new evidence became part of the record, the court's role would change "from that of a reviewing court to that of an administrative law judge, required to sift and weigh evidence in the first instance rather than limited ... to reviewing evidentiary determinations made by the front-line factfinder."[180] Judge Posner concluded that this change is "inconsistent with the fundamental tenets of appellate review."[181] He recognized that several courts had reached a contrary conclusion, but urged them to reconsider their positions in light of his more reasoned decision.

Several circuit courts have rejected the reasoning in *Eads*, and those circuit courts that had previously considered the issue of new evidence and found differently than the *Eads* court have declined the invitation to reconsider their holdings.[182] In *O'Dell,* the Tenth Circuit enumerates

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178. *Id.* at 817.

179. *Id.* (citations omitted).

180. *Id.* at 817-18.

181. *Id.* at 818.

182. Perez v. Chater, 77 F.3d 41, 45 (2d Cir. 1996) ("we hold that the new evidence submitted to the Appeals Council following the ALJ's decision becomes part of the administrative record for judicial review when the Appeals Council denies review of the ALJ's decision."); Wilkins v. Dep't of Health & Human Servs., 953 F.2d 93, 96 (4th Cir. 1991) (holding that the Council properly incorporated new evidence into the record); Nelson v. Sullivan, 966 F.2d 363, 366 (8th Cir. 1992) (finding that new evidence not included in the ALJ record became part of the record when submitted to the Appeals Council); Ramirez v. Shalala, 8 F.3d 1449, 1452 (9th Cir. 1993) (noting that new evidence becomes part of the record when the Council examines the ALJ's decision and the new evidence); O'Dell v. Shalala, 44 F.3d 855, 859 (10th Cir. 1994) ("We join the Fourth, Eighth, Ninth, and Eleventh Circuits, in holding that new evidence becomes part of the administrative record to be considered when evaluating the Secretary's decision for substantial evidence."); Keeton v. Dep't of Health & Human Servs., 21 F.3d 1064, 1067 (11th Cir. 1994) ("the administrative process continues when a claimant seeks review of an ALJ decision . . . and new evidence first submitted to the Appeals Council is part of the administrative record that goes to the district court for review."). *But see* Cotton v. Sullivan, 2 F.3d 692, 696 (6th Cir. 1993) ("We therefore conclude that the district court improperly considered Cotton's new evidence because the claimant failed to demonstrate good cause justifying a remand for administrative consideration of the new evidence.")

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three factors underlying its decision that new evidence constitutes part of the administrative record, thereby rejecting Judge Posner's reasoning. First, the regulations expressly allow a claimant to submit new evidence to the Appeals Council without demonstrating "good cause."[183] A court's disregard of the evidence on review may subvert the purpose of the regulation.[184] Second, the regulation directs the Appeals Council to "evaluate the entire record including the new and material evidence submitted" and requires review if the ALJ's decision is contrary to the weight of the evidence "currently of record."[185] These two directives suggest that the regulations make new evidence part of the administrative record. Third, the Secretary's decision becomes final only after the Appeals Council denies review or issues its own decision. Therefore, the final decision "necessarily includes the Appeals Council's conclusion that the ALJ's findings remained correct despite the new evidence."[186] The Seventh Circuit stands in the minority of jurisdictions that bar reversal of an ALJ's decision based on evidence first submitted to the Appeals Council.

It strikes this author as odd that Judge Posner would so vehemently and openly criticize the Appeals Council,[187] yet allow this same "obscure body" to receive new evidence and deny review of the ALJ's decision without that evidence becoming part of the administrative record subject to district court review. Judge Posner recognizes the inconsistencies and the shortcomings of the Council. He is undoubtedly aware of the tremendously overburdened Council that handles thirty cases each day;[188] that gives fewer than fifteen minutes of paper review to cases;[189] and that rarely sits in panels and, rarer still, hears oral argument.[190] Despite this knowledge, Posner's opinion insulates the Council's rejection of new evidence when it declines to review the ALJ's decision from further review by a more efficacious body, the district court and eventually his court. *Eads* allows more than *potential* agency abuses, it allows *actual*

183. *O'Dell*, 44 F.3d at 859 (citing 20 C.F.R. § 404.970(b) (1998)).
184. *Id.*
185. *Id.* (quoting 20 C.F.R § 404.970(b)).
186. *Id.*
187. *Supra* notes 170-74 and accompanying text.
188. Koch & Koplow, *supra* note 16, at 267.
189. Dubin, *supra* note 157, at 1326.
190. *Id.*

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abuses by an administrative body that Judge Posner has recognized, through personal experience, is woefully inadequate and fundamentally flawed. The information and studies regarding the Appeals Council eliminate any doubt as to the mere potentiality of abuses. These abuses are a reality, of which Judge Posner was fully cognizant. Although the opinion seems strange, both in light of his views of the Council's ability to handle claimants' appeals and the six circuit courts that have taken a contrary approach, it underscores once again that Judge Posner does not fall into the category of judges described by the Federal Courts Study Committee. Despite this author's disagreement with the reasoning and ultimate conclusion in *Eads*, the author cannot fault Judge Posner for a summary or dismissive opinion. It suggests neither that counsel needed to convince the court of the case's importance nor that Judge Posner should expend his judicial resources on worthier issues.

The opinion suggests that a decision to the contrary, or a decision in harmony with six other circuits, would relegate the district court to the role of factfinder. As the Second Circuit pointed out, however, "this concern is unfounded."[191] The court would simply review the entire administrative record, which would include the new evidence, and determine, as it routinely does, whether there is substantial evidence to support the Secretary's final decision.[192]

Eads identifies several alternatives for introducing new evidence. The regulations authorize petitions to reopen.[193] If the claimant submits evidence to the Appeals Council and its refusal "rests on a mistake of law, such as the evidence newly submitted to the Appeals Council was not material to the disability determination, the court can reverse ...."[194] The existence of these curative methods perhaps influenced the decision that the potential for abuses by the Appeals Council did not warrant inclusion of new evidence in the record.

3. Scope of Council Review: *Delong v. Heckler*[195]

In *DeLong*, the Seventh Circuit resolved another Appeals Council issue, namely, the Council's scope of review in disability cases. The ALJ

191. Perez v. Chater, 77 F.3d 41, 46 (2d Cir. 1996).
192. *Id.*
193. 20 C.F.R. § 404.987-89, § 416.1487-89.
194. *Eads*, 983 F.2d at 817 (citations omitted).
195. 771 F.2d 266 (7th Cir. 1985).

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granted the claimant, Warren DeLong, disability benefits until August 18, 1981.[196] On August 12, 1981, DeLong testified that he could return to work, and the ALJ concluded that he was no longer disabled.[197] DeLong then alleged that he accidentally filed an application of appeal to the Council from the ALJ's August 18 decision to terminate benefits, erroneously believing he was signing a new application for benefits.[198] The form he completed was clearly marked as an appeal application and his case was referred to the Council for review based on DeLong's contention that he was still disabled.[199] The Council did not limit its review to whether DeLong was *still* disabled, but also considered whether DeLong was *ever* indeed disabled.[200] DeLong never received notification that the Council intended to broaden the scope of reviewable issues beyond his presented issue of error.[201] The Council concluded that he had never been disabled and reversed the ALJ's decision.[202] The Seventh Circuit held that:

> the Appeals Council has the power, when reviewing an ALJ's decision at the behest of an applicant for social security disability benefits who believes that the ALJ did not make a sufficiently generous award, to throw out the entire award if contrary to the law or facts of the case.[203]

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196. *Id.* at 267.
197. *Id.*
198. *Id.*
199. *Id.*
200. *Id.*
201. *Id.*
202. *Id.*
203. *Id.* "At the behest of an applicant" was a critical element of the court's decision in *DeLong*. It is not entirely clear that the Seventh Circuit would have reached the same conclusion if the Appeals Council had reopened the case without a request from the applicant. This issue, whether reopening and review of a Social Security Administration disability claim is uniquely a function of the claimant or whether the Appeals Council can reopen, *sua sponte*, has also created a split among the circuits. The Seventh Circuit has yet to rule on the issue. Dictum in *DeLong* suggests that it would support an interpretation of the regulations that only permits a claimant to request that a claim be reopened. "The word 'However' in the quoted passage is particularly suggestive that reopening is intended to be for the benefit of the disappointed applicant only – though of course we need not decide in this case whether it must be limited so." *Id.* at 268. *See also* Dugan v. Sullivan, 957 F.2d 1384, 1389 (7th Cir. 1992) (Cudahy, J.) (noting a circuit split and considerations that argue in favor of the Secretary's authority to reopen, but ultimately passing on the issue because "[o]nce again, however, we stop short of a holding on this issue, because we find that the

The decision reached by the Seventh Circuit appears to have been the first time a circuit court considered the issue. Judge Posner's opinion examined the interplay between two regulations, sections 404.967 and 404.969, to determine whether the Appeals Council had the authority to review more than just the applicant's enumerated issues for review. Section 404.967 provides for general Appeals Council review:

> If you or any other party is dissatisfied with the hearing decision or with the dismissal of a hearing request, you may request that the Appeals Council review that action. The Appeals Council may deny or dismiss the request for review, or it may grant the request and either issue a decision or remand the case to an administrative law judge.[204]

DeLong sought appellate review under this section. Also relevant to the analysis, however, is section 404.969, which provides in pertinent part that "[a]nytime within 60 days after the date of a hearing decision or dismissal, the Appeals Council itself may decide to review the action that was taken."[205] Because the two sections allow the claimant and the Appeals Council sixty days to initiate review of the ALJ's decision, "it would be a quite pointless exercise in shuffling paper for the Council, having received the claimant's notice of appeal within 60 days, to then have to issue its own notice of intent to review the case. Such notice would in fact be perfectly redundant."[206] No unfairness results when the Appeals Council reviews an entire case rather than simply the claimant's issues, since it has the power to review a grant of benefits on its own initiative under section 404.969.

Subsequent circuit court decisions have gone both ways on the issue, creating a circuit split. The Sixth Circuit, in *Gronda v. Secretary of Health*

Secretary has failed to meet any of the conditions for reopening."). For an analysis of this issue, see Elizabeth S. Ferguson, Note, *Untangling 'Operation Common Sense': Reopening and Review of Social Security Administration Disability Claims*, 87 MICH. L. REV. 1946 (1989).

204. 20 C.F.R. § 404.967 (1986).

205. *Id.* § 404.969. Section 404.970 then lists several conditions under which the Council can review. The Council's power, therefore, to initiate *review*, sua sponte, is unambiguous. Whether the Council can *reopen* and *revise* determinations and decisions, of its own accord, poses a different question. *See supra* note 203.

206. *DeLong*, 771 F.2d at 268.

& Human Services,[207] adopted Judge Posner's reasoning. The Third and Eleventh Circuits have, however, rejected it.[208] These circuits cite the unfairness inherent in the absence of notification to the claimant. "The *DeLong* court's ruling promotes the use of the element of surprise and [] encourage[s] decisions on less than all the relevant evidence and fewer than all the pertinent legal arguments."[209] Notification is not "redundant" where the Council broadens the scope of review beyond the claimant's issues. "[I]t is no empty gesture to put claimants on fair and prior notice that an appeal of a discrete and narrow issue may jeopardize an entire benefits award."[210]

For reasons noted previously, it is interesting that Judge Posner has vested more authority in the Appeals Council to review a decision that exceeds the scope of the claimant's framed issues without notification to the claimant. Judge Posner has granted the Secretary, through the Appeals Council, sweeping authority and discretion to satisfy its responsibility of awarding benefits. Several reasons beyond those offered by the opinion may explain his position. First, the case was decided in 1985, several years before many of the studies harshly criticized the Appeals Council.[211] Judge Posner may not have yet formed such critical opinions of the Appeals Council. Second, the notification requirement does not eliminate judicial review of the Appeals Council decision, so even if the Council performed its review in a "perfunctory" fashion, the district court and court of appeals would still safeguard against ineffective review. Third, and probably most important, Judge Posner recognized the acute need for greater consistency in the SSA because of the hundreds of ALJs deciding in the aggregate hundreds of thousands of disability cases per year. By clothing the Council with final decision-making authority over the ALJs,

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207. 856 F.2d 36 (6th Cir. 1988).

208. Powell v. Heckler, 789 F.2d 176 (3d Cir. 1986); Kennedy v. Bowen, 814 F.2d 1523 (11th Cir. 1987). The Eleventh and Third Circuits reached the same conclusion, but took different routes to get there. The Third Circuit extrapolated a notice requirement from section 404.969 while the Eleventh Circuit chose to rely on the general notice requirement of section 404.973. *Powell*, 789 F.2d at 179; *Kennedy*, 814 F.2d at 1527.

209. *Kennedy*, 814 F.2d at 1528.

210. *Powell*, 789 F.2d at 180.

211. Judge Posner does note in passing, however, that the Council's ability to review 40,000 cases per year is questionable. *DeLong*, 771 F.2d at 268 ("though the practical ability of the Appeals Council, which reviews 40,000 cases a year, to achieve [greater consistency] has been questioned." (citing MASHAW, *supra* note 3, at 105)).

the court assists the SSA in achieving more compatible disability decisions on a grand scale. As uniformity in the SSA itself increases, the federal caseload decreases.

D. Eligibility for Benefits: Haas v. Chater[212]

The Act conditions a child's receipt of benefits on a finding of eligible to inherit[213] based on state intestate succession law.[214] In other words, the child must properly establish paternity for purposes of inheritance before receiving his father's social security child insurance benefits.[215] It was this requirement that the *Haas* court examined.

In *Haas*, a mother, applying for the benefits on behalf of her child, argued that her child was entitled to the benefits after the father's death. The child was born out of wedlock and eight months after the father died.[216] One month after the birth, the mother filed a petition to establish the father's paternity.[217] The court granted the petition and declared the deceased to be the child's father.[218] Despite this declaration, however, under Indiana law the child had not adequately established paternity for purposes of inheritance. "'For inheritance,'" a child born out of wedlock will be treated as if his parents were married only if (1) the paternity of the child has been established by law in a cause of action that is filed: . . . (B) [w]ithin five (5) months after the father's death."[219] The mother established paternity nine months after the father's death and therefore intestate law would not recognize the deceased as the child's father. The ALJ consequently denied her application.[220] She appealed the denial of social security benefits on behalf of her child, claiming, *inter alia*, that the state statute and its incorporation into the Act were unconstitutional.[221]

The Seventh Circuit rejected her claim and found the intestacy statute and its incorporation into the Act constitutional. "The interest in protecting decedents' estates against phony claims and winding up these

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212. 79 F.3d 559 (7th Cir. 1996).
213. 42 U.S.C. § 416(h)(2)(A) (1996).
214. *Haas*, 79 F.3d at 560-61 (citing IND. CODE. § 29-1-2-7(b) (1999)).
215. *Id.*
216. *Id.* at 560-61.
217. *Id.* at 561.
218. *Id.*
219. IND. CODE § 29-1-2-7(b) (1999).
220. *Haas*, 79 F.3d at 561.
221. *Id.* at 562.

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estates promptly and definitively has been held to justify even tighter limitations."[222] Although some courts have found certain state laws unconstitutional where they render the establishment of paternity impossible, no evidence suggested such an impossibility in *Haas*.[223] The mother knew she was pregnant and, not being married, she must have realized that the child's paternity might be questioned. The statute did not make the establishment of paternity unattainable, "[a]ll she had to do was file the paternity suit within five months of [the father's] death."[224]

Moreover, "federal child insurance benefits" seek "to replace the support the child would have received from his father had the father not died."[225] The applicable Act provisions were designed to determine paternity and the likelihood of support and to identify the likely supporters.[226] Judge Posner noted that "[t]he criteria constitute a coarse filter, but not so coarse a one that we are moved to declare the relevant provisions unconstitutional."[227] The mother offered no evidence that the father, had he lived, would have supported the child. The father had not supported the mother, given any indication he intended to marry her or support the child, or even acknowledged paternity.[228]

Haas is an interesting case in that it raises a constitutional concern, an area of law not commonly associated with the Act. Judge Posner's opinion contains a different tone than many of his other social security opinions. The varied tone stems, perhaps, from the implication of a constitutional right. An economic analysis has arguably less application when the case involves claims of constitutional dimension.[229] The opinion, however, is consistent with Judge Posner's view of pragmatism. Although the *Haas* decision seems to treat some children unfairly,[230] "the pragmatic judge must never forget that he is a judge and that the role of a judge is

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222. *Id.* at 563.
223. *Id.*
224. *Id.*
225. *Id.*
226. *Id.* (construing 42 U.S.C. §§ 416(n)(1)(B), (2), (3)).
227. *Haas,* 79 F.3d at 563.
228. *Id.* at 564.
229. *See* Shapiro, *supra* note 73, at 1023-24.
230. Warren M. Kato, *Social Security Benefits for Child Born Out of Wedlock*, 18 J. JUV. L. 349, 355 (1997).

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constraining as well as empowering."[231] *Haas* posed a danger for the judicial pragmatist, that danger being "intellectual laziness."[232] Judge Posner believes that laziness allows a judge to react rather than analyze. The court could have decided *Haas* by reacting to seemingly unfair treatment of the young boy rather than by analysis, but Judge Posner's commitment to pragmatism precluded this "lazy" approach. This commitment to pragmatism also resulted in a thoroughly reasoned opinion. Again, although one may disagree with the result he reaches, one cannot label Judge Posner a member of the group of federal jurists who take social security cases lightly. Although we may assume that even a judge described in the Report of the Federal Courts Study Committee would have given this constitutional claim similar consideration, Judge Posner differentiates himself from that group of judges by undertaking a similarly thorough analysis irrespective of the magnitude of the claim before him.

E. Federalism in Social Security Law: Parker v. Sullivan[233] *and Jenkins v. Bowling*[234]

Judge Posner's commitment to federalism reveals itself in the vast majority of his opinions, and the social security cases are no exception. *Parker* and *Jenkins* represent two cases that illustrate his views on federalism. In the former, Rithie Parker tried to establish her entitlement to widow's benefits under the Act. She and George Parker married in 1970, but he obtained a divorce decree in 1975.[235] He obtained the decree through the submission of a fraudulent affidavit that swore that his wife had left the state and that her whereabouts were unknown.[236] Mr. Parker was fully aware, however, that his wife was living in the marital residence in Indiana.[237] He did not provide his wife with a copy of the complaint or pleadings, and the court granted him the divorce by default.[238] Once she learned of the decree, Mrs. Parker brought suit to have it set aside as

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231. Richard A. Posner, *Pragmatic Adjudication*, 18 CARDOZO L. REV. 1, 16-17 (1996).

232. *Id.* at 16.

233. 898 F.2d 578 (7th Cir. 1990).

234. 691 F.2d 1225 (7th Cir. 1982).

235. *Parker*, 898 F.2d at 579.

236. *Id.*

237. *Id.*

238. *Id.*

fraudulent. Fifteen months after filing her suit, Mr. Parker died and the court dismissed her suit as moot.[239] The SSA denied her application for benefits, holding that the divorce decree was voidable, not void, and that she was not George Parker's widow.[240] Judge Posner reversed and ordered the SSA to grant the application for her benefits.[241]

The *Parker* decision is quite brief. Its holding and rationale are nearly limited to the facts of the case. Few courts, even within the circuit, have cited it as authority. What is interesting about the case though, is not its holding or its precedential value, but the federalism argument upon which Judge Posner predicates the decision. The Act leaves it to state law to determine the validity of a marriage upon the death of an insured spouse, so the SSA must predict whether the highest state court would have found that the Parkers were still validly married. The problem in *Parker* was that the SSA "shift[ed] the burden of ascertaining state law to the applicant by the heartless expedient of forcing her to conduct a lawsuit in state court for the sole purpose of determining her entitlement to federal benefits."[242] The ALJ had found that Mr. Parker procured the divorce through fraud and there was no indication that a state court would have found otherwise.[243] As such, "unless the Social Security Act makes entitlements depend on substantive validity, rather than nonvoidness, persons in Mrs. Parker's position will be required to bring state-court suits for the sole purpose of qualifying for federal benefits."[244] Judge Posner determined that this prospect was an "affront to federalism."[245] Congress could not have intended such suits when it made state law determinative of entitlement to widow's benefits.

Jenkins involved a class action brought against the administrating officials of Illinois' unemployment insurance program. The class challenged the "held in abeyance" provision of the unemployment compensation statute as violative of the supremacy and due process clauses. The abeyance provision required

239. *Id.*
240. *Id.*
241. *Id.* at 581.
242. *Id.* at 580.
243. *Id.*
244. *Id.*
245. *Id.*

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> that if by reason of [the commission of a felony in connection with his work, or because of theft,] [the person claiming unemployment benefits] is in legal custody, held on bail or is a fugitive from justice, the determination of his benefit rights shall be held in abeyance pending the result of any legal proceedings arising therefrom.[246]

Although federal law does not regulate state requirements for unemployment insurance eligibility, it does attach certain strings because states receive financial assistance from the federal government.[247]

Two such conditions involve provisions under the Act, section 303(a)(1) and (3). The Department of Labor's regulations require "prompt determination of eligibility" and the use of administrative methods that "will reasonably insure the full payment of unemployment benefits to eligible claimants with the greatest promptness that is administratively feasible [and that are] reasonably calculated to insure full payment of unemployment compensation when due."[248] Furthermore, the Secretary of Labor shall not allow a state to receive federal money for administrative costs that does not provide "opportunity for a fair hearing, before an impartial tribunal, for all individuals whose claims for unemployment compensation are denied."[249] The question before the Seventh Circuit, therefore, was whether "Illinois' practice of postponing payment of benefits to applicants who are in legal custody or on bail for a work-related felony or theft, until the charges are resolved, is an administrative method 'reasonably calculated to insure full payment of unemployment compensation when due.'"[250] The court found that the abeyance provision

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246. *Jenkins*, 691 F.2d at 1227 (alteration in original) (quoting ILL. REV. STAT. ch. 48 § 602 B (1981)).

247. *Id.* at 1228.

248. 20 C.F.R. §§ 640.1(a)(2), 640.3(a), 650.1(b) (1998). These regulations relate to the provision that forbids the Secretary of Labor from allowing federal money to go to a state to help offset the costs of administering its unemployment compensation program unless the state's unemployment insurance law provides for "such methods of administration . . . as are found by the Secretary of Labor to be reasonably calculated to insure full payment of unemployment compensation when due." 42. U.S.C. § 303(a)(1) (1994) (repealed 1995).

249. 42 U.S.C. § 303(a)(3) (repealed 1995).

250. *Jenkins*, 691 F.2d at 1229.

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contravened certain provisions of the Act and, thus, was invalid under the supremacy clause.[251]

The *Jenkins* case is rather complicated in its facts and the interplay between unemployment benefits and social security law. Like *Parker*, though, its precedential effect is less interesting than the federalism and economic-based rationale Judge Posner invoked. Initially, Judge Posner notes the objectives that Congress sought to achieve by furnishing federal money for the administrative expenses of state unemployment compensation programs. One of these incentives was the "macroeconomic objective (dampening the business cycle by keeping up the purchasing power of people laid off in a recession) . . . ."[252] He considers this economic benefit throughout the opinion. At one stage, it is weighed against the costs saved by the state in minimal administrative procedures. "The cost saving is genuine. The state needs fewer hearing examiners and other administrative personnel and facilities than it would if it had to make its own independent determination that that applicant had [indeed] committed a work-related felony or theft."[253] He determined, however, that the costs did not outweigh the benefits and, therefore, the postponement of unemployment benefits conflicted with the Act's provisions.[254]

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251. *Id.* at 1233.

252. *Id.* at 1229.

253. *Id.* at 1233.

254. It is interesting to note that Judge Posner mentioned the lack of data to support a contrary finding.

> It is a pity that the record does not contain more data on the relevant costs and benefits. We are not told how much another thousand hearings . . . per year would cost . . . We do not even know the aggregate dollar value of the benefits that are postponed each year under section 602 B, . . . the plaintiffs put in enough evidence of the unreasonableness of the held in abeyance procedure to shift to the state – which after all had, or could easily have obtained, all the necessary information on the costs of additional procedural safeguards and on the dollar value of the postponed benefits – the burden of producing contrary evidence; and the state produced none.

Id. Judge Posner probably would have enjoyed crunching those numbers to determine, indeed, with hard statistics the benefits versus the costs rather than balancing intangibles. This section of the opinion illustrates Judge Posner's preference for anchoring a decision in economic realities.

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When the court fashioned a remedy for Illinois' violation of the supremacy clause, federalism took center stage. Judge Posner recognized that although the nominal defendants in the case were state officers, the actual defendant was the State of Illinois. Illinois enjoys some "sovereign dignity" and a federal court should minimize its "abrasive potential."[255] The court should not presume that the state, upon a judgment that invalidates the abeyance procedure, will not comply with the ruling. "[T]he state should be permitted to decide, in the first instance, how the held in abeyance proviso ... can be altered to comply with ... the Social Security Act."[256] Although the court could have issued a mandatory injunction specifically outlining compliance procedures, Judge Posner's respect for federalism counseled against any such premature administration of strong medicine to the State of Illinois.[257] The court thus remanded the case with instructions for the district court to enter an injunction against the state from enforcing the "held in abeyance" proviso and to retain jurisdiction over the case.[258] Judge Posner reminded the district court to "allow the state a reasonable opportunity to demonstrate, statistically or otherwise, that the measures it takes to comply with the judgment have been successful in eliminating the inordinate error rate and indefinite delays that have persuaded [the court] that section 602 B as currently administered is invalid."[259] He carefully protected the state from an intrusion into its sovereignty until the situation warranted.

CONCLUSION

As noted previously, the Federal Courts Study Committee recently released a report indicating that some federal judges doubt that social security actions warrant serious consideration or attention.

> The present significance of the report of the Federal Courts Study Committee is that it reflects the way some judges think about Social Security cases, i.e. that they are "largely technical," and not sufficiently significant for the time and interest of a federal district court judge.

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255. *Id.* at 1234.
256. *Id.*
257. *See id.*
258. *Id.*
259. *Id.*

> . . . Claimants' attorneys who have cases before these judges must use their initial efforts to encourage the judges to take their clients' cases seriously.[260]

After a careful consideration and analysis of the opinions written by Judge Posner, one reaches at least two conclusions. First, his social security opinions are no less influential than his antitrust opinions and contain the same economic and federalism themes that typify Judge Posner. Second, irrespective of one's agreement with those opinions, he does not fall into the category of judges described above. Judge Posner has not been bashful in his thoughts on revising the current system and perhaps eliminating federal court review altogether, but he does not allow this view to affect his role as a judge. His opinions may contain comments that question the efficacy of the process or pleas to repair the system, but never do they reveal an attitude that his time was too precious or his court too superior for careful consideration of an applicant's appeal. There was never any indication that he needed prodding by counsel to take a case seriously. Judge Posner may not be content with the social security administrative appeals process and even less content with the method for judicial review, but he recognizes and respects that the law prescribes these processes and methods. While he will likely continue to criticize the system and encourage change, he will also continue to undertake his role as judge in social security cases the same way he does in antitrust actions or labor disputes.

260. KUBITSCHEK, *supra* note 5, § 1.1, at 5.

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POSNER AND TORT LAW AS INSURANCE

*Beatrice A. Beltran**

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INTRODUCTION

A typical tort scenario involves a suffering plaintiff who is physically and/or financially devastated by an accident and an injurer defendant who must compensate the victim for the injuries that have been inflicted. Given that victims are often unprepared to deal with the effects of an accident, which can be arduous, the social policy of victim compensation seeks to alleviate the burden that befalls victims. This broad social policy of "cushioning the burden borne by victims of injury (or, by all 'deserving' victims)" is distinguishable from the notions of compensatory justice.[1]

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1. Gary T. Schwartz, *The Ethics and the Economics of Tort Liability Insurance*, 75 CORNELL L. REV. 313, 359 (1990) [hereinafter Schwartz, *Tort Liability Insurance*].

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The policy makes sense where the defendant is a "suitable loss-bearer," an entity that can respond to liability by spreading loss through a small increase in product price or spreading loss through the purchase of liability insurance.[2] It is important that a loss bearer meet one of these criteria, otherwise the tort system will function merely to shift the burden of harm from an injured plaintiff to a defendant who is equally ill-equipped to deal with the resultant harm. In a sense, the damages collected by a victim through the tort system are similar to insurance payments in that they "spread the cost of providing financial resources for accident victims."[3] It is through the compensation function that victims are able to rely on the tort system as a means of insurance.

Over the years, there have been a number of different rationales advanced to justify the tort law system. But as tort law has developed, the system has come to be viewed not only as a means of providing compensation to the injured, but also of deterring future accidents.[4] Tort law serves a deterrent function by providing "negative and positive incentives to individuals so that they conduct various activities more safely to reduce the number and severity of accidents."[5] The goal of deterrence is not to eliminate all accidents. The only way to achieve such an end would be to cease all activities, since any activity has the potential to result

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2. *Id.* at 359-60.

3. Heidi Li Feldman, *Harm and Money: Against the Insurance Theory of Tort Compensation*, 75 TEX. L. REV. 1567, 1570-71 (1997).

4. *See* George L. Priest, *Modern Tort Law and Its Reform*, 22 VAL. U. L. REV. 1, 5 (1987) ("There are two goals of the modern tort law that all can agree upon: to reduce the accident rate as much as is practicable and to provide a sensible and coherent system of compensation insurance for those unfortunate individuals who suffer product- or service-related accidents.").

5. Craig Brown, *Deterrence and Accident Compensation Schemes*, 17 U. W. ONT. L. REV. 111, 111 (1978).

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in an accident.[6] Rather, society seeks to achieve an optimal level of accidents.[7]

The notion of tort law as insurance has been fostered by significant changes in tort law, including the elimination of the privity requirement,[8] the refusal to enforce product warranties,[9] and the expansion of liability.[10] The latter is most evident in the dramatic shift away from the rule of negligence, particularly in the products liability arena.[11] In its place,

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6. *See* John G. Fleming, *The Role of Negligence in Modern Tort Law*, 53 VA. L. REV. 815, 822 (1967) (stating that strict liability requires payment for injuries due to hazardous activities that are not only legal but are also "highly desirable"); Stephen D. Sugarman, *Doing Away with Tort Law*, 73 CAL. L. REV. 555, 573 n.67 (1985) (explaining that liability insurance prevents overdeterrence or the "undesirable squelching of socially acceptable behavior").

7. Brown, *supra* note 5, at 112 (stating that the question before society, "given that we want the benefits of numerous activities that are accident-producing, [is] how can we best reduce the number and severity of accidents to tolerable levels?").

8. *See* Henningsen v. Bloomfield Motors, Inc., 161 A.2d 69 (N.J. 1960).

9. The New York Supreme Court held a manufacturer liable for defects despite a contract that limited liability in *MacPherson v. Buick Motor Co.*, 111 N.E. 1050 (N.Y. 1916). *See* George L. Priest, *A Theory of the Consumer Product Warranty*, 90 YALE L. J. 1297, 1298 (1981). Priest argues that the two traditional theories on the role of product warranties in sales transactions, as exploitative devices that limit a manufacturer's obligation to consumers or as signals to consumers about the attributes of goods, are quite wanting. *Id.* Rather he advances an investment theory of product warranties that views the contract as "optimiz[ing] the productive services of goods by allocating responsibility between a manufacturer and consumer ... to prolong the useful life of a product and to insure against product losses." *Id.*

10. *See* Greenman v. Yuba Power Prods., Inc., 377 P.2d 897 (Cal. 1963).

11. *See* Fleming, *supra* note 6, at 820 (stating that the negligence theory could not cope with the problems of an increasingly technological society. The rule is placed under "unbearable strain" when applied to modern industry, which is "the most fertile of injuries in production, distribution and consumption process.") *See also* James A. Henderson, Jr. and Aaron D. Twerski, *Closing the American Products Liability Frontier: The Rejection of Liability Without Defect*, 66 N.Y.U. L. REV. 1263 (1991) (observing that there has been a slowing of the expansion in American products liability law in favor of plaintiff's right to recover.) This phenomenon can be attributed to the fact that "American products liability law has reached a point from which further meaningful development is not only socially undesirable but also institutionally unworkable." *Id.* at 1266. The expansion of liability has included the elimination of the privity requirement, the replacement of negligence with strict liability, and the application of product liability to production defects as well as defective design and product marketing. *Id.* The next logical step is to eliminate the requirement that plaintiffs prove product defectiveness in order to recover. *Id.* at 1266-67. However, "a system of liability without defect is beyond the capacity of courts to implement." *Id.* at 1267.

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courts adopted a rule of strict liability thereby eliminating one of the most difficult problems accident victims encountered, that of "identifying the precise cause of the mishap in an infinitely complex production process."[12] The seminal case that brought about substantive change in public policy regarding product defects was *Greenman v. Yuba Power Products, Inc.*,[13] where the California Supreme Court adopted a strict liability standard for injuries sustained from defective products.[14] The expansion of liability was conceivable given "the possibilities opened up by insurance for distributing losses over society, and [for] shielding individual defendants from the full impact of liability."[15] The effect of the decision was profound as evidenced by the inclusion of concepts that were articulated in the Restatement (Second) of Torts.[16] It is important to bear in mind that the *Greenman* decision was authored by Chief Justice Traynor, who had long been an advocate of expanding liability based on cost internalization and insurance arguments.[17]

Over time, the controversy whether tort law functions as insurance has spurred enormous debate. Some scholars have argued, however, that while the notion of tort law as insurance has made a distinct impression on the

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12. Fleming, *supra* note 6, at 823.

13. 377 P.2d 897 (Cal. 1963). Greenman was injured when a piece of wood he was working with flew out of the combination power tool he was operating. *Id.* at 898.

14. *Id.* at 901.

15. Fleming James, Jr. & John V. Thornton, *The Impact of Insurance on the Law of Torts*, LAW & CONTEMP. PROBS. 431, 432 (1950).

16. RESTATEMENT (SECOND) OF TORTS § 402A (1965) provides:

> (1) One who sells any product in a defective condition unreasonably dangerous to the user or consumer or to his property is subject to liability for physical harm thereby caused to the ultimate user or consumer, or to his property, if
>
> (a) the seller is engaged in the business of selling such a product, and
>
> (b) it is expected to and does reach the user or consumer without substantial change in the condition in which it is sold.
>
> (2) The rule stated in Subsection (1) applies although
>
> (a) the seller has exercised all possible care in the preparation and sale of his product, and
>
> (b) the user or consumer has not bought the product from or entered into any contractual relation with the seller. *Id.*

17. *See* George L. Priest, *The Modern Expansion of Tort Liability: Its Sources, Its Effects, and Its Reform*, 5 J. ECON. PERSP. 31, 37 (1991) [hereinafter Priest, *Modern Expansion*]. *See infra* notes 131-135 and accompanying text.

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academic community, producing a sundry of law review articles and books on the subject, it has not had a significant impact on the courts.[18] As such, Judge Posner, who is both a pedagogue and a member of the bench,[19] offers a unique perspective on the issue of tort law as insurance. In Section I of this paper, a number of Judge Posner's opinions will be analyzed to support the proposition that, at least as a formal matter, tort law is intended to serve more as a deterrence mechanism versus a compensatory mechanism. Therefore, the tort system should not be regarded primarily as a form of insurance. The roles that compensation and deterrence assume will be examined in light of the particular facts of each case.

Section II of the paper chronicles the development of the theory of tort law as a form of insurance. It examines the rationale supporting the theory of tort law as insurance from the initial proponents of the theory, who were motivated by the desire to compensate victims and prevent future accidents, to the concerns raised by modern insurance theorists, who support cutting back tort law.[20] Members of the latter group assert that

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18. W. PAGE KEETON ET. AL., PROSSER AND KEETON ON THE LAW OF TORTS § 82, at 541(4th ed. 1971). The quote from Chief Justice Traynor below is specifically mentioned as the only instance where a court has actually linked insurance to liability. *Id.* at 553-554. Prosser reasons that the availability of liability insurance has served as a "makeweight" or additional reason for attaching liability but has never by itself been sufficient justification for liability. *Id.* at 556. *See also*, Jane Stapleton, *Tort, Insurance and Ideology*, 58 MOD. L. REV. 820, 824 (1995) (arguing that it is one thing for a court to note the attractive effect of insurance and quite another to promote that effect as the appropriate goal of liability).

19. Judge Posner was a Professor of Law at the University of Chicago School of Law before his appointment to the Seventh Circuit in 1981. He continues to teach at the Law School as a Senior Lecturer.

20. The term "insurance theory" was coined by a critic of the view, Ellen Smith Pryor, *The Tort Law Debate, Efficiency, and the Kingdom of the Ill: A Critique of the Insurance Theory of Compensation*, 79 VA. L. REV. 91, 91 (1993). Though there are a number of proponents of the "insurance theory," this comment will focus on the work of Professor George L. Priest, who has written substantially on the shift toward strict liability in the products liability arena, the adverse effects of this shift and the purported need for reform. It has been noted that "Priest has provided the most comprehensive account of the liability crisis and he is duly recognized as one of the most influential scholars in the field." Steven P. Croley and Jon D. Hanson, *What Liability Crisis? An Alternative Explanation for Recent Events in Products Liability*, 8 YALE J. ON REG. 1, 10 (1991) (citations omitted). When this comment refers to modern insurance theorists, it is discussing not only the work of Priest but those of other scholars who propound similar ideas.

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continued reliance on tort law as insurance will harm those the system was most intended to help, the poor who are unable to purchase insurance.

In the following section, Section III, several long-standing criticisms lodged against the theory of tort law as insurance are considered. The section will focus on the inability of the tort system to fulfill its goal of providing compensation to those who are injured. A variety of issues must be examined to determine if the tort law system can accomplish its compensation function, including whether the tort system truly compensates victims for their injuries, whether the system is too expensive as an insurance mechanism and whether tort law is superfluous given that insurance can be readily purchased. These issues will also be examined in light of Judge Posner's views on the matter to determine whether the criticisms are similar or if they raise other well-founded concerns.

The determination that tort law fails to meet its compensation goal does not end the inquiry, since tort law also serves as a deterrence mechanism. Thus, Section IV of the paper deals with the claims that tort law fails to deter accidents. Many of these critics cite the presence of liability insurance as removing the threat of tort liability and thus eliminating the deterrent effect of tort law. Moreover, they refer to the tort system's inability to absolutely deter accidents as proof of its failure. However, it will be shown that the availability of liability insurance does not eviscerate the deterrent effect of the tort law system. In addition, the critics err in failing to understand the interplay between the threat of tort liability and other factors in significantly deterring accidents.

Finally, this comment concludes that the tort system does not effectively meet its compensation function. However, it reaches this conclusion on different grounds than those relied upon by the modern insurance theorists. The system's inadequacy results from undercompensation of victims, rather than the more typical claims of overcompensation. It is the tort law system's inability to truly compensate victims, particularly in situations involving serious bodily injury, that signifies its failure. Concerns about overcompensation are misplaced and the anxiety surrounding tort law's ability to deter is based on the wrong assumptions. Adjustments to our thinking regarding the tort system will show that it adequately performs its deterrence function. Rather than insisting that the system deter in absolute terms, the threat of tort liability when combined with other factors will effectively serve as a deterrent mechanism.

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I. POSNER ON COMPENSATION, DETERRENCE AND TORT LAW AS INSURANCE

Tort law is a fault-based system that is heavily grounded on notions of individual responsibility. There is little connection, however, between the degree of fault and the penalty that is imposed on the injurer.[21] Rather, the penalty depends in large measure on the severity of the injury that has been sustained by the victim.[22] Thus, to a certain degree, tort law is motivated by notions of "compensatory justice," whereby the defendant who is responsible for the plaintiff's injury is obligated to ensure that the victim is compensated for the injury sustained.[23] In addition, tort law is motivated to prevent similar accidents from occurring. It is well recognized that the "underlying objectives of tort liability . . . are to compensate the victims of wrongdoing and to deter future wrongdoing."[24]

Given that compensation is a fundamental goal of tort law, insurance is essential in order to guarantee that the system will function well. From an individual's perspective, insurance provides a means to equalize money over time through the premium paid by an insured, thereby reducing current wealth in exchange for the insurer's guarantee to pay should a loss occur.[25] Insurance is also important in that it provides a certain sense of security to its holders. Individuals without insurance can be subject to possibly

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21. Fleming, *supra* note 6, at 818.

22. *Id.*

23. Schwartz, *Tort Liability Insurance*, *supra* note 1, at 328. *See also* RICHARD A. POSNER, ECONOMIC ANALYSIS OF LAW 288-89 (5th ed. 1998) (noting that since Aristotle it has been argued that the basic function of a legal regime is "corrective justice," or to rectify wrongful acts. He argues that a legal system driven by economic principles cannot be said to do corrective justice, if that is interpreted to mean compensating for all injuries.) *But see* Sugarman, *supra* note 6, at 603-04 (arguing that the presence of liability insurance "vitiate[s] individualized corrective justice . . . [instead] tort law has become a process for having one insurer pay another, which is far removed from any meaningful sense of individual justice.").

24. Cenco, Inc. v. Seidman & Seidman, 686 F.2d 449, 455 (7th Cir. 1982) (professional malpractice case); *see also* Jones v. Reagan, 696 F.2d 551 (7th Cir. 1983) (constitutional torts case).

25. *See* George L. Priest, *The Current Insurance Crisis and Modern Tort Law*, 96 YALE L. J. 1521, 1539 (1987) [hereinafter Priest, *Current Insurance Crisis*]. *See also* KENNETH S. ABRAHAM, DISTRIBUTING RISK 2 (1986).

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devastating tort liability judgments.[26] Judge Posner recognized the overall importance of insurance when he stated

> [b]oth accident and liability insurance have long been available to prospective victims of accidents and prospective injurers alike, and before there was market insurance there was informal insurance provided through the family. If people who want insurance and are willing to pay for it can obtain it in the insurance market or in some informal substitute, there is no apparent reason to use the tort system to provide insurance also.[27]

It should be noted, however, that parties face significant costs in drafting such contracts, which often preclude their use. "[T]he costs may well exceed the benefits, relative to regulation by tort law" because the possibilities that these contracts seek to regulate, such as death and serious bodily injury, are quite remote.[28] It is not the direct cost of drafting, as one might assume, that imposes the cost, but rather the expense associated with having the information necessary to enter into such contracts.[29] As such, where parties before an accident are able to agree on the proper allocation of risks then there is no reason to rely on the tort system to provide compensation.[30]

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26. Schwartz, *Tort Liability Insurance*, *supra* note 1, at 321-22 (arguing that even if a defendant acts in what he perceives to be a reasonable manner, a jury could nonetheless find his actions to be negligent. Rather than run the risk of error or uncertainty, protection can be gained through insurance).

27. WILLIAM M. LANDES & RICHARD A. POSNER, THE ECONOMIC STRUCTURE OF TORT LAW 57 (1987) (footnotes omitted).

28. *Id.* at 280.

29. *Id.* at 280-81. Imperfect information can be problematic for insurers as well, given the problem of adverse selection, the tendency of high-risk individuals to seek insurance protection. This can and does result in driving low risk individuals out of the insurance pool; however, insurance companies have a number of tools available to them to address these problems.

30. *See* All-Tech Telecom, Inc. v. Amway Corp., 174 F.3d 862, 865 (7th Cir. 1999), where Judge Posner states that:

> suppliers can protect themselves from the loss caused them by the fire by buying business-loss insurance, by charging a higher price, or by including in their contract with the retailer a requirement that he buy a minimum quantity of goods from the supplier, regardless. The suppliers thus don't need a tort remedy. *Id.*

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Judge Posner noted another problem associated with the compensation aspect of the tort system when he wrote "[t]ort damages are not always fully compensatory, especially where serious personal injuries are concerned."[31] It may appear at first glance that because tort law is incapable of meeting its compensation function that the system fails altogether. However, such an analysis would be incomplete given that there has yet to be an examination of whether tort law successfully performs its deterrence role. Judge Posner acknowledged the prominence of tort law's deterrence function when he wrote:

> [t]he tort system is an exceedingly costly insurance mechanism. This is a staple point made by opponents of the tort system. The only thing wrong with the point is that the tort system may be cost justified when viewed as a means of deterring unsafe behavior rather than just insuring some accident victims.[32]

Tort damage awards can only provide victims with monetary compensation for their injuries and, as mentioned previously, they do not always provide full compensation, particularly where the plaintiff has suffered serious injury.[33] This insufficiency provides an incentive to victims to "take precautions even if their failure to do so would not cut down their entitlement to damages by one cent if they were injured."[34] As

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See also Northern Indiana Pub. Serv. Co. v. Carbon County Coal Co., 799 F.2d 265, 277 (7th Cir. 1986). Judge Posner discusses the defenses of impracticability and frustration in contract law as doctrines of risk spreading. These defenses shift the risk to the party that is better able to prevent the risk from occurring or to reduce the disutility of the risk, such as through the purchase of insurance. *Id.* at 278. However, in a fixed price contract where there has already been an assignment of the risk of increased market prices to either the buyer or the seller, there is no place for the defenses. *Id.* Here, the buyer incorrectly predicted the market, thereby locking him into a bad contract. *Id.* He could not raise one of the aforementioned defenses in order to shift the risk to the seller. *Id.*

31. *See* POSNER, *supra* note 23, at 185. He further states:

> Damages awards for pain and suffering, even when apparently generous, may well undercompensate victims seriously crippled by accidents. Since the loss of vision or limbs reduces the amount of pleasure that can be purchased with a dollar, a very large amount of money will frequently be necessary to place the victim in the same position of relative satisfaction that he occupied before the accident.

Id. at 214-15.

32. LANDES AND POSNER, *supra* note 27, at 57-58.

33. POSNER, *supra* note 23, at 185.

34. *Id.*

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such, tort law is better justified as a means of deterring behavior that society deems risky and undesirable.

The different components of Judge Posner's view on tort law, as a form of insurance, can be examined through the various judicial opinions he has authored. The greater emphasis he places on deterrence, rather than on compensation, will be examined in light of the unique set of facts in each of the following cases.

A. McMunn v. Hertz Equipment Rental [35]

McMunn illustrates Judge Posner's comment that the ability of parties to allocate risks prior to an accident negates reliance on tort law as insurance. The case involved the leasing of machinery by Eichleay, a construction contractor, from Hertz Equipment Rental, to perform its construction contract with a third party.[36] However, Hertz was unaware that Eichleay was in the construction business; in fact, it was undisputed that Hertz did not know of the purposes for which Eichleay intended to use the loader.[37] This case arose when an Eichleay employee, McMunn, was injured while operating the Bobcat loader at a construction site. McMunn brought an action against Hertz charging negligence in its failure to detect that the loader was defective.[38] In turn, Hertz impleaded Eichleay by referring to a clause in the lease wherein Eichleay promised to indemnify Hertz for any tort suit that arose from the lease.[39] Eichleay countered by arguing that the clause was unenforceable under an Indiana statute.[40] Judge Posner determined that the statute was intended to increase safety at construction sites. Before the statute was passed, general contractors entered into indemnity agreements with their subcontractors to avoid suits

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35. 791 F.2d 88 (7th Cir. 1986).
36. *Id.* at 89.
37. *Id.* at 91.
38. *Id.* at 89.
39. *Id.* at 89-90.
40. *Id.* at 91. The statute provided that:

> [a]ll provisions, clauses, covenants, or agreements contained in, collateral to, or affecting any construction or design contract except those pertaining to highway contracts, which purport to indemnify the promisee against liability for death or bodily injury to persons . . . from the sole negligence or willful misconduct of the promisee . . . are against public policy and are void and unenforceable.

Id. (quoting IND. CODE § 26-2-5-1 (1975)).

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that might arise from an injury sustained by an employee of the subcontractor while working at a construction site.[41] These agreements were believed to cause more accidents because the shift in liability removed any incentive for the general contractor to provide a safe work environment.[42]

The presence of the indemnity agreement underscores the importance both parties attached to the deterrence of future accidents. It can be assumed that before the project began, the parties considered the potential injuries that might be sustained and entered into a contract to address these possibilities. Undoubtedly, the parties assessed who was in a better position to bear the cost of the accident. Judge Posner emphasized deterrence when he wrote:

> [i]ndemnity agreements are a common device for shifting the burden of liability from a tort-feasor to someone better able to bear the burden. The someone may be an insurance company that is able to spread risk better than the tort-feasor or it may be another tort-feasor, who could have prevented the accident at lower cost than the indemnitee.[43]

In assessing who is best able to bear the burden, one of the fundamental inquiries is which party is in a better position to prevent the accident from occurring. However, as previously noted, a basic problem of insurance is the lack of perfect information since the insured often has more information than the insurer.[44] In *McMunn*, the employer, Eichleay, had significantly more information regarding the intended uses of the loader, which he did not impart to Hertz.[45] Given the lack of information on the part of the rental company, Eichleay was in a better position to prevent accidents. Eichleay knew what the loader was intended for, the amount of work that would have to be accomplished using the loader, the dangers that the workmen would face using the loader, and the safety measures that could be undertaken.[46] The presence of the indemnity agreement, however, makes the transfer of such information unnecessary.

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41. *Id.* at 92.
42. *Id.*
43. *Id.* at 91.
44. *See* KENNETH S. ABRAHAM, DISTRIBUTING RISK 2 (1986).
45. *McMunn*, 791 F.2d at 91.
46. *Id.*

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Through the indemnity agreement, the general contractor shifted liability to subcontractors who must be compensated for the additional risk to which they are now exposed. This additional compensation is the price the general contractor pays for carelessness and "[t]here is much evidence that workers demand and receive such compensation."[47] The indemnity agreements act much like liability insurance in that it may lead some to act with less care. However, just as the increased carelessness will eventually lead to greater costs in the form of heightened premiums, there will be demands for higher compensation levels for the added risk to which workers are exposed. Judge Posner observes that less attention to risk would not matter if "tort compensation were always full compensation" and when it is not then the "victims may be worse off."[48] Here, McMunn's inability to collect from Hertz does not mean that his suffering will be ignored. Rather, as Judge Posner briefly mentions, in the construction industry, as in many other employment settings, employees now turn to workers' compensation as their means of insurance rather than to the tort system.[49] This system assures that McMunn will receive some form of compensation for the injuries he sustained. His compensation award is likely to be less than a tort damage award, although he will not be subjected to the rigmarole of the tort system.[50] In sum, the victim in this situation could not rely on the tort system as an insurance mechanism given its displacement by the scheme of workers' compensation. The higher wage that McMunn more than likely received and the workers' compensation award he will claim ensure that he will not be left to bear the burden of his injuries alone. In terms of deterrence, the parties shifted the responsibility to the employer who was better able to address necessary precautions to reduce accidents at the construction site.

B. Indiana Harbor Belt RR Co. v. American Cyanamid Co.[51]

In *American Cyanamid,* Judge Posner spends considerable time discussing how the imposition of liability serves as a means of deterring future accidents, but hardly reflects on the issue of compensation. He also assesses whether a strict liability or negligence regime is more likely to

47. *Id.* at 92.
48. *Id.*
49. *Id.*
50. *Id.*
51. 916 F.2d 1174 (7th Cir. 1990).

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prevent accidents from occurring. American Cyanamid Company manufactures acrylonitrile, a chemical used in making "acrylic fibers, plastics, dyes, pharmaceutical chemicals, and other intermediate and final goods."[52] It loaded 20,000 gallons of liquid acrylonitrile into a railroad tank car for transport to its plant in New Jersey.[53] The car was carried north from the Cyanamid plant in Louisiana to the Blue Island railroad yard of Indiana Harbor Belt Railroad, a small switching line, located just outside of Chicago.[54] A few hours after its arrival railroad employees noticed that fluid was gushing from a broken outlet on the bottom of the car.[55] Acrylonitrile is flammable, highly toxic and possibly carcinogenic.[56] Given that local authorities were unaware of how much of the chemical had been released, they ordered the evacuation of homes near the yard.[57] Later it was discovered that only about a quarter of the acrylonitrile had leaked.[58] The Illinois Department of Environmental Protection ordered the switching line company to take decontamination measures, ultimately costing almost one million dollars, to alleviate concerns about soil and water contamination.[59] Seeking to recover its costs incurred from the order, Indiana Harbor brought an action alleging: (1) that American Cyanamid had acted negligently in maintaining the leased tank car and (2) that the transportation of acrylonitrile through a major metropolitan area is an abnormally dangerous activity for which the shipper should be held strictly liable.[60]

Judge Posner began by noting that the "baseline common law regime of tort liability is negligence"[61] under which the hazards of an activity can be avoided merely by being careful. There are, however, accidents that cannot be avoided simply by taking care and these situations require

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52. *Id.* at 1175.
53. *Id.*
54. *Id.*
55. *Id.*
56. *Id.*
57. *Id.*
58. *Id.*
59. *Id.*
60. *Id.* *See* POSNER, *supra* note 23, at 194. (stating that "[t]hrough the concept of ultrahazardous activities, tort law imposes strict liability on activities that involve a high degree of danger that cannot feasibly be prevented by the actor's being careful or potential victims altering their behavior"). *Id.*
61. *Indiana Harbor*, 916 F.2d. at 1177.

shifting the activity to another location or reducing the scale of the activity.[62] With these types of activities, a rule of strict liability provides an incentive to find methods of accident prevention through relocation, alteration or reduction (maybe to the point of elimination) of the hazardous activity.[63] For example, the strict liability doctrine applies to situations involving the use of dynamite and other such explosives, which are dangerous even when handled with care and for which safer alternatives are always being sought.[64] The chemical in this case, acrylonitrile, was listed as the fifty-third most hazardous chemical of the 125 hazardous materials that are shipped in highest volume on the nation's railroads.[65] Though certainly dangerous, given its flammable and toxic nature, acrylonitrile is not so destructive as to damage and corrode the valves of a tank car maintained with due care.[66] The leak was not caused by the innately dangerous properties of the chemical, but rather by the carelessness of any one of a number of actors.[67] Judge Posner reasoned that, "[a]ccidents that are due to a lack of care can be prevented by taking care; and when a lack of care can . . . be shown in court, such accidents are adequately deterred by the threat of liability for negligence."[68] He saw no compelling reason to impose a strict liability rule since the probability of a spill was negligible if the tank car had been properly maintained.[69] Much emphasis is again placed on finding the party who is best able to prevent accidents from occurring. Judge Posner contends that there are a number of ways that this accident "might have been prevented at a reasonable cost by greater care on the part of those who handled the tank car of acrylonitrile. It is difficult to see how it might have been prevented at reasonable cost by a change in the activity of transporting the chemical."[70] Furthermore, there was concern that applying strict liability in this case has far reaching consequences in that its logical end would result in holding

62. *Id.*
63. *Id.*
64. *Id.*
65. *Id.* at 1178.
66. *Id.* at 1179.
67. *Id.*
68. *Id.*
69. *Id.*
70. *Id.* at 1181.

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shippers of the other 124 hazardous materials strictly liable for any leaks and any subsequent damage.[71]

After devoting a substantial portion of the opinion to the issue of deterrence, Judge Posner dedicated minimal attention to the issue of compensation. Judge Posner notes that in attempting to determine the appropriate liability regime both parties focused on what standard, negligence or strict liability, will more effectively control these types of accidents rather than on finding the "deepest pocket" and attaching liability there.[72] Later, the plaintiff referred to the financial disparity between the parties, that is, Cyanamid is a large solvent firm while Indiana Harbor Belt, a small switching line, was almost ruined after the accident.[73] Judge Posner responded by noting that although Indiana Harbor Belt is a small firm, it has "mighty parents," that is it is a jointly owned subsidiary of Conrail and the Soo line.[74]

The opinion focuses on how the imposition of a rule of strict liability or negligence would affect activity levels. The imposition of liability will prevent accidents that can be avoided with due care, in the instant case by ensuring that the leased tank car is properly maintained. Though the activity is one that presents certain dangers, it also produces positive societal effects. Of less concern is whether a small switching line, which was nearly destroyed by this single accident, will be compensated for its losses. This case emphasizes Judge Posner's concern with imposing a rule of liability that will best regulate the level of acceptable accidents.

C. Welge v. Planters Lifesavers Co.[75]

Welge illustrates that to ensure that tort law serves its deterrent function care must be taken to prevent overdeterrence of socially acceptable activities. In refusing to hold the plaintiff, an average consumer, liable for an injury he sustained while engaged in an ordinary activity, Judge Posner shows that tort law seeks to achieve an optimal level of deterrence. Richard Welge took some peanuts from a jar of Planters peanuts to sprinkle atop an ice cream sundae he was preparing.[76]

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71. *Id.*
72. *Id.* at 1182.
73. *Id.*
74. *Id.*
75. 17 F.3d 209 (7th Cir. 1994).
76. *Id.* at 210.

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Afterwards, to recap the jar he pushed down on the cap with his right hand using a normal amount of force.[77] The jar shattered into pieces severely cutting Welge's hand.[78] The peanuts had been purchased a few weeks earlier by Karen Godfrey, with whom Welge boards, at a K-Mart store in Chicago.[79] At the time of the purchase, there was a $2 rebate offer from the maker of Alka-Seltzer to anyone who had bought a "party" item, such as peanuts, but the offer required the purchaser to submit the part of the label containing the bar code as proof of purchase.[80] Godfrey accomplished this by using an Exacto knife to carefully remove the label.[81] It was a week later that the accident took place.[82] Welge brought a products liability suit against three defendants, K-Mart, the retailer, Planters, the product manufacturer, and Brockway, the jar manufacturer.[83] The district court granted defendants' motion for summary judgment citing plaintiff's failure to exclude other causes of the accident aside from a defect in the manufacturing process.[84]

Welge and Godfrey testified that from the time the jar of peanuts was purchased to the time of the accident the jar was not subject to anything out of the ordinary. Judge Posner noted that their testimony was uncontested rather the defendants focused their energies on Godfrey's use of the knife to remove the proof of purchase label on the jar.[85] However, given that consumers often use such implements to remove price labels, the use of the knife cannot be said to be a misuse of the product.[86] Judge Posner reasons that even if the product was misused in this way the defense is unavailable to the defendants because they invited the misuse.[87] K-Mart was aware of the Alka-Seltzer rebate promotion through which customers were invited to "misuse" the product.[88] The plaintiffs were not required to eliminate every possible cause of the accident. This discussion

77. *Id.*
78. *Id.*
79. *Id.*
80. *Id.*
81. *Id.*
82. *Id.*
83. *Id.*
84. *Id.*
85. *Id.*
86. *Id.*
87. *Id.* at 211.
88. *Id.*

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highlights the issue of deterrence and how much care is required of a consumer. The defendants' insistence that plaintiffs eliminate all possible causes of the defect aside from their actions can lead to absurd ends.[89] The defendants would have required the plaintiff to place the jar of peanuts under lock and key in order to show that it was a defect in the product that caused Welge's injury.[90] Rational consumers simply would not act in such fashion given that the probability of harm is so remote. Instead, Welge took the necessary level of care that was required of him. In examining this case, it is the normalcy of Welge's actions that attract the reader's attention. It is a common occurrence in households across the country for an individual to take a helping of peanuts from a jar and return the jar atop the refrigerator without incident. Nonetheless, the accident occurred and Welge was harmed. Since the defect that caused the accident was unlikely to have been caused after the jar of peanuts was purchased, the "probability that the defect was introduced *by one of the defendants* is very high."[91] It does not matter which of the defendants actually caused the harm since under a strict liability regime a seller is liable for defects in his products that may have been introduced at some earlier stage of production.[92] Any one of these defendants were in a better position to cure the defect than was Welge or any other consumer. When consumers purchase jars of peanuts they do not inspect the bottle closely for any possible defects, they assume that the product they are purchasing is safe.[93] The consumer is required to take an appropriate level of care and it was shown that the jar was not "jostled, dropped, bumped, or otherwise subjected to stress beyond what is to be expected in the ordinary use of the product."[94] To require more from the consumer may lead to the prevention of more accidents, but not at an acceptable level. Consumers would be required to take extra precautions that are unnecessary given that the dangers are quite remote.

While there is great discussion about deterrence in this case, there is little, if any, about compensation. The case appears to present the typical

89. *Id.* As Posner jests, elves may have come out in the stealth of night and damaged the jar of peanuts unbeknown to either Welge or Godfrey. *Id.*

90. *Id.*

91. *Id.* at 212.

92. *Id.*

93. *Id.*

94. *Id.* at 210.

David versus Goliath predicament. In his description of the parties, Judge Posner depicts Welge as "forty-something but young in spirit"[95] then goes on to characterize K-Mart, one of the defendants, as simply a "large and solvent firm."[96] The imagery is one that the public is accustomed to and for which it has a pat response. The defendants, large companies, will not suffer greatly if they are held liable for this injury. Rather, they will readily shift the cost of Welge's injury to the consumers who buy their products in the form of higher prices at the checkout stands. This situation is certainly more palatable than allowing Welge to bear the burden of the injury on his own. Judge Posner's focus is largely on the deterrence function of tort law and the concern that adoption of the plaintiff's standard in this case would lead to overdeterrence. Minimal discussion of the need to compensate the victim in this situation indicates the prevalence of tort's deterrence goals for Judge Posner.

D. Pomer v. Schoolman[97]

Through *Pomer*, Judge Posner most effectively shows that the tort law system does not fulfill its compensation function. Despite the gravity of the injuries involved, in situations where the harm suffered can be traced to the injured's failure to take due care, the tort system does not readily provide compensation. This case involves a rather gruesome accident in which a farm hand, Pomer, suffered serious physical injury, the amputation of both his legs.[98] Pomer was hired by Schoolman to drive a semi-trailer truck to haul grain to grain elevators.[99] On the day of the accident, a fellow employee, King, was harvesting corn with a Deere combine, which he stopped next to Pomer's truck in order to load the truck.[100] King's task was to guide the chutes in the back of the combine over the open bins of the truck.[101] While loading the truck, King was looking over his shoulder at the chute and the truck.[102] Although the combine was stationary, the corn head was not turned off, which was standard procedure since turning

95. *Id.*
96. *Id.* at 212.
97. 875 F.2d 1262 (7th Cir. 1989).
98. *Id.* at 1264.
99. *Id.*
100. *Id.*
101. *Id.*
102. *Id.*

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off the corn head before all the corn in it has been shucked would foul the machine.[103] Pomer left the cab of his truck, walked to the back to watch the corn being loaded and craned his head upward to see if the bins in the truck were filling up.[104] Pomer was suddenly caught in the corn head and King immediately reacted by putting the corn head in reverse but by that time the machine had mangled Pomer's legs.[105]

Count I of the complaint charged Schoolman, the employer, and King, the fellow employee, with negligence in his failure to turn off the machine prior to loading the corn into the truck and for failing to maintain a careful lookout for Pomer.[106] In Count II, Pomer sought punitive damages against both these defendants.[107] In another count of the complaint, Pomer charged Deere with alleged negligent design of the combine and the corn head because of a lack of safety devices that would have prevented the accident, or in the alternative that Deere had sold a defective product.[108] After the parties finished presenting evidence, the district judge ruled that Pomer failed to show evidence that supported Count II of the complaint.[109] The only means by which Schoolman could be held liable was through the doctrine of *respondeat superior.*[110] However, given that King was a fellow employee and negligence of a fellow employee cannot be imputed to the employer, the district judge granted a directed verdict for Schoolman.[111] Pomer was not given leave to amend his complaint to add a count charging Schoolman with negligence in entrusting a dangerous instrument to an "allegedly immature and untrained" King.[112] In the end, only the case against King and Deere was presented to the jury, which resulted in verdicts for the defendants.[113] The jury observed the corn head

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103. *Id.*
104. *Id.*
105. *Id.*
106. *Id.*
107. *Id.*
108. *Id.* at 1265.
109. *Id.*
110. *Id. See* POSNER *supra* note 23, at 204-05. (noting that the doctrine of respondeat superior has deterrent effects. It allows the employer to become the substitute enforcer of tort law, where the primary enforcement mechanism, a tort action against the immediate tortfeasor, is not available. The employer can use the threat of termination as a substitute for employee tort liability in making the employee act with due care.)
111. Pomer v. Schoolman, 875 F.2d 1262, 1265 (7th Cir. 1989).
112. *Id.*
113. *Id.*

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in operation and determined that the danger posed by the machine was obvious despite Pomer's lack of experience.[114] The jury held and the court affirmed that King had not acted negligently since he could not be faulted for failing to keep an eye on Pomer given that there was no reason to believe anyone would approach an operating corn head or to believe that Pomer, whose job was simply to drive the truck, would approach the machine.[115] There was no evidence introduced to show that these types of accidents were common or that one had ever occurred before.[116]

The rules that govern the employment relationship apply in this case and the tort that resulted was based on this contractual relationship. From a contract perspective, if an employee believed that injury due to a careless co-worker was probable, then the employee would have negotiated terms in a contract that reflected these additional risks.[117] The lack of such a contract presumes that the employer raised the employee's pay to offset any additional risk of injury the employee may face,[118] as was postulated in *McMunn*.[119] In addition, an employee typically has the opportunity to observe the safety measures that are taken by the employer or his fellow employees. Knowing that a fellow employee's actions affects his health and safety, an employee has an incentive to ensure that the other takes due care.[120] In *Pomer*, however, the accident occurred the second day of Pomer's work on the harvest, which happened to be his first day working near the corn head.[121] Also, though an experienced truck driver, Pomer had little experience working on farms.[122] His lack of experience should have led Pomer to take more rather than less care. It is quite telling that in its recitation of the facts the court referred to statements made at the scene of the accident by Pomer insisting that no one should blame King rather that he was solely responsible for the accident.[123] Pomer knew that the accident was caused only by his momentary lapse of judgment, which unfortunately carried a tremendous price. Thus in terms of deterrence,

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114. *See id.* at 1269.
115. *Id.* at 1268.
116. *Id.*
117. *Id.* at 1266.
118. *Id.*
119. 791 F.2d 88 (7th Cir. 1986).
120. *Pomer*, 875 F.2d at 1266.
121. *Id.* at 1264.
122. *Id.*
123. *Id.*

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Pomer was in the best possible position to prevent this accident. It would be in error to shift the responsibility for this gruesome accident onto other parties who were in no position to prevent the accident.

Judge Posner paid brief attention to the compensation issue though the facts of this case, particularly the severity of the injuries sustained by Pomer, lend themselves to a more detailed discussion. But as Judge Posner observed, the jury was uncomfortable finding King, the young farm worker, negligent when his employer had been exonerated from any liability.[124] Further, it was unlikely that the jury viewed Schoolman as a "deep-pocket" defendant and ultimately released the only deep-pocket defendant in the case, Deere and Company.[125] Unlike the plaintiff in *McMunn*,[126] Pomer will have to bear the burden of his injury. At the time of the accident, although worker's compensation schemes had made employers strictly liable for injuries sustained by employees, farming was one of the few industries that remained unaffected.[127] As such, the consequences of this accident fell squarely on the shoulders of the Pomers. The severity of Pomer's injury when compared to his level of carelessness seems "grossly disproportionate to the fault implied by his momentary heedlessness" but there is nothing to indicate that the defendants were at fault.[128] Posner noted the common law of Illinois "does not make an injurer the insurer of his victims . . . it is up to Illinois to plug in what to many observers will seem an anachronistic and even cruel gap in the state's law of industrial accidents."[129] The people of Illinois expressed their discomfort with such a seemingly unfair result through passage of legislation that would prevent any future recurrences.[130] The legislation

124. *Id.* at 1265.

125. *Id.*

126. 791 F.2d 88 (7th Cir. 1986).

127. *Pomer*, 875 F.2d at 1267.

128. *Id.* at 1269.

129. *Id.*

130. The Illinois legislature responded by amending the Workers' Compensation Act to make it applicable to employers and employees who are engaged in enterprises or businesses that are deemed "extra hazardous." 820 ILL. COMP. STAT. ANN. 305/3 (West 1993). The statute lists twenty different work scenarios that fall under the extra hazardous label, including "[a]ny business or enterprise in which electric, gasoline or other power driven equipment is used in the operation" and "[a]ny enterprise in which sharp edged cutting tools, grinders or implements are used." *Id.* If such a statute were in place at the time of Pomer's accident, then Pomer would have received some compensation. The

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ensures that other victims, who find themselves in the same unfortunate position as Mr. Pomer, will no longer have to face the daunting prospect of dealing with consequences of their injury alone.

In each of the cases discussed above, deterrence, not compensation is the goal of the tort law system. In *McMunn*, the presence of the workers' compensation scheme made resorting to the tort system for compensation unnecessary. In that opinion, Judge Posner also touches upon the crucial issue of whether tort law truly compensates victims given the nature of severe injuries. In both *Welge* and *American Cyanamid*, Judge Posner does little more than mention the presence of deep pocket defendants. Judge Posner's most in-depth discussion of the tort system's compensation function comes in *Pomer*, which is appropriate given the grave nature of the plaintiff's injuries. Ultimately, Judge Posner's opinion upheld a jury determination of no liability on the part of the employer and the fellow employee thereby leaving Pomer to suffer the consequences of his injuries without any form of compensation.

The minimal attention accorded to tort's compensation function can be traced to the significant question of whether the system can effectively achieve this goal. The next section examines how the desire to compensate victims contributed to the theory of tort law as a form of insurance. In addition, it studies the evolution of the theory including the concerns by modern insurance theorists that the tort system often overcompensates victims. The contention that tort law fails to fulfill its compensation function, whether due to overcompensation or undercompensation, is more fully analyzed in Section III.

II. TORT LAW AS INSURANCE

Although it was not until 1963 that a strict liability rule was adopted for defective products,[131] the foundation for this decision and for reliance on tort law as insurance was set forth by Chief Justice Traynor, who almost

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activity involving the corn head would likely fall under one of the aforementioned categories thereby ensuring Pomer would receive a workers' compensation award.

131. Greenman v. Yuba Power Prods., 377 P.2d 897 (Cal. 1963).

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two decades prior penned the often quoted concurrence in *Escola v. Coca-Cola Bottling Co.*[132] The quote bears repeating:

> [e]ven if there is no negligence, however, public policy demands that responsibility be fixed wherever it will most effectively reduce the hazards to life and health inherent in defective products that reach the market. It is evident that the manufacturer can anticipate some hazards and guard against the recurrence of others, as the public cannot. Those who suffer injury from defective products are unprepared to meet its consequences. The cost of an injury and the loss of time or health may be an overwhelming misfortune to the person injured, and a needless one, for the risk of injury can be insured by the manufacturer and distributed among the public as a cost of doing business.[133]

Thus, the tort system can be used to place additional pressures on the manufacturer to create safer products. By eliminating the need to show that the manufacturers failed to act with due care, more plaintiffs can recover for their injuries. This is justified in part because manufacturers are in a better position to compensate for injuries given their ability to pass along a portion of the cost of injuries to the consumer through an increase in the product price.[134] The manufacturer is thus transformed into an insurer who is "well positioned to create a risk pool and pass along the costs of injuries to all members of the pool."[135] Such a system alleviates the burdens that befall a hapless victim while protecting the financial viability of the manufacturer. Since any consumer who purchases a defective product can be harmed, a system whereby all consumers contribute to a compensation pool is deemed fair.

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132. 24 Cal. 2d 453, 150 P.2d 436 (1944) (Traynor, J., concurring). *See* Priest, *supra* note 17, at 36 n.3 (describing the concurrence as having achieved "iconic status").

133. 24 Cal. 2d at 462.

134. Chief Justice Traynor argued that the "risk of injury from defective products should be guarded against by the manufacturer [who] is best situated to afford [general and constant] protection." *Id.* at 462. *See also* Priest, *supra* note 17, at 38 (arguing that the revolutionary changes in tort law sought to internalize injury costs and provide compensation insurance to the injured victims).

135. Feldman, *supra* note 3, at 1595.

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The ability of the manufacturer to more effectively deter accidents and spread the cost of insurance is exemplified in *Welge v. Planters Lifesavers Co.*[136] There the manufacturer was in a better position than the consumer to inspect the bottle of peanuts for possible defects that could lead to injury.[137] An average consumer deals with a number of products daily and cannot be expected to carefully examine each before its use. Rather, it is more likely that a consumer expects the product to be in a good working condition upon purchase. In promoting a strict liability rule, Chief Justice Traynor certainly cited the need to compensate an injured victim but he also placed great weight on the ability of the manufacturer to prevent the accident from occurring.[138] He believed that a strict liability regime would not only provide insurance to victims of unavoidable accidents but would avert such accidents from occurring in the first place.[139]

Interestingly, despite this avowed benefit, the tort system does not adhere solely to the strict liability rule but continues to rely on negligence as well.[140] In cataloging the differences between these two regimes, Judge Posner notes that strict liability "operates to insure victims against unavoidable accidents. It is a gain only if the cost of insurance through the tort system is less than the cost to potential victims of buying accident insurance policies in the insurance market; almost certainly it is greater."[141] However, the substantial administrative costs linked to the determination of liability, may be justified if there are savings in accident costs.[142] An instructive case on how these two approaches to liability reflect different ideas about the nature of tort liability is *Indiana Harbor Belt RR v. American Cyanamid.*[143] In *American Cyanamid*, Judge Posner describes negligence as the baseline rule from which one could stray only

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136. 17 F.3d 209 (7th Cir. 1994).

137. *Id.* at 212.

138. The Chief Justice wrote that in the "manufacturing processes, frequently valuable secrets, are ordinarily either inaccessible to or beyond the ken of the general public. The consumer no longer has means or skill enough to investigate for himself the soundness of a product, even when it is not contained in a sealed package." Escola v. Coca Cola Bottling Co., 24 Cal. 2d at 467 (Traynor, J., concurring).

139. *Id.* at 462.

140. POSNER, *supra* note 23, at 196.

141. *Id.*

142. *Id.* at 220.

143. 916 F.2d 1174, 1179 (7th Cir. 1990).

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if it resulted in loss prevention benefits.[144] He attributed the harm that resulted in that case to carelessness and reasoned that it could have been avoided by simply taking due care.[145] Based on this reasoning, it was unnecessary to rely on a rule of strict liability.[146] However, if the opinion had been driven by the notion of risk distribution or compensation, a different result would likely have been reached. If the driving concern is to compensate the injured party, then liability should attach to the party that is able to pass along the costs.

Modern proponents of tort law as insurance observed that the expansion of tort liability allowed those who had been unable to purchase insurance, particularly the poor, the opportunity to do so.[147] This is accomplished by including the insurance premium in the price of the product or service that is being sold.[148] By tying insurance to the sale of products or services, consumers who may otherwise be unable to purchase insurance can obtain coverage.[149] Again, a manufacturer was deemed to be in a better position to obtain insurance for a product or service because it can self-insure or enter into one contract that will cover all users.[150] It is important to note, however, that the modern insurance theorist's notion of tort as insurance differs significantly from that of Justice Traynor. Where Justice Traynor focused on manufacturers, the insurance as tort theorists focus on consumers and analyze tort as insurance "by comparing consumers to purchasers of first-party insurance."[151] While Chief Justice Traynor based victim compensation on the more traditional notion of "restoring the victim's losses,"[152] modern insurance theorists employ the "individual demand for first-party insurance"[153] as the appropriate measure of compensation.

If compensation for victim's injuries is to be based on first-party insurance preferences, tort damages must equal only the coverage that an

144. *Id.* at 1177.
145. *Id.* at 1180-81.
146. *Id.* at 1179.
147. Priest, *supra* note 25, at 1525.
148. *Id.*
149. *Id.*
150. *Id.* at 1535.
151. Feldman, *supra* note 3, at 1595.
152. *Id.*
153. *Id.*

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injurer would receive from first party insurance.[154] Thus an award for both pecuniary and non-pecuniary, i.e. damages for pain and suffering, losses will fail to provide "optimal insurance for unpreventable losses."[155] To support this contention, modern insurance theorists note the substantial differences that exist between first-party and tort law provided insurance.[156] First-party insurance does not provide coverage for non-pecuniary losses because of concerns about adverse selection and moral hazard, as evidenced by the lack of a market for pain and suffering insurance.[157] Also, first-party insurance contracts typically include deductible and co-insurance provisions.[158] These measures, intended to control moral hazard, are not available through insurance provided by the tort system.[159] Modern insurance theorists believe that providing insurance through tort law has been detrimental to the insurance market and that these markets cannot be restored until insurance issues are dealt with directly, which can be accomplished only by extricating the insurance function from tort law.[160]

Modern insurance theorists express grave concern that the expansion of tort liability has actually led to a reduction in the total available insurance coverage.[161] They assert that this decrease has most drastically affected the low-income and the poor.[162] In addition, there is concern that the advantages gained by tort law insurance are outweighed by "excessive

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154. *Id.*

155. Priest, *supra* note 25, at 1553.

156. *See, e.g., id.*

157. *Id. But see*, Croley and Hanson, *supra* note 20, at 59 (rejecting Priest's argument that nonpecuniary loss damages do not serve any deterrent benefit and consumers do not demand insurance for them). The authors find evidence that consumers not only want nonpecuniary-loss insurance but that some have actually purchased it. *Id.* at 60. Also, Priest fails to recognize that there are other significant problems to a market for non-pecuniary loss insurance that may explain the lack of supply. *Id.* at 61. For example, consumers have very little of the information necessary to write a complete contract and the costs associated with obtaining that information may swallow up the benefit. *Id.* at 61-62. Croley and Hanson insist that the tort system should instead be viewed as an "efficient public response to a market failure: the inability of insurance markets to respond to consumer demand for non-pecuniary loss." *Id.* at 66-67.

158. Priest, *supra* note 25, at 1553.

159. *Id.*

160. *See, e.g., id.* at 1588-89.

161. *See, e.g.*, Priest, *supra* note 17, at 31.

162. *See, e.g., id.*

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coverage, the inability to segregate risks in third-party contexts, and regressive distributive effects."[163] Essentially, the shift toward tort law insurance leads low-risk consumers to reduce the use of products with prices incorporating high tort insurance premiums. The concern is that low risk consumers, particularly low-income consumers, may find that the price of the product or the service is greater than the benefit provided by the insurance.[164] This could eventually cause these consumers to drop out of the market.[165]

Although Judge Posner and the modern insurance theorists appear to agree that tort law fails to fulfill its compensation goal, they approach the problem from very different perspectives. Their complaints regarding tort's inability to fulfill its compensation goal appear to lie at opposite ends of the spectrum. However, their objections are based on the inherent nature of injuries, particularly serious bodily injury, which cannot truly be compensated. Modern insurance theorists are concerned with overcompensation in situations where awards are made for pain and suffering damages that lead to a call for the extraction of the insurance function from tort law.[166] On the other hand, Judge Posner has observed that damages for pain and suffering may well undercompensate victims of serious accidents.[167] Interestingly, Judge Posner has noted that most discussions regarding damage awards are based on the premise that the "proper baseline for determining marginal utility of income is the pre-accident self."[168] If damages were calculated based on the future disabled self, then there may be a higher marginal utility of income for the disabled self than the pre-accident self.[169] In such a scenario, tort law would serve

163. *See* Priest, *supra* note 25, at 1559.

164. *Id.*

165. *Id.* at 1559-60.

166. *See, e.g.*, Priest, *supra* note 17, at 49.

167. *See* POSNER, *supra* note 23, at 214-15 (noting that the loss of limbs or vision reduces the amount of pleasure that can be purchased with each dollar thereby requiring more money to put the victim in the same position of satisfaction that was occupied prior to the accident). In discussing why compensatory damages are paid to victims rather than to the state, Posner focuses on the deterrent effect of tort law. He notes that the payment to the victim maintains the tort system as an "effective, credible deterrent to negligence" and prevents the victim from taking too many precautions. *Id.*

168. POSNER, *supra* note 23, at 219.

169. *Id.* (assuming that the disabled self is not destined to be irreversibly comatose). *But see* Feldman, *supra* note 3, at 1586 (explaining that "tort damages repair a victim's capacity to flourish." Flourishing refers to the quality of an individual's life. *Id.* at 1585.

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as a "trustee for the disabled self."[170] This is certainly highlighted by the facts of *Pomer v. Schoolman*,[171] where Mr. Pomer undoubtedly placed a higher value on consumption expenditures in his disabled state than he would in his pre-accident state. The accident has cost him the loss of both his legs, which has severe effects on his ability to earn an income and support himself, since his prior occupation was that of truck driver and occasional farm hand. There are activities that Mr. Pomer will now be precluded from participating in given his physical condition after the accident. No amount of money can truly compensate Mr. Pomer for the injuries he has sustained.

The notion of tort law as a form of insurance was borne of the desire to provide compensation to consumers who were injured by defective products and to prevent future accidents from occurring. But as the next section will show there has been tremendous unease surrounding tort law's ability to compensate victims. Opponents of the theory of tort law as insurance frequently cite overcompensation as a problem with the system. Yet, the system is riddled with undercompensation. Indeed, a fundamental issue is whether a victim can every truly be made whole by a damage award. This question brings to the forefront the fundamental goals of tort damage awards and in so doing assesses whether tort law can ever effectively fulfill its compensation function.

III. CRITICISMS OF TORT LAW AS INSURANCE

The decision to consider the manufacturer's insurance or insurability represents a fundamental shift regarding whether a defendant's insurance should be relevant to his liability. The traditional view is that the presence of insurance should not play any role in determining liability since such information is deemed to be unfair because of the "inflammatory potential"[172] that such revelations could have on the case. The more

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Comatose victims suffer more than simply lost wages and loss of physical health. *Id.* at 1592. Although comatose victims are believed to experience nothing, neither pain nor pleasure, an award of tort damages could be made to enhance "nonexperiental aspects of flourishing." *Id.* at 1591.

170. POSNER, *supra* note 23, at 219.

171. 875 F.2d 1262 (7th Cir. 1989).

172. Stapleton, *supra* note 18, at 824. The author argues that it is "morally incoherent" for a tort system based on individual responsibility to allow the presence of insurance to have its own independent impact. *Id.* at 825.

modern trend, however, considers the realities of insurance in establishing liability.[173] There is some concern that the consideration of a tortfeasor's insurance status will naturally lead to the logical end that if the plaintiff could have protected himself through first-party insurance then there is no reason to provide coverage through tort.[174] It is not surprising that commentators, such as Stapleton, who greet the court's decision to consider insurance status with regret, detect fundamental flaws with tort law as insurance.[175] First, the argument relies on the assumption that there is a consensual bargaining relationship between all plaintiffs and defendants.[176] However, this postulate contravenes the typical tort scenario where obligations arise between parties that are mere strangers to one another.[177] Second, there is a danger that the assumption that a victim needs insurance naturally leads to the conclusion that the plaintiff does not have a right to protect his interests through tort.[178] This denies the possibility that there are other functions that tort law fulfills:

> the possibility that sometimes there are reasons why the law may want to grant [the victim the] right and the accompanying entitlement to a restorative measure of damages: for example, because it wants to deter certain conduct of defendants or because it regards the injury as a wrong which 'justice' requires to be 'corrected', or an 'outcome' for which the defendant should be held responsible.[179]

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173. *See* George K. Gardner, *Insurance Against Tort Liability-An Approach to the Cosmology of the Law*, 15 LAW & CONTEMP. PROBS. 455, 464 (1950) (stating that during settlement plaintiffs' and defendants' lawyers take into account the fact that a large portion of all tort damage awards are borne by the insurance companies); Brown, *supra* note 5, at 115 (claiming that in the United States, although the presence of insurance is not revealed during the trial, obtaining liability insurance has become so prevalent that jurors normally assume that the defendant is insured). *See also* Kent D. Syverud, *On the Demand for Liability Insurance*, 72 TEX. L. REV. 1629, 1632 (1994) (arguing that lawyers and insurers, acting with their own interests in mind, with the encouragement of legal and political institutions, have driven consumers to overconsume liability insurance).

174. Stapleton, *supra* note 18, at 833.

175. *Id.* at 833-39.

176. *Id.* at 836.

177. *Id.* at 836 n.56 (noting that the landmark cases such as *Greenman* and *Henningsen* involved injured parties who were not in privity with the manufacturer).

178. *Id.* at 837.

179. *Id.*

In this regard, Stapleton agrees with Judge Posner that tort law performs a deterrence function.[180] Stapleton's most basic criticism is that the proponents of tort law as insurance are prevaricating when they claim that their analysis is not motivated by political concerns.[181] She charges that modern insurance theorists feign concern about individual autonomy but their views support "enrichment of injurers."[182] Although the analysis by the modern insurance theorists is inherently attractive in that it promotes autonomy by arguing that individual preferences should be respected, it fails to take account of other equally important goals, such as deterrence and corrective justice.[183] Tort law as insurance will have significant redistributional effects as "business is enriched and injured individuals are stripped of protection."[184] Given that these changes can be substantial, they should be discussed in a frank and open manner.[185]

Other criticisms of tort as insurance continue to focus on the basic foundations of the argument. As suggested earlier, one of the most vehement complaints lodged against tort as insurance is that it overcompensates victims by providing for pain and suffering damages.[186] The argument is based on the belief that rational consumers will only purchase insurance they believe will compensate them for their loss.[187] As such, if a victim is unwilling to purchase insurance to protect against certain harms, such as pain and suffering, then it would be superfluous for tort law to provide this type of compensation. Further, it is claimed that the lack of a market for pain and suffering insurance serves as a clear

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180. *Id.* (noting that Landes and Posner "point out pithily: 'the tort system is an exceedingly costly insurance mechanism . . . the only thing wrong with the point is that the system may be cost justified when viewed as a means of deterring unsafe behaviour rather than just insuring some accident victims'").

181. *Id.*

182. *Id.* at 845.

183. *See id. See also* Feldman, *supra* note 3, at 1583 (observing that there are situations where paternalism is not problematic such as when society believes that an individual is incapable of making correct judgments and as such overrides their preferences for their own well-being).

184. Stapleton, *supra* note 18, at 837.

185. *See id.* at 839.

186. Priest, *supra* note 25, at 1553-59. *But see* William M. Landes & Richard A. Posner, *A Positive Economic Analysis of Products Liability*, 14 J. LEGAL STUD. 535, 564 (1985) (observing that "punitive damages are not awarded routinely in products liability cases . . . only where there are circumstances of aggravation").

187. Priest, *supra* note 25, at 1553-59.

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indicator that rational individuals are unwilling to purchase such insurance.[188] The critics have argued that "significant reform of tort law will come only when judges scale back liability rules to remove the compensation insurance features of the law."[189] They contend that the inability of the damage award to cure the victim's injuries should lead to a paring back and ultimately to an elimination of pain and suffering awards.[190]

However, their objections appear to confuse what consumers, and ultimately what victims, need with what they want.[191] Consumers today are faced with many competing needs and unfortunately insurance coverage is often sacrificed in the face of more compelling needs.[192] An individual who is injured primarily wants the effects of the injury undone. However, in most situations it is impossible to return the injured to his state prior to the accident. It seems intuitive, however, that no amount of monetary compensation can erase the harm suffered by the injured or can return the victim to the state they were in before an accident. Despite this fact, judges and juries award tort damages to allow victims to be made whole by their injurers.[193] Although "there is no such thing as a perfect anesthetic,"[194] an injured party should be allowed to take comfort in the

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188. *Id.* *But see* Croley & Hanson, *supra* note 20, at 59-60 (1991) (claiming consumers not only appear to want non-pecuniary loss insurance but are actually purchasing such insurance).

189. Priest, *supra* note 17, at 49.

190. Priest wrote "it is appropriate not only to restrain, but to prohibit, punitive damage awards in products liability and other tort contexts." Priest, *supra* note 25, at 1589.

191. Modern insurance theorists "equate[] well-being with preference satisfaction and contend [] that money cannot genuinely repair pain and suffering. These propositions enjoy widespread intuitive appeal. Nevertheless, they are wrong." Feldman, *supra* note 3, at 1577.

192. For example, in 1996, there were 42 million Americans who had no health insurance. U.S. DEPT. OF COMMERCE ECON. AND STATISTICAL ADMIN., STATISTICAL ABSTRACT OF THE U.S. 115 (118th ed. 1998). Of that figure, 14.6% were children between the ages of 6 and 11 and 13.8% were children under the age of 6. *Id.* at 125. It is difficult to imagine that parents who are able to purchase insurance to protect their child would be unwilling to do so. A more plausible explanation is that although they would like to purchase insurance and provide a certain level of security for their children, other circumstances, such as cost, preclude them from doing so.

193. Feldman, *supra* note 3, at 1579.

194. Croley & Hanson, *supra* note 20, at 61.

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damages that they are awarded. [195] Thus the compensation provided by tort law is not based on the individual preferences of the victim as revealed by the type of insurance that is purchased ex-ante because:

> [t]ort damages . . . are not usually taken to rest on first-party preferences. Rather, tort liability arises from a failure to respect a socially mandated level of care or safety, and compensation depends on the costs of redressing resultant injuries, rather than the costs of supplying the victim with goods or services specified by prior agreement.[196]

Instead, tort law seeks to compensate a victim for the injury he has suffered based on a view expressed by society that we are all called upon to exercise due care in our dealings with each other. When an individual fails to perform to the expected and required level of care, then he is subject to pay for the harms that he has caused. The system thereby ensures that a victim is not left to deal with the consequences of the accident and injury alone through the damages awarded, particularly in situations involving serious physical harm.

Although the notion of tort law as a form of insurance was inspired, in part, by the desire to compensate consumers who were injured by defective products, the very nature of injuries suggests that a victim can never truly be compensated. In light of the inability of tort law to ever fulfill its compensation goal, the system's ability to deter becomes significantly more important. The following section will analyze the claims that tort law is unable to prevent future accidents.

IV. THE DETERRENCE FUNCTION OF TORT LAW

Given the many and varied problems that appear to surround the compensation function of tort law, it is essential to determine whether tort law fulfills its other equally important goal of deterring future accidents. Just as the compensation function has been attacked on several fronts, there are also a number of problems raised with regard to the deterrence function. There are those who claim that several other factors, aside from the threat of tort liability, deter potentially harmful conduct, including morality and

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195. Feldman, *supra* note 3, at 1576 ("[T]here is no reason to think it unreasonable for people to expect money in the case of injury.").

196. *Id.* at 1596.

the notion of self-preservation.[197] Individuals take care because of a belief that inflicting harm on others is wrong.[198] In addition, since the lack of care poses a danger not only to others but also to one's own safety, individuals will take the necessary precautions.[199] These, combined with other factors, such as the economic pressures of market forces, regulations that are "formal behavioral control mechanisms," ignorance of the threat of tort liability, general incompetence, i.e. individuals and firms cannot always act as would a reasonable person, discounting the threat of liability, and the belief that liability will invoke only a small penalty, all undermine tort law's deterrent potential.[200] Thus, if tort law were abolished, as the argument goes, these factors would ensure that there would not be a significant rise in injuries.[201] However, these critics err in considering these factors as separate from the use of tort law as a deterrence measure. On the contrary, these factors work in conjunction with the threat of tort liability to effectively reduce accident levels.

Moreover, the presence of insurance is believed to suspend any real threat of actual liability and has effectively eliminated the deterrent function of tort law.[202] Liability insurance "shifts the *direct* economic deterrent pressure of tort law from would-be tortfeasors to insurance companies."[203] In so doing, liability insurance allows manufacturers and producers to absorb a severe blow that might be dealt by a significant tort damage award. The availability of liability insurance sends the message either that deterrence is not the primary objective of tort law, or that deterring bad conduct is not an objective of tort law at all.[204] Some

197. *See, e.g.* Sugarman, *supra* note 6, at 561-64. *But see* LANDES & POSNER, *supra* note 27, at 9-11 (rejecting on both empirical and theoretical grounds the argument that individuals, particularly those who carry liability insurance, are unaware of and are unmotivated to take due care by the threat of tort liability but are instead dominated by other concerns such as personal safety).

198. Sugarman, *supra* note 6, at 563.

199. *Id.* at 562.

200. *Id.* at 561-63

201. *Id.* at 562.

202. Fleming, *supra* note 6, at 823 ("The deterrent function of the law of torts was severely, perhaps fatally undermined by the advent of liability insurance."). *But see* James, *supra* note 15, at 441 (insisting that tort law deterred dangerous conduct and that "there is no substantial reason to believe that the existence of wide-spread insurance has fostered irresponsibility.").

203. Sugarman, *supra* note 6, at 573.

204. Fleming, *supra* note 6, at 824.

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scholars have compared the American tort law system, which permits the presence of a liability insurance market, with the prevailing systems in socialist countries where the acknowledged primary goal of tort law is "to deter and to educate the public to avoid injury."[205] In stark contrast to the American system, the compensation of victims in such countries assumes only a secondary role. In pursuit of its deterrence objective, the former Soviet Union, for example, disallowed any form of liability insurance.[206] Although other countries were not as restrictive, they nonetheless employed measures that promoted deterrence and kept the liability of injurers within "reasonable bounds."[207]

One of the major reasons why liability insurance is said to eliminate the deterrence function lies in the problem of moral hazard, which "refers to the tendency for insurance against loss to reduce incentives to prevent or minimize the cost of loss."[208] By attaching liability to certain outcomes on a specific party, the incentive for the other party to avoid such harm is removed.[209] The expansion of tort liability is seen by many to have made the moral hazard problem even more acute. Yet moral hazard is not only a feature of expanding liability. Although the expansion of manufacturer's liability "transfers risk from consumers to manufacturers and, thus, increases the insurance manufacturers provide to consumers," it is also the case that "limiting manufacturer's liability transfers risks from manufacturers to consumers and, thus, increases the insurance consumers

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205. Brown, *supra* note 5, at 115. *See* Fleming, *supra* note 6, at 826-27.

206. Fleming, *supra* note 6, at 826.

207. *Id.* at 827.

208. Tom Baker, *On the Genealogy of Moral Hazard*, 75 TEX. L. REV. 237, 239 (1996); *see also* Schwartz, *supra* note 1, at 338 ("insurance policy can release the insured from cost constraints in a way that affects how he arranges his conduct"); Richard A. Epstein, *Products Liability as an Insurance Market*, 14 J. LEGAL STUD. 645, 653 (1985) ("Individuals with insurance against certain types of losses are more likely to engage in risky conduct than those who do not have that insurance."); Priest, *supra* note 25, at 1547 ("Moral hazard refers to the effect of the existence of insurance itself on the level of insurance claims made by the insured."). This section of the paper take a mere glimpse at moral hazard. For a more in-depth discussion on Judge Posner's views on the issue of moral hazard, *see* Eric Beal, *Posner and Moral Hazard*, 7 CONN. INS. L.J. 81 (2000).

209. Priest, *supra* note 25, at 1547 (distinguishing between ex-ante and ex-post moral hazard, where the former involves reductions in precautions taken to by the insured to prevent the loss and the latter involves the increase in claims made against the insurance policy).

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provide to manufacturers."[210] Indeed, anything less than a rule of strict liability in product defect situations would create a "manufacturer moral hazard problem."[211] Thus, moral hazard analysis does not provide a clear justification either for or against strict liability.

Furthermore, there are a number of different tools available to insurance companies that mitigate the problem of moral hazard, such as the use of deductibles, coinsurance provisions, caps, and the exclusion of coverage for certain activities.[212] It is within the power of insurance companies to include provisions in the insurance policy to protect against moral hazard. This is particularly so since insureds lack the bargaining power to insist upon any conditions in the insurance contract and are often in a "take it or leave it" position.[213] One of the most powerful tools in the insurance company's arsenal is certainly the ability to set premiums.[214] Although an insurance company exposes itself to an increased probability of loss when it undertakes to provide insurance to the morally hazardous, it can protect itself by increasing the premiums charged. Such an increase in premiums will not be directed at all insureds but only at the morally hazardous.

Much of the criticism regarding tort law's ineffectiveness as a deterrence mechanism is also based on the unreasonable requirement that tort law provide an absolute level of deterrence. The critics would do well

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210. Baker, *supra* note 208, at 274.

211. *Id. See also* Priest, *supra* note 25, at 1559. Priest argues that greater dependence on tort law insurance may lead low-risk consumers to reduce their consumption of products if the product prices include high tort insurance premiums. Low-risk consumers, especially low-income consumers, may find that the insurance premium makes the price of the good greater than the benefit that it would provide.

212. *See* ABRAHAM, *supra* note 25, at 2. In *Clark Equipment Co. v. Dial Corp.*, 25 F.3d 1384, 1388 (7th Cir. 1994), Posner wrote:

> [i]nsurance companies insist on limits, both of time and of amount in their undertakings to indemnify, fearing that without limits in both the duration of the insurance contract and the amount of damages insured against the insured will lack any incentive to conduct his activities in a prudent manner that will minimize the insurance company's exposure.

Id. at 1388. *But see* Sugarman, *supra* note 6, at 574 (arguing that insurers rarely use these forms of economic pressure).

213. *See* ABRAHAM, *supra* note 25, at 33.

214. *Id.* at 2-3.

to view tort law as providing a significant level, though not an absolute level, of deterrence. The two competing levels of deterrence involve:

> the "strong" form of the deterrence argument -- which assumes that tort law does in fact deter as thoroughly as economic models suggest -- and the more "moderate" form of the argument -- which assumes that tort law provides a significant amount of deterrence, yet considerably less than the economists' formulae tend to predict.[215]

Viewed in this light, the threat of tort liability will have an effect on the reduction of accidents though not at the level previously envisioned. So long as individuals are part of the process, there will always be room for error. Accidents will occur even if all preventive measures are taken. Tort law seeks to prevent only those accidents that are not optimal.[216] As noted earlier, there is a means by which all accidents could be prevented but that would entail ceasing all activity, given that any activity has the potential to cause harm.[217] Though society would support such an end result, the means by which it is arrived at would be deemed socially unacceptable. Instead, society is resigned to the fact that accidents will occur. Thus, tort law functions to keep the level of accidents to a bare minimum or a socially permissible level, rather than merely allowing them to go unnoticed.

Judge Posner supports the notion of a "moderate" form of deterrence as evidenced when he wrote:

> [A]lthough there has been little systematic study of the deterrent effect of tort law, what empirical evidence there is indicates that tort law likewise deters, even where, notably in the area of automobile accidents, liability insurance is widespread . . . and personal safety might be expected to be of greater concern than the potential financial consequences of an accident.[218]

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215. Gary T. Schwartz, *Reality in the Economic Analysis of Tort Law: Does Tort Law Really Deter?*, 42 U.C.L.A. L. REV. 377, 378-79 (1994) [hereinafter Schwartz, *Economic Analysis of Tort Law*].

216. Brown, *supra* note 5, at 112.

217. *Id.*

218. LANDES & POSNER, *supra* note 27, at 10 (footnote omitted).

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Judge Posner relies on surveys relating to the effects of tort law on automobile accidents as evidence that "tort law leads to lower accident rates."[219] In addition, he observes that "there is widespread agreement that the imposition of tort liability on professionals . . . and on business and other enterprises, does affect behavior, does deter – some think too much!"[220] Finally, while acknowledging concerns that tort law may be "less than [an] adequate system of social control in many ... areas," the studies upon which he relies indicate that tort law is "far from totally inefficacious."[221] Such an evaluation comports with the "moderate version of the deterrence rationale."[222]

Interestingly, the crisis experienced by the insurance industry in the mid-1980s has been explained as a natural consequence of the expansion of liability.[223] However, the unavailability of liability insurance may be interpreted to mean that the system is performing its deterrence function well. Rather than signifying a breakdown in the tort system, it could mean that insurers are correctly targeting only that conduct which can be controlled by the defendant.[224] In so doing, it is addressing the moral hazard issue. Furthermore, the decision by manufacturers to either discontinue a product or to not introduce a new product line should not be classified as the ill effects of the products liability system.[225] Instead, it should be viewed in a positive light, for why should a manufacturer be allowed to continue or to begin selling a product that is not altogether safe? Consumers are not necessarily better off because there are more products on the shelves from which to choose; they are better off only if those products are safe. A system that keeps dangerous products away from consumers who are in a worse position than manufacturers to investigate a product and determine accurate risk levels is a well-functioning system.

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219. *Id.* at 11 n.33.

220. *Id.* at 11 (footnote omitted).

221. *Id.* at 12-13.

222. Schwartz, *supra* note 215, at 389.

223. Priest, *supra* note 25, at 1521, 1522 (noting that the crisis peaked in 1986 and was characterized by exorbitant premiums for certain products and services as well as the refusal by insurance companies to offer coverage for particular products and activities at any premium).

224. Schwartz, *supra* note 1, at 343 (being very careful not to be aggressive about this point though it seems "implausible" that the moral hazard issue somehow became more serious between 1980 and 1985).

225. Croley & Hanson, *supra* note 20, at 83.

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Each of the factors considered above: (a) that tort law works with other factors such as morality, self-preservation and market forces; (b) that insurance companies have a number of tools at their disposal to address the moral hazard problem; and (c) that tort law serves to deter on a more "moderate" level, respond to much of the criticisms that have been lodged against the effectiveness of tort law as a deterrent. Together these factors ensure that the tort system continues to perform its deterrent function. The interplay of these factors combined with the inability of the tort law system to adequately provide compensation highlights the more efficient use of the system as a deterrence measure.

V. CONCLUSION

The tort law system's twin goals of compensating victims for their injuries and deterring future accidents are laudable. However, as the discussion above has shown, there is immense controversy regarding whether it can effectively achieve either of these goals. At its most basic, when a victim is able to rely on the tort system to ensure that he will not have to bear the burden of his injury alone, then tort law functions as insurance. But where tort law fails to provide such insurance, the consequences can be devastating as seen in the case of *Pomer v. Schoolman.*[226]

There are a number of factors that have been cited as preventing tort law from truly compensating victims and thus from functioning as a form of insurance. First, there has been tremendous discussion over whether tort damages actually compensate an injured victim. Judge Posner has observed that in situations involving serious bodily injury, tort damages can be insufficient.[227] Where grave physical injury is involved, the assertions by modern insurance theorists that tort law overcompensates victims through the award of damages for pain and suffering ring hollow. Given the very nature of injuries, it is the concern about undercompensation that captures the inherent problem of tort law's compensation goal. No matter the size of a damage award, tort damages cannot return an injured plaintiff to his condition prior to the accident.[228]

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226. 875 F.2d 1262 (7th Cir. 1989).

227. *See* POSNER, *supra* note 31 and accompanying text.

228. Feldman, *supra* note 3, at 1579-80 (observing that in situations involving serious physical injury tort victims may use their damages to restore lost abilities but are not

Given the very nature of serious physical harm, it is inconceivable that any financial package could actually compensate a victim. These damage awards merely help to alleviate the problems faced by victims, though they nonetheless fail to truly compensate for injuries.[229] The value of tort awards can be better understood if the notion of making a victim "whole" is viewed as a function of an individual's capacity to "flourish," which involves a person's quality of life, rather than a return to the status quo ante.[230] Tort damages can certainly provide a victim the opportunity to flourish in other ways.

Second, the tort system can siphon off a substantial portion of the damages for administrative costs and attorney's fees leaving the victim with even less coverage.[231] Though the desire to protect and provide for victims is commendable, under some circumstances, tort law is an extremely expensive means of providing insurance.[232] Third, as the review of only a handful of Judge Posner's opinions reveals, the presence of devices such as indemnity agreements[233] and worker's compensation[234]

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required by the state to do so. "A fake arm, an assistant, or any other surrogate for the victim's lost limb is just that -- a substitute, not a return to the actual status quo ante.").

229. Rather than equating making an injured victim "whole" with returning him to his state prior to the accident, Feldman introduces the idea of "human flourishing," which pertains to the quality of the individual's life. From this vantage point, she writes:

> [T]ortious injury interferes with flourishing; damages restore flourishing or the capacity for it, or both. What tort awards make whole, therefore, is the injured party's capacity for flourishing and in some cases his flourishing itself. Tort compensation can achieve this because an individual can flourish in more than one way. If injury forecloses one possibility, money can open others.

Id. at 1588.

230. *Id.*

231. *See The Liability System*, INS. ISSUES UPDATE, (Insurance Information Institute, New York, N.Y.), December 1999 at 1 (citing a 1995 study by Tillinghast, which broke tort costs down as follows: "an estimated 24 cents go to litigants for their actual (economic) losses and 22 cents to compensate for pain and suffering. Of the remaining 54 cents, 16 cents pays for claimants' lawyers and 14 cents for defense costs, and 24 cents for administrative costs."). *See also* Ortiz v. Fibreboard Corp., 527 U.S. 815, 867 (1999) (relying on the Report of the Judicial Conference Ad Hoc Committee on Asbestos Litigation in their dissent Justices Breyer and Stevens stated that "attorney's fees and other 'transaction costs' . . . consume an estimated 61 cents, with only 39 cents going to victims.").

232. *See supra* note 231.

233. *See supra* notes 41-43 and accompanying text.

234. *See supra* notes 49-50 and accompanying text.

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makes reliance on the tort system less necessary. Finally, the ability of individuals to purchase insurance that will provide them with protection should an accident occur, reveals that the law's compensation function is less essential.[235] Despite these factors, the tort system continues to play a role, though somewhat less significant than originally envisioned, because each of these tendencies is not realized in every instance.

Given the system's inability to meet its compensation and insurance functions in absolute terms, significant weight is placed on tort law's achieving its deterrence goal. When the threat of tort liability is combined with other factors that lead individuals to take more care, and when the system is expected to deter on a moderate rather than an absolute level, then it more successfully meets its deterrence goal. Tort law works in conjunction with a variety of other factors, such as an individual's sense that inflicting harm on others is wrong, concern regarding the danger that risky conduct poses on his or her own safety, and regulatory programs at the local, state and federal levels that establish minimum standards of care, to prevent accidents.[236] Rather than viewing these factors as separate components that deter accidents, they should be viewed as interdependent elements, which ensure that accidents are reduced to the optimum level. This will result in preventing those accidents that can be avoided from inflicting unnecessary harm. Moreover, it should be recognized that tort law cannot meet the unreasonable requirement of absolute deterrence, but does deter socially unacceptable conduct to a significant degree.[237] If the prevailing view, which requires the tort system to provide an absolute deterrence, continues, then it is no surprise that critics of the system pronounce that tort law fails to meet its goal and should be abolished. But if the goal of tort law is to deter on a more moderate, though nonetheless significant level, then the system is a success and should be allowed to continue.[238] Studies examined by Judge Posner regarding the effectiveness of tort law, though not comprehensive, indicate that the system is currently meeting this more moderate level of deterrence.[239] Altering these notions about tort law should not present significant difficulty because these changes are reasonable, particularly when

235. *See supra* note 27 and accompanying text.
236. *See supra* notes 199-200 and accompanying text.
237. Schwartz, *supra* note 215, at 378-79.
238. *Id.*
239. *See supra* notes 220-23 and accompanying text.

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compared with the alternatives that some critics offer such as the elimination of the tort system altogether.[240]

Finally, for many the presence of liability insurance has sounded the death knell for tort law's deterrence function. Liability insurance is viewed as shifting economic pressure from a would-be tortfeasor to his insurance company thereby raising the problem of consumer moral hazard. However, any rule other than strict liability in a products defects case would foster a manufacturer moral hazard situation. Furthermore, insurance companies have a number of tools at their disposal to curb the moral hazard problem, including the use of deductibles, coinsurance provisions, exclusion of coverage for certain activities and the ability to set premiums.

There appear to be valid concerns regarding whether tort law can effectively perform its compensation function, given the inherent nature of injuries. However, an analysis of the purported problems that surround the tort system's purported inability to effectively serve as a deterrence mechanism reveals that the concerns are unwarranted. The tort system prevents accidents from occurring at a moderate and effective level. These findings support Judge Posner's view that tort law is intended to serve more as a deterrence mechanism than compensation and, as such, it should not be viewed principally as a form of insurance.

240. *See* Sugarman, *supra* note 6, at 617 (arguing that "were tort law for accidents repealed, society as a whole would gain.").

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POSNER AND ERISA: A SURVEY

*Aldo R. Edwards van Muijen**

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INTRODUCTION

In the Fall of 1963, while a young attorney named Richard Posner concluded his judicial clerkship,[1] lives were unraveling in South Bend, Indiana. The demise of Studebaker, Corp., the nation's oldest automobile manufacturer, by December would leave over 11,000 autoworkers unemployed.[2] But what ignited a furor across the nation and in the halls of Capitol Hill was the fact that Studebaker's poorly funded single-employer pension plan left over 4,000 employees, aged forty to fifty-nine, who each

1. Richard Posner served as Law Clerk to Justice William Brennan in the United States Supreme Court from 1962-1963. 2 ALMANAC OF THE FEDERAL JUDICIARY 19 (Megan Chase et al. eds., 2001).

2. Michael Allen, *The Studebaker Incident, in* PENSION AND EMPLOYEE BENEFIT LAW 62, 63 (John H. Langbein et al. eds., 2d ed. 1995).

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had at least ten years of service and were already fully vested in the plan, with fifteen cents on the dollar toward their retirement.[3]

The public outcry over the Studebaker incident and similar pension plan defaults led to the eventual adoption of the Employee Retirement Income Security Act of 1974.[4] With this Act and its progeny, legislators attempted to strike a balance between the need to provide a uniform national regulatory structure to prevent the recurrence of the Studebaker tragedy,[5] while at the same time offering incentives to American business to improve the lives of workers through private retirement savings and employee welfare benefits.

While Congress has over the last twenty-five years periodically revised, amended or revamped ERISA to meet the needs of the public or other constituencies, the federal judiciary has established from the outset the balance between "[defining] the scope of the substantive protections ERISA . . . provides to employees"[6] and "maintain[ing] the voluntary growth of private plans."[7] Since federal judges both interpret and make the law that shapes ERISA,[8] understanding the role of the federal judiciary is critically important to the ERISA community. Among federal judges, Chief Judge Richard Posner has been prominent in identifying and clarifying ERISA's contours since his appointment to the Seventh Circuit in 1981. To date, Judge Posner has penned at least thirty-four opinions on various ERISA topics and these opinions have been cited over 1,700 times. By identifying themes in Judge Posner's ERISA jurisprudence and examining sample cases within his ERISA canon, this survey seeks to serve these purposes: (a) to understand Judge Posner's methodology and philosophy when ruling on ERISA decisions; (b) to determine Judge Posner's consistency and direction over time; and (c) to examine the extent of Judge Posner's use of insurance law concepts in his ERISA decisions.

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3. *Id.*

4. Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001-1461 (1999). Hereafter referred to as "ERISA."

5. According to the authors of the legislation, the primary goal was to "safeguard workers against loss of their earned or anticipated benefits." 120 CONG. REC. 31, 277 (1974) (statement of Sen. Javits).

6. KENNETH S. ABRAHAM, INSURANCE LAW AND REGULATION 364 (2d ed. 1995).

7. 120 CONG. REC., *supra*, note 5, at 77.

8. Judge Posner noted that the United States Supreme Court, in *Firestone v. Bruch*, 489 U.S. 101, 110 (1989), instructed the federal judiciary to create common law in order to plug gaps in ERISA. Miller v. Taylor Insulation Co., 39 F.3d 755, 758 (7th Cir. 1994).

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The caseload of a federal judge, even at the appellate level, does not afford the same opportunity to produce systematic writings as the structure of academia. Unlike writing a treatise or paper, opinions are written not to promote a viewpoint or explain an ambiguity, but rather to resolve the vexing legal issues of the claimants. The jurist generally is limited in his or her writings to the issues before the court, and even then that jurist is obligated to follow precedent and the dictates of the contract or statutes rather than having the freedom to lecture at will. This is so with Judge Posner's ERISA jurisprudence as well. Juxtaposed against a famous decision cited more than 200 times is an issue-specific case that has been infrequently cited and is, for all intents, forgotten by history.

Nevertheless, systematic scrutiny of a range of decisions on like subjects over time may provide some predictive value concerning a particular jurist's inclinations and thresholds. In Judge Posner, the academic community is fortunate to have a jurist who, since appointment to the Seventh Circuit, has quietly amassed a veritable warehouse of ERISA decisions, many on the cutting edge of ERISA jurisprudence. While there are many significant decisions in Judge Posner's ERISA canon, this survey will focus on decisions that fall within four classifications: (1) decisions involving fiduciary issues; (2) decisions involving the denial of benefits using the arbitrary and capricious standard; (3) decisions involving the denial of benefits using estoppel; and (4) decisions involving ERISA's structural issues.

After examining sample cases that represent the best of Judge Posner's efforts in each classification, this survey will turn to a macro-analytical methodology that hopes to shed some light on Judge Posner's ERISA decisions by looking at the trends that arise from quantitative analysis of his prior decisions. This analysis will use the classifications explained above to examine trends in Judge Posner's decisions over time, as well as to examine Judge Posner's influence as measured by each decision's impact on other courts and secondary sources.

I. JUDGE POSNER ON FIDUCIARY DUTY UNDER ERISA

A. Overview

As alluded to above, there is an internal tension engineered into the design of ERISA as a whole, between protecting the rights of the plan participants and encouraging the growth of the voluntary employee retirement system. This tension exists rather dramatically in ERISA cases

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related to fiduciary duty. This is because, as a practical matter, if the system regulating fiduciaries, sponsors and administrators is too cumbersome and the potential for liability of trustees and fiduciaries is too great or overly burdensome, then employers may opt not to provide any benefits at all.[9] Each fiduciary duty case cries out for the judge to make policy decisions about whether the interests of the plan participants or the interest of the fiduciary or trustee should prevail.[10]

How has Judge Posner -- a textualist jurist[11] -- reconciled the need in ERISA fiduciary duty cases to make public policy decisions with his own proclivity for following the statutes as written? If any theme could be drawn from a group of individual opinions spanning a multitude of circumstances and nearly twenty years, this theme for Judge Posner's fiduciary duty ERISA decisions would be accountability. But this does not mean that Judge Posner's ERISA jurisprudence amounts to the mechanical application of liability to plan trustees, employers, and others that are meant to keep plans solvent and beneficiaries protected. Rather, Judge Posner envisions accountability on a grand scale; fiduciaries must be accountable to plan participants, but likewise government agencies and the courts themselves must be accountable to both the legislative intent and the specific provisions of ERISA.

To date, nearly one-third of the cases that comprise the body of Judge Posner's ERISA decisions involve questions related to the duties of plan fiduciaries. Not surprisingly, many of Judge Posner's most well-respected ERISA decisions come from this field. In analyzing Judge Posner's ERISA fiduciary duty decisions, it becomes evident that his textualist approach renders decisions that are both true to the statute yet sophisticated enough to allow for the varied and complex transactions that are the hallmark of modern ERISA practices.

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9. Senator Jacob Javits stated, "[the] new law represents an overall effort to strike a balance between the clearly demonstrated needs of workers for greater protection [while avoiding federal rules] that would discourage voluntary initiatives for further expansion and improvement." 120 CONG. REC. 31, 277 (1974) (statement of Sen. Javits).

10. Through *stare decisis*, each policy decision made by the jurist affects the range of choices available in future considerations of similar issues.

11. Judge Posner's approach is "'textualist' because [he] emphasizes the statute as the primary source of law and defines [his] task as making the statute as workable as possible." Edward A. Zelinsky, *Travelers, Reasoned Textualism, and the New Jurisprudence of ERISA Preemption*, 21 CARDOZO L. REV. 807, 808 (1999).

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Significant decisions within the fiduciary duty framework include: *Peoria Union Stock Yards Co. v. Penn Mutual Life Insurance Co.*[12] (determining who is a fiduciary to an existing plan), *Donovan v. Robbins*[13] (examining co-fiduciary liability and introducing contribution to ERISA), *Brock v. TIC International Corp.*[14] (discussing federal oversight of fiduciaries, the "prudent man" rule and the statute of limitations) (superceded by change in statute), *Martin v. Consultants & Administrators, Inc.*[15] (concurrence) (examining fiduciary obligation and fraudulent concealment), *Reich v. Continental Casualty Co.*[16] (exploring recovery from third party non-fiduciaries under common law principle of restitution). Judge Posner's majority opinion in *Peoria Union* will serve as a sample of his decisions relating to fiduciary duty under ERISA.

B. Peoria Union Stock Yards Co. Retirement Plan v. Penn Mutual Life Insurance Co.[17]

Peoria Union was Judge Posner's first ERISA opinion after his appointment to the Seventh Circuit. It remains one of his most influential. In 1993, Justice Ginsberg used the rationale of *Peoria Union* as the basis for the United States Supreme Court's majority decision in *John Hancock Mutual Life Insurance Co. v. Harris Trust & Savings Bank.*[18] The opinion highlights a theme that recurs in Judge Posner's fiduciary duty decisions -- that of accountability. The underlying message to the defendant (in this case, an insurer that allegedly retained the bulk of the interest earned from the investments of a client ERISA plan) is that accountability for relationships of trust will supercede titular or semantic classifications of a party's status. Moreover, the opinion exemplifies Judge Posner's talent for creative textualism insofar as the opinion stays true to the statute, but achieves this fidelity by re-characterizing the nature of the contract.

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12. 698 F.2d 320 (7th Cir.1983).
13. 752 F.2d 1170 (7th Cir.1985).
14. 785 F.2d 168 (7th Cir. 1986).
15. 966 F.2d 1078 (7th Cir. 1992).
16. 33 F.3d 754 (7th Cir. 1994).
17. 698 F.2d 320 (7th Cir. 1983).
18. 510 U.S. 86, 101 (1993) (Ginsberg, J.). This review of the facts and outcome of the case mirrors Justice Ginsberg's excellent summary in *Hancock*.

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1. Facts of Peoria Union

Peoria Union centered on the relationship between the employer/sponsor of a defined-benefit retirement plan[19] and the insurance company retained by the employer to administer the retirement plan's assets. The investment contract that became the focus of the dispute required Peoria Union Stockyard, the employer, to contribute annually to a deposit account at Penn Mutual, the insurer/administrator, to fund the plan.[20] When an employee retired, the employer could purchase the annuity from the insurance company with a portion of the funds on deposit or it could withdraw funds and purchase the annuity for its employee from another insurance company.[21] The income available in the deposit account[22] fluctuated with the investment experience of Penn Mutual. Although there was no guarantee of interest after the first three years,[23] any interest earned by the deposit account beyond the interest guarantee was required to be credited to the deposit account.[24]

In the district court, Peoria Union argued that, by keeping two sets of books that obscured the true performance of the assets invested in the deposit account, Penn Mutual breached its fiduciary duty under ERISA.[25] Penn Mutual argued that it was not a fiduciary and, as an insurer providing an annuity-related contract, it was insulated by the "guaranteed benefit policy" exception to ERISA.[26] The district court sided with Penn Mutual,

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19. Defined benefit plans are promises to pay participants a set level of benefits upon retirement. The benefit level is characteristically determined by a formula based on length of employment (years of service) and final or cumulative compensation. *See* Peter T. Scott, *A National Retirement Income Policy, in* PENSION AND EMPLOYEE BENEFIT LAW 41, 41 (John H. Langbein et al. eds., 2d ed. 1995).

20. Peoria Union Stock Yards Co. Ret. Plan v. Penn Mut. Life Ins. Co., 518 F.Supp. 1302, 1306 (C.D. Ill. 1981).

21. Peoria Union Stock Yards Co. Ret. Plan v. Penn Mut. Life Ins. Co., 698 F.2d 320, 321 (7th Cir. 1983).

22. Thus, the income available to fund the retirement plan's obligations to Peoria Union retirees.

23. Penn Mutual guaranteed interest on the employer's contributions made during the first three years of the contract at a rate declining from 7 1/2 percent the first year to 3 1/2 percent the third year. *Peoria Union*, 698 F.2d at 322.

24. *Id.*

25. *Peoria Union*, 518 F.Supp. at 1307.

26. *Id.* Concerning the "guaranteed benefit policy" exception, Judge Posner explained, in his opinion, that Congress intended to insulate insurers who, in receiving plan

determining that in contracting with Peoria Union, the insurer never contemplated assuming the role of fiduciary.[27] When Peoria Union appealed, Penn Mutual argued that the transaction was part of the delivery of an annuity product and therefore the suit fell within the "guaranteed benefit policy" exception under ERISA § 401(b)(2).[28] The Posner court took the appeal to determine whether Penn Mutual's handling of the funds fell within the "guaranteed benefit policy" exception as an annuity or whether, as an investment advisor, Penn Mutual breached its fiduciary duty to the retirement plan.[29]

2. Judge Posner's Opinion in *Peoria Union*

After explaining the nature of the transactions between Peoria Union's trustees and Penn Mutual, Judge Posner compared the transactions in *Peoria Union* to the "Flexible Fund Annuity Account" that the Supreme Court held to be a security in *SEC v United Benefit Life Insurance Co.*[30] He observed that the contract in *Peoria Union* was similar to the deferred annuity contract in *United Benefit* in that the insurance company actually served as an investment agency and permitted the pension plan to share in the company's investment experience.[31] Moreover, in both cases, the insurance company guaranteed a minimum return so low as to place the investment risk on the investor rather than on the insurance company.[32] Based on the characteristics of the plan, the Posner court concluded that during the accumulation phase the annuity plan was an investment contract.[33] According to Judge Posner's analysis:

> The pension trustees did not buy an insurance contract with a fixed payout; they turned over the assets of the

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assets in the form of standard annuity contracts, might be made fiduciaries to the trustees who purchase the annuity contract. *Peoria Union*, 698 F.2d at 327.

27. *Peoria Union*, 518 F.Supp. at 1308.

28. Section 401(b)(2) states that when "a guaranteed benefit policy is issued by an insurer, the assets of the plan shall be deemed to include such policy, but shall not...be deemed to include any assets of [the]insurer." Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1101(b)(2) (1999).

29. *Peoria Union*, 698 F.2d at 327.

30. *Id.* at 325 (citing SEC v. United Benefit Life Ins. Co., 387 U.S. 202 (1967)).

31. *Id.*

32. *Id.* at 321-27, *cited in* Otto v. Variable Annuity Life Ins. Co., 814 F.2d 1127, 1132 (7th Cir. 1986).

33. *Otto*, 814 F.2d at 1132.

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> pension plan to [the insurer] to manage with full investment discretion, subject only to a modest income guaranty. If the pension plan had hired an investment advisor and given him authority to buy and sell securities at his discretion for the plan's account, the advisor would be a fiduciary within the meaning of [ERISA], and that is essentially what the trustees did during the accumulation phase of the contract....[34]

3. Analysis of Judge Posner's Decision in *Peoria Union*

a. Judge Posner's Methodology Concerning Fiduciary Duty Under ERISA

Peoria Union exhibits the nuanced textualism for which Judge Posner's fiduciary duty ERISA cases have garnered much acclaim. Judge Posner was able to maintain a narrow interpretation of the term "fiduciary" under ERISA § 3(21)(A)(i) and the integrity of the "guaranteed benefit policy" exception to fiduciary rules under ERISA § 401(b)(2), not by stretching the reading of the statute, but, rather, by re-characterizing the relationships between the parties to the contract.

In *Peoria Union*, Judge Posner derived the crux of his holding by employing a three-step process that used economic analysis and analogy to precedent to reach a point where the court ostensibly could render a decision based on statutory interpretation. First, Judge Posner broke down the roles of each party by function and over time. In doing so, he examined the defendant's accountability to the plaintiff during each of the various stages of the contract.[35] Next, he linked the contract in *Peoria Union* to the contract in *SEC v. United Benefit Life Insurance Co.*, which in essence gave him the United States Supreme Court's sanction to recast the investment contract from an annuity contract to the split investment-phase and annuity-phase contract.[36] Finally, he strictly applied the fiduciary

34. John Hancock Mut. Life Ins. Co. v. Harris Trust & Sav. Bank, 510 U.S. 86, 103-04 (1993) (Ginsberg, J.) (quoting *Peoria Union*, 698 F.2d at 327).

35. *Peoria Union*, 698 F.2d at 325.

36. *Id.* at 324.

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rules under ERISA § 3(21)(A)(i)[37] to derive Penn Mutual's fiduciary responsibility under the investment phase of the contract without doing injustice to the "guaranteed benefit policy" clause in ERISA § 401(b)(2) that took effect during the annuity phase of the contract.[38]

Significant here is not that Judge Posner arrived at an outcome favorable to a sympathetic plaintiff, but that he used economic analysis to go beyond initial appearances in determining the roles and functions of the parties to the dispute. In 1983, prior to the absorption of the insurance industry into the financial services world, the annuity-related transactions of Penn Mutual Life Insurance Company would at first blush fall easily within the parameters of ERISA § 401(b)(2), the "guaranteed benefit policy" exception.[39] With some degree of prescience, Judge Posner's *Peoria Union* decision recognized that a contract's practical attributes are more significant than the nominal functions of the parties engaging in the contract. Judge Posner's opinion represented a novel approach that ensured the loyalty of financial service providers within the context of ERISA's "guaranteed benefit policy" exception, and accordingly held parties accountable when they abused relationships based on trust.

b. Judge Posner's Use of the Insurance Law Paradigm in Analyzing ERISA Fiduciary Duties in *Peoria Union*

Within the ERISA framework, Judge Posner could have employed either an insurance paradigm by treating Peoria Union's contract as an annuity, or a securities paradigm by treating the accumulation portion of the contract as a security. As an "insurer" providing an annuity product, Penn Mutual tried to avail itself of the "guaranteed benefit policy" exception Congress included in ERISA.[40] But this clause notwithstanding,

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37. Under ERISA's definition of fiduciary, "a person is a fiduciary with respect to a plan to the extent (i) he exercises . . . any authority or discretionary control respecting . . . disposition of its assets." 29 U.S.C. § 1002(21)(A) (1999).

38. *Peoria Union*, 698 F.2d at 327.

39. Judge Morgan in his district court opinion noted that Penn Mutual "undertook to do nothing except to accumulate the fund, to credit interest to the fund from time to time, and to expend such portions of the fund . . . to satisfy the annuity obligations which were created by the Plan." Peoria Union Stock Yards Co. v. Penn Mut. Life Ins. Co., 518 F. Supp. 1302, 1307 (1981).

40. ERISA § 401(b)(2) states that when "a guaranteed benefit policy is issued by an insurer, the assets of the plan shall be deemed to include such policy, but shall not . . . be deemed to include any assets of [the]insurer." 29 U.S.C. § 1101(b)(2) (1999).

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the case would have had dramatically different outcomes when viewed from the insurance paradigm. Had the decision been rendered under the tenets of insurance law, the result would likely have been opposite due to the differences inherent in the nature of the investment contract vis-à-vis the insurance contract. Judge Posner elected to avoid the concepts of insurance law in favor of securities law with great specificity.

At its most basic level, the investment contract envisioned by Judge Posner to exist during the accumulation phase of the contract in *Peoria Union* was an exchange of promises. The Peoria Union trustees promised to pay expenses and reasonable fees in exchange for Penn Mutual's promise to provide investment expertise and labor in the form of administration.[41] While Peoria Union's trustees understood that investment results would fluctuate under the contract, they nevertheless accepted Penn Mutual's promise "as the agreed equivalent of [its] own. . . . [Both] parties contemplate[d] . . . an exchange of the two performances,"[42] in this case, payment of fees in exchange for the execution of competent and honest investment services.

> It is upon the [performance of mutual promises] that the rules of law respecting implied and constructive conditions, the rules of mutual dependency of exchanged promises, are based. It is not regarded as a square deal for one of the promisors to be required to render the performance promised by him when he has not received and is not going to receive the performance that was promised to him in return.[43]

And in this light, the imposition of duties as required by the fiduciary rules of ERISA and the securities laws make sense; Peoria Union trustees agreed to pay for investment services until such investments were converted into annuities. In this respect, they should have received the

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41. Section 6.1 of the investment contract between Penn Mutual and Peoria Union provided that "Penn Mutual may deduct . . . charges from Contractholder's Deposit Account . . . [including an] expense charge . . . estimated by Penn Mutual based on the estimate of deposits for that Contract Year . . . ." *Peoria Union*, 518 F. Supp. at 1306 n.4.

42. ARTHUR L. CORBIN, CORBIN ON CONTRACTS 194 (1964) *quoted in* Bob Works, *Excusing Nonoccurrence of Insurance Policy Conditions in Order to Avoid Disproportionate Forfeiture: Claims Made Formats as a Test Case*, 5 CONN. INS. L.J. 506, 580 (1999).

43. *Id.*, *quoted in* Works, *supra* note 42, at 580.

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accountability due a fiduciary relationship from Penn Mutual, which under securities law is part of the investment services relationship.

By contrast, under the tenets of insurance law, the annuity contract is not an exchange of two performances, but rather is an aleatory contract.

> [In an aleatory contract], [t]he performance that is promised may never be rendered, and yet the failure to render it may not be a breach of the promise. Both parties to such a promise . . . are incurring a hazard or taking a chance; and the hazard is so far conspicuously incurred that neither party can justly complain if the chance goes against him . . . . When such aleatory promises are exchanged, it is not necessarily contrary to the prevailing notion of justice that one of the two parties should get something for nothing.[44]

If the entire contract in Peoria Union had been read under the insurance paradigm, then Penn Mutual's actions would not only escape ERISA's fiduciary rules by way of the "guaranteed benefit policy" exception, ERISA § 401(b)(2), but Penn Mutual's escape from liability would be justifiable within the context of insurance law's concept of aleatory promises. From the insurance law perspective, Penn Mutual would only be accountable to Peoria Union if it did not live up to its agreement "to provide for benefits the amount of which is guaranteed"[45] when the risks turned against Penn Mutual.

While Penn Mutual argued that it priced its services upon the assumption that the entire contract fell within the aleatory framework, Judge Posner drew the distinction between the aleatory and exchange contracts on the basis of the risks incurred by the parties. Since there was little risk or hazard during the investment phase of the contract, Judge Posner reasoned that the aleatory framework -- and therefore the insurance paradigm -- was unacceptable in this situation.[46]

The United States Supreme Court adopted Judge Posner's view in *John Hancock Mutual Life Insurance Co. v. Harris Trust & Savings Bank*.[47] Justice Ginsberg noted that "we follow the Seventh Circuit's lead .

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44. *Id.* § 728, at 401, *quoted in* Works, *supra* note 42, at 581.

45. ERISA § 1101(b)(2)(B) (defining the term "guaranteed benefit policy").

46. Peoria Union Stock Yards Co. v. Penn Mut. Life Ins. Co., 698 F.2d 320, 327 (1983).

47. 510 U.S. 86 (1993).

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. . and seek guidance from this Court's decisions construing the insurance policy exemption ordered in the Securities Act of 1933."[48] The approach adopted in *Peoria Union* and *United Benefit,* specifying the "division of the contract into its component parts and examination of risk allocation in each component[,] . . . appears well suited to the matter at hand because ERISA instructs that the [ERISA § 401(b)(2)(B)] exemption applies only *'to the extent that'* a policy or contract provides for *'benefits the amount of which is guaranteed'*."[49]

II. DENIAL OF BENEFITS CASES, PART I – THE ARBITRARY AND CAPRICIOUS STANDARD

A. Overview

Whereas the fiduciary duty cases such as *Peoria Union* relate to the global administration of the plan, the following two sections examine Judge Posner's rulings in cases between the plan and claimants trying to receive benefits under the plan. Plaintiff claimants pursue denial of benefit cases[50] using a variety of techniques under ERISA. Generally, claimants argue that the plan trustees or administrators abandoned their fiduciary duty by denying the plaintiff's claim in an arbitrary and capricious manner. Alternatively, plaintiffs have relied on federal common law to claim that plans are estopped from denying the benefits based on promises allegedly made by the plan or its representatives. Consequently, Judge Posner's decisions concerning the denial of benefits under ERISA can be examined either as decisions in reference to the "arbitrary and capricious" standard, or as decisions involving the use of estoppel by litigants to justify or overcome the denial of benefits.

This section examines the "arbitrary and capricious" standard in Judge Posner's denial of benefit cases. These cases, where participants assert that fiduciaries acted improperly in denying their claims, present a dilemma for the courts; on the one hand, ERISA was primarily designed to protect the interests of the workers, who are frequently in a weak bargaining position

48. *Id.* at 101. *See also* 15 U.S.C. § 77c(a)(8) (1995) (excluding from the reach of the Securities Act "[a]ny insurance or endowment policy or annuity contract or optional annuity contract").

49. *John Hancock*, 510 U.S. at 102.

50. Cases arising from a plan's denial of benefits allegedly due to a claimant.

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vis-à-vis powerful plan administrators. On the other hand, ERISA is equally concerned with the actuarial soundness and sustainability of pension plans, without which American workers would lose the security and financial well-being needed for a prosperous retirement. As a black-letter rule, the decision by a pension trust to deny benefits to a claimant will only be set aside when the court determines that the plan administrator's decision is "arbitrary and capricious."[51]

Judge Posner's decisions examining the potentially "arbitrary and capricious" behavior of the fiduciary include: *Van Boxel v. Journal Co. Employees' Pension Trust*[52] (introducing the concept of the sliding scale arbitrary and capricious standard), *Lorenzen v. Employees Retirement Plan of the Sperry and Hutchinson Co., Inc.*[53] (examining trustee's fiduciary duty to inform participant of rights), *Pohl v. National Benefits Consultants, Inc.*[54] (exploring preemption and lack of recovery under state law claims), *Cutting v. Jerome Foods, Inc.*[55] (interpreting plan's subrogation rights under the arbitrary and capricious standard), *Ladd v. ITT Corp.*[56] (discussing fiduciary's abuse of discretion in denial of benefit in disability claim), and *Herzberger v. Standard Insurance Co.*[57] (creating "safe harbor" language under the abuse of discretion standard). Judge Posner's majority opinion in *Pohl* will serve as a sample of his decisions concerning the arbitrary and capricious standard as applied to fiduciaries in denial of benefit cases.

B. Pohl v. National Benefits Consultants, Inc.[58]

A central theme in the ERISA literature about the Arbitrary and Capricious standard concerns the rights of claimants whose state law causes of action have been preempted by ERISA. By accident or by design, Judge Posner's majority opinion in *Pohl* has become a battlefield case in the thorny thicket of ERISA preemption, lauded by some and

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51. Van Boxel v. Journal Co. Employees' Pension Trust, 836 F.2d 1048, 1049 (7th Cir. 1987).
52. 836 F.2d 1048 (7th Cir. 1987).
53. 896 F.2d 228 (7th Cir. 1990).
54. 956 F.2d 126 (7th Cir. 1991).
55. 993 F.2d 1293 (7th Cir. 1993).
56. 148 F.3d 753 (7th Cir. 1998).
57. 205 F.3d 327 (7th Cir. 2000).
58. 956 F.2d 126 (7th Cir. 1991).

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decried by others.[59] The issue in controversy concerns whether ERISA permits plans to be held accountable for the mistaken utterances of plan employees. The priorities at stake here balance the plan's interest in maintaining solvency through the uniform provision of benefits against the participant's interest in being treated fairly and in making the plan live up to its representations.[60]

1. Facts in *Pohl*

In *Pohl*, participants in a welfare benefit plan relied on the oral representations of coverage by the plan administrator to engage psychiatric services that took the participants beyond the maximum dollar amount coverage of the policy.[61] An employee of the plan administrator told the participant that the plan would cover eighty percent of the costs of treatment.[62] In fact, the plan limited payment for psychiatric treatment to $10,000. On denial of his total claim, the participant brought a common law action in state court, which the defendant then removed to federal court under ERISA. The district court ruled that state common law claims were preempted, and, therefore ERISA provided no remedy for the plaintiff's claims.[63]

2. Judge Posner's Opinion in *Pohl*

On appeal, Judge Posner first addressed the preemption issue by reviewing *Pilot Life Insurance Co. v. Dedeaux*[64] and ERISA § 514(a).[65] On this authority, he concluded that ERISA "knocks out any effort to use state law, including state common law, to obtain benefits under such a plan."[66]

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59. Weighted for time, *Pohl* is easily Judge Posner's most frequently cited case.

60. *Pohl*, 956 F.2d at 127.

61. *Id.*

62. *Id.*

63. *Id.*

64. 481 U.S. 41 (1987) ("The deliberate care with which ERISA's civil enforcement remedies were drafted and the balancing of policies embodied in its choice of remedies argues strongly for the conclusion that ERISA's civil enforcement remedies were intended to be exclusive.") *Id.* at 54.

65. ERISA § 514(a) states that ERISA "shall supercede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan. . . ." 29 U.S.C. § 1144(a) (1999).

66. *Pohl*, 956 F.2d at 127.

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Judge Posner then explored the possibility that the plaintiff's claim was not a claim for plan benefits, which would be preempted, but rather a claim against the losses they suffered by the plan's misleading representation. In this context, he tested the flexibility of the "relates to" term in ERISA § 514(a), questioning whether oral modification was permissible where the plaintiff was not seeking to enlarge his coverage based on the administrator's oral representation.[67] Judge Posner decided, however, that the plaintiff's claim is precisely the type which ERISA's framers circumscribed; the purpose of confining benefits to written terms that cannot be orally modified "would be thwarted if participant[s] could maintain suits . . . based on oral representations. . . . [A]ny money [participants] obtain . . . would be functionally a benefit to which the written terms of their plan do not entitle them."[68] Judge Posner concluded by noting that "[t]he fact that ERISA does not provide a substitute remedy reflects not a senseless gap in the statute, but a determination to carry through the policy [of protecting the financial integrity of pension and welfare benefit plans] by confining participants to the benefits spelled out in writing."[69]

Judge Posner then briefly examined the possibility that the participants had a claim and remedy against the administrators as fiduciaries. He quickly disposed of the issue by noting that defendants worked in a clerical and administrative capacity and therefore were not fiduciaries.[70] Consequently, the district court's decision was affirmed.

3. Analysis of Judge Posner's Decision in *Pohl*

a. Judge Posner's Methodology in *Pohl*

More than any other case yet to arise in Judge Posner's ERISA canon, *Pohl* provided a veritable all-you-can-eat buffet for academics of various persuasions. *Pohl* was not particularly notable for its outcome or the methodology used to arrive at the conclusion -- the opinion was a

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67. *Id.* at 128.

68. *Id.*

69. *Id.*

70. *Id.* at 128-29 ("ERISA makes the existence of discretion a *sine qua non* of fiduciary duty . . . [a]nd NBC, the plan administrator, had no discretion . . . the [company] was not [a fiduciary under ERISA], and hence the Pohls have no claim against it under the fiduciary provisions of ERISA."). *Id.*

straightforward application of the statutory language under ERISA § 514(a) to the facts of the case. Rather, the decision represented perhaps the clearest expression of the textualist view concerning the issue of preemption. In his unique and unforgettable prose, Judge Posner characterized the ERISA language -- at least in respect to oral modifications of the plan -- whole and well-conceived by the legislature and without "senseless gaps."[71] To the textualist school, Judge Posner's opinion in *Pohl* presented a clear indictment of jurists who, by providing remedies for participants through extrapolation of the intent behind ERISA's statutory language, created remedies "solely by judicial, not congressional, will."[72]

On the other side, those commentators concerned with the apparent "betrayal without remedy"[73] that resulted from strict application of ERISA preemption in combination with ERISA's limited enforcement provisions under ERISA § 502(a) decried *Pohl* as "a ringing endorsement . . . of the betrayal without remedy rationale."[74] Between the two positions, the debate that emerged from *Pohl*, especially in the context of other decisions by the Posner court, was that of distinguishing where genuine gaps existed that needed to be plugged by federal common law and where omissions represented Congress' intent to provide no remedy.

b. Judge Posner's Use of the Insurance Law Paradigm in *Pohl*

Pohl involved the denial of a participant's benefits under an employee-sponsored welfare benefit plan -- simply put, the employee's insurer denied his claim after its representative told him he had coverage. But for ERISA, how would this claim have been resolved?

The defendant insurer under such circumstances in a non-ERISA environment would likely face liability, at the least, under its duty of good

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71. *Id.*

72. Jeffrey Brauch, *The Federal Common Law of ERISA*, 21 HARV. J.L. & PUB. POL'Y 541, 604 (1998).

73. "Betrayal without remedy" was a phrase coined in *Degan v. Ford Motor Co.*, 869 F.2d 889, 895 (5th Cir. 1989). It has come to represent a dissatisfaction among jurists and academics with the possibility under ERISA of negligent, even willful harm perpetrated against the participant by the plan or fiduciary with no available remedy due to ERISA's statutory framework.

74. *Preemption — The Inconsistent Oral Promise to Pay Benefits: Betrayal Without Remedy: Part V*, 3 NO. 3 ERISA LITIG. REP. 9, 13 (Feb. 1993).

faith and fair dealing to its insured. In *Dercoli v. Pennsylvania National Mutual Insurance Co.*,[75] the imposition of duty was based on the insurer's assumption of responsibility in processing the insured's claim, the insurer's knowledge that the insured was relying upon the insurer's advice and counsel, and the insurer's knowledge of the policy. Arguably, the plaintiff in *Pohl* could fall within this framework. Since the facts point toward mistake on the part of the insurer, it is unlikely that Pohl could pursue a fraudulent misrepresentation claim. But a claim based on the doctrine of reliance could conceivably apply under the *Pohl* scenario, as well as the original negligent misrepresentation claim that the plaintiff actually filed in state court.[76]

Viewed as an insurance claim outside of the ERISA framework, the claims of the plaintiff in *Pohl* theoretically have merit under state laws that regulate claims dealing with the business of insurance.[77] But under ERISA, the plaintiff's claims did not. While not specific about its status, the description of the plan indicated that it was a self-insured welfare plan administered by a third party and, thus, within the "deemer" clause.[78] Therefore, *Pohl* fell squarely within federal jurisdiction as contemplated by ERISA. The disparate treatment given to similar claims that differ only in status as ERISA cases versus non-ERISA cases lies at the heart of the betrayal without remedy dilemma. The recent Supreme Court decision *Pegram v. Herdrich*,[79] which examined HMO liability under ERISA, seemed to acknowledge this dilemma when it indicated that ERISA's preemption clause may be narrower than originally believed. While holding that ERISA does not contain a remedy for claimants against HMOs, the Court suggested that these actions may be brought in state court.[80]

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75. Dercoli v. Pennsylvania Nat'l Mut. Ins. Co., 554 A.2d 906, 910 (Pa. 1989).

76. *Pohl*, 956 F.2d at 127.

77. Ollerman v. O'Rourke Co., 288 N.W.2d 95, 108-09 (Wis. 1980).

78. ERISA § 514(b)(2)(B), commonly referred to as the "deemer" clause, mandates that no employee benefit plan "shall be deemed to be an insurance company ... for purposes of any law of any State purporting to regulate insurance. . . ." 29 U.S.C. § 1144(b)(2)(B) (2000).

79. 120 S. Ct. 2143 (2000).

80. *See id.* at 2158.

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III. DENIAL OF BENEFITS CASES, PART II – ERISA AND ESTOPPEL

A. Overview

The discussion of *Pohl* has alluded to two separate approaches to denial of benefits questions that are not specifically addressed under ERISA. *Pohl* represented the textualist approach that essentially denied any remedy not specifically granted in ERISA's statutory language. Alternatively, plaintiffs have relied on federal common law to claim that plans are estopped from denying the benefits based on promises allegedly made by the plan or its representatives. Estoppel, however, is a Janus-faced technique; frequently defendant plan administrators will rely on estoppel to deny the claims made by participants against the plan. Judge Posner's ERISA decisions include not only cases that involve the use of estoppel by plan administrators or fiduciaries to deny benefits to participants, but also decisions that permit the use of estoppel by participants to overcome the plan administrator's denial of benefits.

Cases that use estoppel to deny benefits to the participant include: *Fuller v. CBT Corp.*[81] (examining employer reliance on summary plan description in denial of healthcare benefits), *Health Cost Controls of Illinois, Inc. v. Washington*[82] (determining employer reliance on summary plan description to deny benefits in subrogation issue), and *Clair v. Harris Trust and Savings Bank*[83] (clarifying employer's position with summary plan description against claim of delay of benefits). Cases that use estoppel to provide benefits to the participant include: *Miller v. Taylor Insulation Co.*[84] (exploring use of promissory estoppel for a written representation in single-employer welfare benefit plan), and *Doe v. Blue Cross & Blue Shield United of Wisconsin*[85] (discussing equitable estoppel of the statute of limitations). Judge Posner's majority opinion in *Doe* will serve as a sample of his decisions concerning the use of estoppel in denial of benefit cases.

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81. 905 F.2d 1055 (7th Cir. 1990).
82. 187 F.3d 703 (7th Cir. 1999).
83. 190 F.3d 495 (7th Cir. 1999).
84. 39 F.3d 755 (7th Cir. 1994).
85. 112 F.3d 869 (7th Cir. 1997).

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B. Doe v. Blue Cross & Blue Shield United of Wisconsin[86]

1. Facts in *Doe*

The plaintiff was enrolled in a qualified employee welfare benefit plan and sought benefits for psychiatric care under that plan.[87] While initially paid, benefits were formally denied the following year.[88] Four years later, after exhausting the internal appeals process as required under ERISA § 503(2), the plaintiff attempted to bring suit. The plan documents, however, stated that no legal action could be commenced later than three years from the time of loss. The plan documents (and ERISA) also required that an internal process needed to be completed prior to filing suit.[89]

The internal appeals process formally ended several months before the three year contractual limitation, but the parties kept negotiating after the internal appeals process terminated adversely for the plaintiff.[90] Moreover, documents passed between the plaintiff's and defendant's lawyers suggesting that the negotiations continued beyond the contractual limitations deadline. Notwithstanding, the district judge rejected the claim.[91]

2. Judge Posner's Opinion in *Doe*

Judge Posner applied the doctrine of equitable estoppel to preclude an ERISA-governed benefits plan from invoking its limitation period to bar the plaintiff's claim for benefits.[92] Recognizing that "the applicability of estoppel principles in ERISA cases is controversial because ERISA forbids the conferral of benefits other than in accordance with the written ERISA plan,"[93] Judge Posner explained that the correspondence that served as the foundation for the plaintiff's estoppel argument amounted to a written modification of the underlying contract for benefits and, therefore,

86. *Id.*
87. *Id.* at 872.
88. *Id.*
89. *Id.* at 873.
90. *Id.* at 875.
91. *Id.* at 876.
92. *Id.* at 876-77.
93. *Id.* at 875.

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eliminated the need to look beyond the terms of the plan in granting the plaintiff's relief. Judge Posner explained:

> We are not even sure that it is necessary to get into considerations of what is equitable. In effect, the defendants offered the plaintiff a tolling agreement of indefinite duration but expiring when settlement negotiations finally broke down, and the plaintiff accepted, thereby binding the defendants. It was a contract embedded within the larger contract constituted by the benefits plan. In such a case the application of the doctrine of equitable estoppel is nothing exotic; it amounts to nothing more than the application of basic contract principles.[94]

3. Analysis of Judge Posner's Decision in *Doe*

a. Judge Posner's Methodology in *Doe*

As noted in *Bailey v. Allstate*,[95] the general rule concerning statute of limitations is to follow the provisions of the plan where no statutory language is available. According to Judge Posner, since "ERISA does not contain a statute of limitations for suits to recover benefits . . . the practice of the federal courts . . . is to borrow the limitations period in the most nearly analogous state or federal statute of limitations."[96] Judge Posner concluded in *Doe*, however, that in cases where there was a contractual provision that "reasonably limits" the time within which a claim must be brought, many courts, including those within the Seventh Circuit, have elected to apply the contractual provision instead of the pertinent state statute of limitations.[97]

Equitable estoppel entered this scenario where the parties to the contract modified the contractual provision relating to the statute of limitations in writing. By holding the parties to the modified agreement, parties were estopped from relying on the provisions of the original

94. *Id.* at 877.

95. Bailey v. Plan Adm'n for Allstate Ins. Co., No. 97 C 6485, 1998 WL 413485, at *2 (N.D. Ill. Jul. 17, 1998).

96. *Doe*, 112 F.3d at 873.

97. *Id.*

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contract.[98] In this context, Judge Posner read the application of equitable estoppel in ERISA cases as simply a matter of applying well-defined principles of contract law provided both the contract and its revisions met with the guidelines established under ERISA.[99] By framing the issue as a matter of contract law rather than statutory interpretation of ERISA, Judge Posner sidestepped the potentially thorny statutory requirement that benefits not be paid otherwise than in accordance with the written plan.[100] He justified this position by noting that written modifications of such procedural statute of limitation provisions were remote from the substantive concerns that lay behind the statutory requirement.[101]

While Judge Posner's decision in *Doe* worked on both an equitable and contractual basis, it begs the question of what level of remoteness is required to ignore statutory requirements such as the no-modification principle implicit in ERISA § 402(a)(1). The document that Judge Posner considered to be the instrument of plan modification was not a formally executed rider agreement to the plan, but, rather, the modification in *Doe* was drawn from an implication culled from a confirmation letter.[102] This informal alteration of plan documents through routine correspondence might be viewed, contrary to Judge Posner's conclusion, as precisely the type of modification that both the statute and its corresponding no-modification principle were meant to avoid.

b. Judge Posner's Use of the Insurance Law Paradigm in *Doe.*

Doe involved a plaintiff seeking medical benefits for psychiatric services from his employer-provided insurer.[103] Although the plaintiff

98. *Id.* at 876 ("[Where] the claim of estoppel is based on a letter . . . [w]e think . . . that *written* modifications of *such* provisions, at least, are not barred. Such modifications are remote from the concerns that lie behind the statutory requirement that benefits not be paid otherwise than in accordance with the written plan."). *Id.*

99. *See* 29 C.F.R. § 2560.503-1 (detailing the claims procedure to be followed by qualified ERISA plans).

100. 29 U.S.C. § 1102(a)(1). Courts have interpreted this ERISA provision to forbid oral modification of plan documents. Judge Posner posits that even if this no-modification principle is extended to include written documents, it would not be applicable to purely procedural provisions of the plan, as is the case in *Doe.*

101. *Doe*, 112 F.3d at 876.

102. *Id.*

103. *Id.* at 872.

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may have made numerous claims that might have been interpreted differently under insurance law and ERISA, the specific issue before the Posner court was one of contractual interpretation concerning the statute of limitations as spelled out in the contract itself. As such, the matter would have been decided in a similar manner under both insurance law and ERISA paradigms. Whether other courts would have decided the case in the manner that Judge Posner did is an open question; however, citations to this case, both in the Seventh Circuit and other jurisdictions, are overwhelmingly positive.

IV. JUDGE POSNER'S STRUCTURAL ERISA CASES

A. Overview

Judge Posner's fiduciary duty opinions were written to ensure that those who controlled the assets of plans operated within the guidelines of ERISA and common sense. His denial of benefits opinions examined the claims of aggrieved parties seeking benefits in the context of the various techniques claimants used to bring an issue before the court. In contrast with both of these cases, Judge Posner's structural ERISA decisions are concerned with the mechanics of the plans themselves. The opinions attempt foremost to determine what the proper structure and function of the plans at issue are both under the specific documents pertaining to each individual plan and generally in the context of ERISA. Consequently, one would expect the decisions in Judge Posner's structural ERISA cases to demonstrate his textualist prowess, particularly with reference to his readings of plan documents.

Judge Posner's cases concerning the structure and function of plans under ERISA include: *Bidlack v. Wheelabrator Corp.*[104] (examining the status of retiree healthcare benefits after termination of multi-employer plan), *Brundage-Peterson v. Compcare Health Services Insurance Corp.*[105] (interpreting the definition of Welfare Benefit Plan under ERISA to determine when a plan exists), *James v. National Business Systems*[106] (determining whether a plan exists under ERISA), *Winstead v. J.C. Penney*

104. 993 F.2d 603 (7th Cir. 1993) (en banc).
105. 877 F.2d 509 (7th Cir. 1989).
106. 924 F.2d 718 (7th Cir. 1991).

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Co., Inc.[107] (discussing ramifications of multiple coverage by two ERISA welfare benefit plans), and *Commonwealth Edison Co. v. Vega*[108] (examining ERISA preemption of State unclaimed property acts).[109] Judge Posner's majority opinion in *Bidlack* will serve as a sample of his decisions concerning structure and function of ERISA plan cases.

B. Bidlack v. Wheelabrator Corp.[110]

More than a case about the terminability of retiree benefits under collective bargaining agreements, *Bidlack* served as a test of whether Judge Posner placed greater influence on economic analysis or textualist formalism. The debate in *Bidlack* revolved around whether fidelity to the explicit terms of the collective bargaining agreement was the only permissible way to limit an employer's right to modify retirement benefits.

1. Facts in *Bidlack*

Bidlack involved an assertion of a right to lifetime health benefits through an expired collective bargaining agreement (CBA) on behalf of retired employees of a company. Plaintiff retirees claimed that the healthcare benefits they were entitled to under the CBA that the plaintiffs' union entered into prior to the closing of their plant extended beyond the termination of the CBA.[111] Judge Posner noted that, since the matter involved a CBA, whether or not the retirees were entitled to such benefits depended entirely on the contract between the company and the employees.[112] In any event, Judge Posner held that ERISA did not require the vesting of welfare benefits; if they vested at all, they did so under the terms of a particular contract.

2. Judge Posner's Opinion in *Bidlack*

Judge Posner's majority opinion first addressed the absence of express language in the CBA indicating that the retirees had a vested right in lifetime health benefits. In concluding that the absence of express

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107. 933 F.2d 576 (7th Cir. 1991).

108. 174 F.3d 870 (7th Cir. 1999).

109. For more information on *Commonwealth Edison Co. v. Vega*, *see* Robert Simpson's treatment, 7 CONN. INS. L.J. 223 (2000).

110. 993 F.2d 603 (7th Cir. 1993) (en banc).

111. *Id.* at 604.

112. *Id.* at 604-05.

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language was not fatal to the plaintiffs' claim, Judge Posner also recognized that it was possible for a contract to create obligations that survive the termination of the agreement, such as a post - employment restrictive covenant or a commitment to arbitrate disputes.[113] Nevertheless, because of the gravity of assuming that a fixed term contract such as a CBA has created a perpetual obligation, Judge Posner argued for a presumption that a CBA ceases to obligate the employer when its term ended.[114] Judge Posner's opinion rejected the twin extremes of requiring an explicit formula of words to defeat the presumption and of permitting unlimited testimony about the parties' subjective intentions.[115] Instead, Judge Posner opted for a middle ground whereby the language of the agreement would govern unless the parties could show that extrinsic evidence was necessary to show: (1) that a written contract that appeared to be clear was actually ambiguous; (2) that a term or terms in the contract was ambiguous; or (3) that there was "some yawning void . . . that cries out for an implied term."[116] If the agreement was facially complete, then extrinsic evidence could not be used to add terms to it.[117] In creating this adjudicative structure, Judge Posner commented that "contracting parties who want to be spared the uncertainties of trial by jury have only themselves to blame if by failing to specify the limits of their undertakings they open the door to extrinsic evidence of contracted meaning."[118]

Under these rules, a majority of the judges agreed that the terms of the CBA were ambiguous on the question of whether a right to lifetime health benefits had vested in the retirees. Judge Posner found vagueness in terms that provided once retirees reached the age of sixty-five the company would pay the full cost for their health insurance, and that after their death, their spouses would receive supplemental health benefits, also at the company's expense.[119] Without extrinsic evidence to clarify the CBA, it was impossible to say whether or not the company had promised lifetime health benefits. Because nothing in the agreement qualified that clause or

113. *Id.* at 606.
114. *Id.* at 606-07.
115. *Id.* at 607.
116. *Id.* at 608.
117. *Id.*
118. *Id.* at 609.
119. *Id.* at 608.

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tried to tie it to the duration of the CBA, the majority found that it offered some evidence that the benefits were to last for life.[120]

3. Analysis of Judge Posner's Decision in *Bidlack*

a. Judge Posner's Methodology in *Bidlack*

While the issue of whether to allow extrinsic evidence in determining the vesting rights of retirees under an expired CBA may seem rather narrow, the entire decision gained greater weight when seen in the context of the philosophical argument (some say battle)[121] between Judges Posner and Easterbrook. Both textualist jurists, Posner and Easterbrook split on issues concerning management's ability to retain unconstrained discretion over its decision to provide retiree benefits. Judge Posner's pragmatic economic analysis concluded that vague contract language did not negate the possibility of a promise, and this potential promise could effectively be gleaned through reliance on extrinsic evidence.[122] Judge Easterbrook's more formal approach voiced the concern that extrinsic evidence contrary to plan documents would allow third-party beneficiaries to enforce old agreements regardless of what the union and management currently negotiated.[123] But both textualist approaches seem at odds with normative notions of justice. "Against a widely held, intuitive sense that employee expectations of continued health care coverage are being unfairly disappointed, courts maintain a rigid formalist view of the limits on employer liability because they see the alternative as being limitless liability and an unfathomable morass of conflicting and undefined expectations."[124] The difference between the Posner and Easterbrook opinions, then, is that Judge Posner's brand of economic analysis finds it permissible to allow employers to make mistakes that harm both themselves and the plans for which they bargained.[125]

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120. *Id.* at 611.

121. *7th Circuit Splits in En Banc Decision Regarding Terminability of Retiree Health Plans*, 2 NO. 4 ERISA LITIG. REP. 23, 25 (1993).

122. Seth Kupferberg, *Double Effects in Economics and Law, with Special Reference to ERISA*, 73 OR. L. REV. 467, 497 (1994).

123. *Bidlack*, 993 F.2d at 618 (Easterbrook, J., dissenting).

124. Catherine L. Fisk, *Lochner Redux: The Renaissance of Laissez-Faire Contract in the Common Law of Employee Benefits*, 56 OHIO ST. L.J. 153, 177-78 (1995) (footnotes omitted).

125. *See* Kupferberg, *supra* note 122, at 497.

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b. Judge Posner's Use of the Insurance Law Paradigm in Bidlack

Like *Doe*, *Bidlack* was primarily an exercise in contractual interpretation that touched on insurance issues in only a limited way. Apart from an analysis of concepts in social insurance that exceed the scope of this discussion, no substantive insurance issues are applicable.

V. CONSISTENCY AND TRENDS IN JUDGE POSNER'S ERISA DECISIONS

Prior sections of this work have examined sample decisions within Judge Posner's ERISA canon to gain an appreciation for his methodology and style of analysis. While many of his decisions provide valuable guidance to ERISA's legal community in their own right, it is also instructive to examine Judge Posner's work collectively. The following discussions examine Judge Posner's ERISA canon in terms of his published juridical philosophies, track the consistency of his opinions under the classification established earlier, and examine his influence over time.

A. Economics and Textualism Revisited

Does Judge Posner interpret ERISA, and the pension or employee welfare benefit plans thereunder, loosely or strictly? Judge Posner himself addressed the question of interpretation in his 1995 book, *Overcoming Law*: "When 'interpretation' is used in the sense of decoding, all you need is the text and the code. When it is used in the sense of creating new meanings, you need more -- more than what is in a lawyer's kitbag."[126]

This sentiment seemingly rejects any inclinations toward judicial activism on Posner's part. But as the case summaries demonstrate, Judge Posner also rejects the overly formulaic textualism found in the originalism of Judge Bork or Justice Scalia. Instead, Judge Posner advocates a pragmatic textualism. He states in *Overcoming Law* that:

> One cannot choose among these [textual] interpretations on semantic or conceptual grounds. Choice must be based on which interpretation seems best in a sense that includes but also transcends considerations of fidelity to

126. RICHARD A. POSNER, OVERCOMING LAW 207 (1995).

> a text and a tradition. The interpretive question is ultimately a political, economic, or social one to which social science may have more to contribute than law.[127]

So Judge Posner also rejects out of hand the originalist framework, wherein answers to current questions can be culled from foundational texts alone. What results can be termed pragmatic textualism, and it is this pragmatic textualism that links a desire for fidelity to a contract or statute to the discipline of economic analysis of law. This pragmatic textualism is especially evident in the sample cases reviewed: *Peoria Union*, *Pohl, Doe* and *Bidlack*. They are pragmatic decisions insofar as they are result-oriented based on Judge Posner's economic analysis of where the equities lay,[128] but they also retain the close readings of statute and contract that typify the textualist school and have particular significance within the ERISA framework.

But what are the goals that Judge Posner pragmatically stretches toward? More specifically, which parties benefit from Judge Posner's ERISA decisions? Do these cases show a trend, as some commentators have suggested, to favor business interests over those of workers? Judge Posner implies that the long-range cost of ERISA must be read not only in terms of the cost to the employer or plan, but to the other beneficiaries and participants as well.[129] Does this inherently tip the scales against individual claimants, and if so, is this defensible?

Judge Posner's answers to these questions can be gleaned from examining the flow of the decisions in Judge Posner's ERISA canon. Finally, it is instructive to examine the influence of these decisions on other courts and commentators over time.

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127. *Id.*

128. Judge Posner frequently uses economic analysis to prove that "the equities are not all on one side" in seemingly obvious questions that hide deeper complexities. Lorenzen v. Employee Retirement Plan of the Sperry and Hutchinson Co., 896 F.2d 228, 234 (7th Cir. 1990).

129. Judge Posner stated:

> It is highly desirable to have a uniform national rule. Many employers have branches in more than one state and transfer employees from state to state with some frequency. An employee so transferred will remain under the same ERISA plan; but if courts in different states interpret identical plan language differently, the employee's rights under his plan . . . may change with every transfer.

Herzberger v. Standard Ins. Co., 205 F.3d 327, 330 (7th Cir. 2000).

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B. Consistency in Judge Posner's ERISA Decisions

Throughout this examination of Judge Posner's ERISA opinions, a clear attribute of Judge Posner's decision making was his penchant to speak to many different audiences. Even though his jurisprudence often was addressed to parties other than the litigants, Judge Posner nevertheless created a record of winning and losing parties. While thirty-four opinions do not constitute a viable statistical sample, some interpretation of Judge Posner's ERISA win/loss record can, nevertheless, provide predictive trends. Win/loss statistics were compiled by classifying litigants as 1) employers, plan administrators, plan trustees, or plan fiduciaries (called hereafter the Plan), and 2) all others (called hereafter the Claimants; which typically would include participants, beneficiaries, third party claimants, the Department of Labor, and individual states).

In total, groups representing the Plan won approximately 78% of the cases that constitute Judge Posner's ERISA canon. But to suggest that these data indicate partiality on Judge Posner's part toward any particular litigants, classes, or interests is not justified. Rather, the data indicate a preference on Judge Posner's part for litigants that fall within the dictates of the statute or law in question. In a complex statutory environment such as ERISA, this implies an unwillingness to accommodate unsophisticated Claimants who bring claims on the basis of what seems right rather than on clear legal principles. Thus, unless motivated by economic analysis that suggests a reality other than what appears in the facts surrounding a case, Judge Posner is likely to find for the party that stays within the strict dictates of the law, even though in many decisions he states his distaste for the result.[130]

But ERISA can be seen as more than the insulated decisions of the court. Like the Studebaker Incident that brought the legislation into being, ERISA is about people. As noted in Judge Cudhay's *Lorenzen* dissent, "[t]he human costs of this kind of decision are so overwhelming, economics is the wrong analysis to bring to the problem."[131]

Judge Posner has occasionally emphasized the human element in favor of other priorities. In the seldom-cited *Tyson v. International Brotherhood of Teamsters*,[132] Judge Posner strained the meaning of both statute and

130. *See* Kupferberg, *supra* note 122, at 497.

131. *Lorenzen*, 896 F.2d at 239 (Cudhay, J., dissenting).

132. 811 F.2d 1145 (7th Cir. 1987).

contract, appealing to the policy rationale behind the legislation to fashion an outcome favorable to a sympathetic plaintiff. Judge Posner's ruling allowed an employer to compensate a disabled employee for four weeks in which the employee did not work, thus giving the employee access to disability benefits. But it is significant to note that the facts upon which the ruling turned were very specific. In contrast to his decisions based on economics, Judge Posner's decisions rooted in compassion seem crafted to leave the smallest possible footprint. This seemingly indicates an aspiration or belief on Judge Posner's part that his influence in the ERISA arena should be determined by his economic analysis or by the textualist quality of his decisions.

C. Influence of Judge Posner's ERISA Decisions

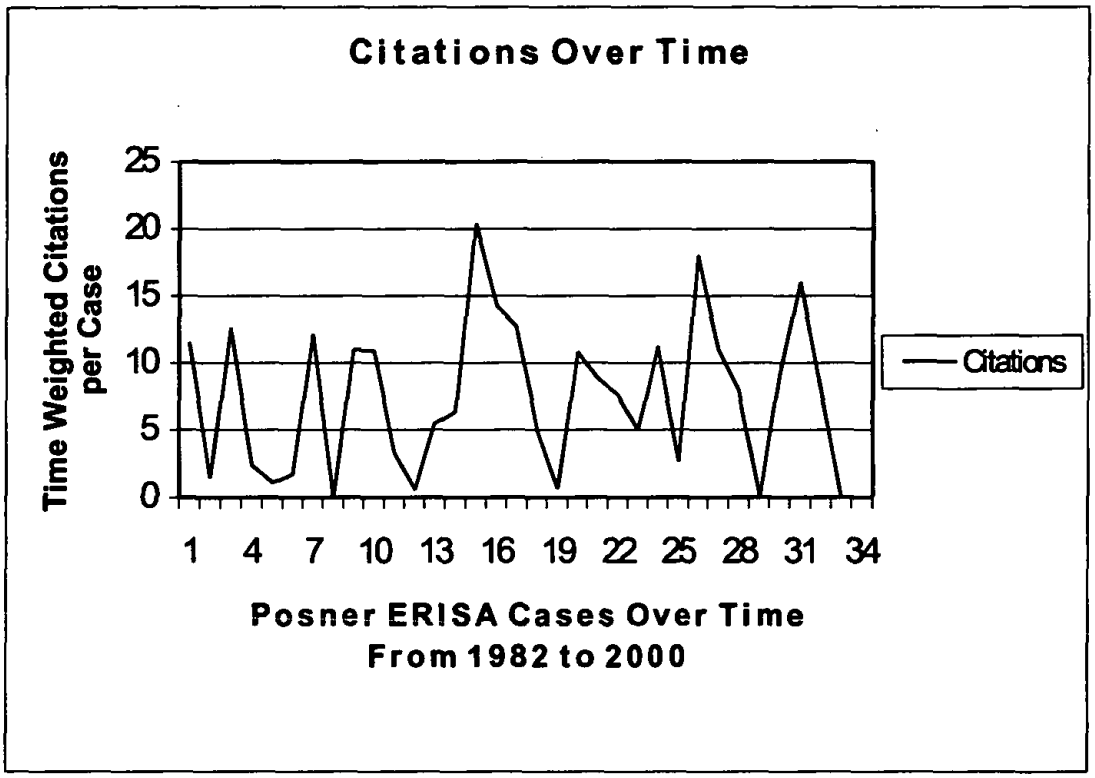
Determining the influence of Judge Posner's decisions was accomplished through a time-weighted analysis of the total canon as well as by comparing the relative strength of each classification.[133] As indicated in the chart below, the influence of Judge Posner's most popular ERISA decisions has remained fairly constant over time. This means that the level of interest in Judge Posner's "famous" decisions, such as *Peoria Union*, *van Boxel*, and the like, has remained steady, with no one decision standing clearly more significant than any other "famous" decision. This indicates a consistency in terms of the interest others express in Judge Posner's work, which in turn could be read to signify a level of quality at which Judge Posner's major ERISA decisions have come to be esteemed.

More interesting is the frequency with which Judge Posner's ERISA decisions have become "famous." The data indicate that Judge Posner's more recent decisions have a higher likelihood of being widely cited, suggesting that the academic community is more apt to find value in Judge Posner's recent work than they were in the past. While this may be a function of prerogatives exercised by Judge Posner since assuming the duties of Chief Judge of the Seventh Circuit, the trend more likely reflects

133. For each case, the raw number of citations accrued (according to Westlaw KeyCite) was divided by the age in years of the opinion to determine the age weighted influence for each decision. Relative strength by classification was determined both by examining judicial citations and secondary source citations. Note that the significance of the most current citations are skewed based on the availability of these opinions to the ERISA community.

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the increasing esteem with which the ERISA community regards Judge Posner's ERISA decisions.



Concerning the influence of Judge Posner's decisions by classification, his best-regarded decisions are those concerned with the arbitrary and capricious standard in relation to the denial of benefits. These cases are followed by his fiduciary duty cases, which have the highest number of raw citations, but are generally older than the other cases. This data indicates that Judge Posner's combination of economic analysis and textualism relate best to matters concerning the high-level administration of plans, rather than the workings of plans vis-à-vis their participants and beneficiaries.

CONCLUSION

Judge Posner has been characterized by lawyers in his jurisdiction of being alternately too liberal or too conservative, depending on the

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experience of the lawyer interviewed.[134] What becomes striking from examining a unified body of his work -- albeit a narrow slice of a much larger jurisprudential pie -- is that Judge Posner aims at rational, economically "fair" solutions to individual problems with little regard to external factors or the influence of competing agendas. Indeed, Judge Posner's ERISA decisions demonstrate the pragmatic liberalism that he espouses in his 1995 book, *Overcoming Law*; in his approach to ERISA cases it is evident that Judge Posner "rejects . . . the idea of using some comprehensive doctrine . . . to supply the answers to questions about either reality or personal conduct."[135]

While Judge Posner dutifully, often energetically, interprets the contracts and statutes relevant to each case, he does so without respect to the parties at bar. If Judge Posner is reputed to be pro-business, this is so only in a holistic sense; Judge Posner's ERISA decisions, particularly those dealing with estoppel, show an interest in maximizing the effectiveness of the system as a whole and an attempt to clarify relevant law to provide greater functionality.

Finally, it is worth noting that, from an insurance law perspective, Judge Posner is unwilling to constrain himself to any particular sub-discipline. Instead of dealing specifically with insurance law topics in the context of ERISA, Judge Posner manages to tie the issues before him to the statute or the contract. When common law issues do arise, Judge Posner takes into account insurance law arguments, but balances these against other factors and outlooks in coming to a final decision. Judge Posner's outlook, then, is not to view ERISA as a subset of insurance law, but rather to use insurance law as a common law tool to factor in his decision making when statutory or contractual devises are unavailable.

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134. 2 ALMANAC OF THE FEDERAL JUDICIARY 23-24 (Megan Chase et al. eds., 2001).

135. POSNER, *supra* note 126, at 29.

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ANOTHER TRIP INTO THE GREAT SWAMP: THE SEVENTH CIRCUIT'S PREEMPTION OF THE ILLINOIS UNCLAIMED PROPERTY ACT UNDER ERISA

Robert Simpson[*]

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INTRODUCTION

> Way, way back in the beginning of things, when this old world was just a baby, there lived a whole gathering of creatures -- big ones, little ones, and every kind you can imagine, down at the edge of the great swamp. Most of the time there was a considerable amount of peace, love, and understanding between them, and generally speaking they were about as neighborly as you can imagine -- you see back then everything the brethren needed to get by with was right there amongst them, and if it happened that one of them couldn't locate what he needed, well you can bet your Sunday shoes that one of his neighbors would have it, and they would work out a fair swap. Of course, every great once in a while -- or maybe it was now and then -- I can't remember -- if the day was a just a little too long or the old round moon was just a little too round, some of those happy children would get to thinking, and that is how old man trouble got his start.[1]

Sometimes, life imitates the folk tales we heard as children. The State of Illinois's attempt to use the Illinois Unclaimed Property Act (IUPA) to

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1. JOEL CHANDLER HARRIS, BRER RABBIT AND THE WONDERFUL TARBABY, 1-2 (Rabbit Ears Books 1990).

capture unclaimed benefits owned by the annuitants of a large pension plan organized under the Employee Retirement and Income Security Act (ERISA) of 1974 was one of those times when a State got to thinking and old man trouble got his start.[2] In the ERISA world, trouble is so commonplace that it has spawned a flood of litigation that has challenged courts to determine the meaning, application and preeminence of ERISA's Section 514 preemption powers over state laws that touch the private pension field.[3] While there is always the temptation to blame inexperienced practitioners for ERISA's troubles, the truth may be that the statute is so poorly designed and written that it is a flawed act begging for congressional or judicial repair.[4] Commentators have viewed the volatile

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2. Commonwealth Edison Co. v. Casillas, No. 97-C-0006, 1998 U.S. Dist. LEXIS 7236, at *1 (N.D. Ill. May 8, 1998), *aff'd sub nom.* Commonwealth Edison Co. v. Vega, 174 F.3d 870 (7th Cir. 1999), *cert. denied sub nom.* Topink v. Commonwealth Edison Co., 525 U.S. 873 (1999).

3. De Buono v. NYSA-ILA Med. and Clinical Servs. Fund, 520 U.S. 806, 808 n.1 (1997) (noting that in 16 years the U.S. Supreme Court heard no fewer than 13 ERISA preemption cases and that the subject has caused a flood of litigation in the lower courts evidenced by a LEXIS search showing 2,800 ERISA preemption opinions); *see also* Jane D. Bailey, *Tenth Circuit Survey, ERISA Preemption*, 74 DENV. U. L. REV. 473, 487 (1997) (stating that the ERISA preemption is highly litigated because of the complexity of the statute and the courts' frustration over attempting to interpret its preemption, savings and deemer clauses).

4. *See, e.g.*, Mertens v. Hewitt Assocs., 508 U.S. 248, 251-52 (1993) (describing ERISA as a comprehensive and intricate statute designed to ensure that anyone who exercises any control or responsibility over an employee benefit plan is held to the highest standards of behavior when dealing with the plan); *see also* John Hancock Mut. Life Ins. Co. v. Harris Trust & Sav. Bank, 510 U.S. 86, 100 (1993) (stating that § 514 is "not a model of legislative drafting"); William M. Acker, Jr., *Can The Courts Rescue ERISA?*, 29 CUMB. L. REV. 285, 285-87 (1998) The Honorable William M. Acker, Jr., Senior United States District Judge for the United States District Court for the Northern District of Alabama, views ERISA as a badly flawed statute whose "shortcomings are so myriad that the only possible judicial fix would be by the Supreme Court of the United States taking a much more active role than it has taken thus far in reconciling conflicts between the circuits and in filling the congressionally created interstices by some consistent, fair and logical jurisprudence." *Id.* at 286. Judge Acker further comments that he would like to see judges declare the statute as nonsensical and refer the entire matter to Congress for correction. Judge Acker believes that the absences of an expressed congressional meaning of the phrase "relate to" has caused whimsical results when federal and state courts attempt to interpret this phrase. Noting that one wag said ERISA stands for "Everything Ridiculous Imagined Since Adam," the judge points to an avalanche of litigation resulting in more than 2,800 opinions on ERISA preemption. *Id.* at 285.

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mixture of conflicting state, federal and pensioner interests as a tumultuous environment that forces any court facing a Section 514 issue to travel a treacherous path through the preemption thicket.[5]

This Note examines Judge Posner's holding in *Commonwealth Edison Co. v. Vega*[6] that Illinois's attempt to use the IUPA to capture unclaimed pension plan benefit checks was preempted under ERISA's Section 514. This Note considers the potential results of a ruling in Illinois's favor and asserts that in preempting the IUPA insofar as it applies to unclaimed ERISA pension plan benefits, Judge Posner correctly established that state unclaimed property acts directly and substantially impact ERISA pension plans. This approach is justified because the existence of unclaimed property acts in all fifty states and the District of Columbia[7] makes it reasonable to expect that if Illinois had prevailed, other states would follow Illinois's lead to procure any unclaimed pension plan benefits available to their state treasuries.

In order to provide background for a discussion of *Vega*, Section I examines the potential social and economic impact of unclaimed pension plan benefits and provides a brief discussion of Section 514. Section II presents the procedural history, facts, and arguments presented in the district court, the Seventh Circuit and in Illinois's Writ of Certiorari to the United States Supreme Court in *Vega*, and sets forth Judge Posner's opinion in the Seventh Circuit Case. Section III examines why Judge Posner's holding is correct and describes the potential problems that would face an ERISA Plan and the courts had Judge Posner decided in Illinois's favor.

I. BACKGROUND

A. The Potential Economic Impact of Unclaimed Pension Benefits

The economic impact of unclaimed pension plan benefits is a product of demographics, the dynamics of the pension market place and the potential value of unclaimed pension benefits. The United States

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5. Bailey, *supra* note 3, at 473 ("[A]ny court forced to enter the ERISA preemption thicket sets out on a treacherous path.").

6. 174 F.3d 870 (1999).

7. Russell E. Greenblatt, *ERISA Preemptions of State Unclaimed Property and Escheat Laws*, 9 BENEFITS L.J. 51, 52-71 (1996) (providing a chart comparing the major requirements of the Unclaimed Property Acts of all 50 states and the District of Columbia).

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Department of Labor statistics show that approximately 90 Million Americans participate in 700,000 pension plans holding total assets of $4.3 Trillion.[8] As a result of the phenomenal growth of private pension plans, these plans now account for an estimated 20% of outstanding stock investments and 17% of all outstanding bond holdings in the United States.[9]

There are two basic types of pension plans: [1] Defined Benefit Plans in which the employer is responsible for the entire financing and investment risk of the plan, and [2] Defined Contribution Plans which are primarily financed by employees bearing the investment risk.[10] The most prominent type of Defined Contribution Plan is the 401(k). The marriage of private financing to ERISA's guarantee of a worker's right to his or her vested pension benefits under private pension plans promises America's workforce some retirement income beyond Social Security payments.[11] To

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8. Dep't of Labor, *ERISA's Anniversary – 25 Years of Commitment to Employee Pension & Health Benefits*, *at* http://www.dol.gov/dol/pwba/public/pubs/factsht1.htm (Sept. 1999) (hereinafter *Dep't of Labor Web Site*). 87.4% of all companies with 100 or more employees sponsor some form of a retirement pension plan. Profit Sharing/401(k) Council of America, *401(k) Plan Sponsorship Growth 1994-1998*, *at* http://www.psca.org/grow401k.html (last visited Mar. 12, 2000).

9. Dep't of Labor Web Site, *supra* note 8. In 1974, there were 270,000 pension plans covering 42 million participants holding only $225 Billion in assets. *Id.*

10. Dep't of Labor Web Site, *supra* note 8. A Defined Contribution Plan accepts employer and employee contributions into an individual account held for each participant. The employee receives whatever benefit the account value will support. The Defined Contribution Plan features a general pool of assets from which the employee upon retirement receives a fixed periodic payment and the employer bears the investment risk. Hughes Aircraft Co. v. Jacobson, 525 U.S. 432, 439-40 (1999). *See also* Shepley v. New Coleman Holdings, Inc., 174 F.3d 65, 68 (2d Cir. 1999) (citing 29 U.S.C. § 1002 (34)-(35)) (noting ERISA distinguishes between two types of employee pension plans, "Defined Benefit Plans" and "Individual Account Plans" also known as "Defined Contribution Plans"); Profit Sharing/401(k) Council of America, *42nd Annual Survey of Profit Sharing and 401(k) Plans*, *at* http//www.psca.org/surv42nd.html (last visited Mar. 12, 2000) (401(k) trend is to provide employer matches on a payroll period basis with 46.8% of all plans providing matches with average company contribution equal to 4.9% of total payroll).

11. 29 U.S.C. § 1001(a) (1999) (explaining that ERISA is aimed at ensuring the "continued well being and security of millions of employees and their dependents" who are directly dependent upon private pension and welfare benefit plans for their financial security); *see also* Alessi v. Raybestos-Manhattan, Inc., 451 U.S. 504, 510 (1981) ("In *Nachman*, we observed that Congress through ERISA wanted to ensure that 'if a worker has been promised a defined pension benefit upon retirement -- and if he has fulfilled whatever conditions are required to obtain a vested benefit . . . he actually receives it.'" (quoting

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fulfill this promise, the vested assets must be converted into benefit payments made to the plan participant or his beneficiary.

Sadly, however, not all of the owed pension benefits reach their intended recipients. While there are no public statistics detailing the value of unclaimed checks and benefits held by private pension plans, the potential size of the problem may be reasonably inferred by the amount of reported unclaimed pension benefits from public sources. The Pension Benefit Guarantee Corporation (PBGC) estimates that ten thousand participants are owed $19 million in unclaimed pension benefits from the pension plans of failed companies that are now administered by the PBGC.[12] Nationally, benefits ranging in size from $10 to more than $100,000 have gone unclaimed by workers for various reasons, including a worker's mobility or lack of awareness that he or she is owed a pension benefit.[13] One reason for this problem may be that when participants leave a job for reasons other than retirement, they fail to inquire about their vested pension benefits and simply forget about them over time.[14]

One result of this situation is the growth of public programs and private companies dedicated to helping people locate and secure their pension benefits. The Pension Action Center at the University of Massachusetts at Boston sponsors a program to assist pensioners in recovering unclaimed pension plan benefits. This program has recovered $6,562,000 in unclaimed pension benefits to date.[15] Similarly, the Social

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Nachman Corp v. Pension Benefit Guar. Corp., 446 U.S. 359, 375 (1980))); *Nachman*, 446 U.S. at 361-62 (noting that Congress spent almost a decade studying U.S. private pension plans and that a predicate for ERISA was the fact that millions of workers are impacted by these plans). *See generally* Jeffrey A. Brauch, *ERISA at 25-and Its Most Persistent Problem*, 48 KAN. L. REV. 285, 285-88 (2000).

12. *At Deadline,* PENSIONS & INVESTMENTS, July 26, 1999, *available at* 1999 WL 9699264. These funds are administered by the PBGC and are beyond the reach of state unclaimed property acts. *Id.*

13. Melissa Preddy, *Pension Cash Goes Unclaimed*, THE DETROIT NEWS (Aug. 24, 1999), http://detnews.com/1999/biz/9908/24/08240086.htm (notes that despite requirements for plan sponsors to mail annual statements to plan participants that many workers will "fall through the cracks").

14. Douglas Armstrong, *It Pays to Check on Your Eligibility For A Pension*, MILWAUKEE JOURNAL SENTINEL ONLINE, *at* http://www.jsonline.com/bym/Your/aug99/990801itpaystocheckonyourel.asp (Aug. 1, 1999) (stating that many workers in their thirties and forties change jobs and forget about their pension benefits).

15. Nancy Boland Johnson, *Project Helps Retirees Track Down Their "Lost Pensions,"* BOSTON GLOBE, Jan. 30, 2000, *available at* 2000 WL 3314760.

Security Administration now notifies pensioners of any unclaimed private pension plan benefits when they apply for Social Security Benefits.[16] The PBGC also maintains a web page and distributes a booklet devoted to the recovery of unclaimed pension benefits.[17] Twenty-five states sponsor web sites that may be searched for information regarding unclaimed property held by the state.[18] There are also commercial web sites offering to recover unclaimed pension benefits for a fee.[19]

The problem in helping retirees claim their vested pension benefits lies in retiree's limited access to pension information.[20] If a retiree does not

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16. Preddy, *supra* note 13.

17. The PBGC's web page allows a search by last name or the first letter of a last name for any unclaimed pensions held by PBGC administered plans. The name of the company that originally held the pension plan and the person's last known address is also provided. People who are not entitled to a benefit are advised to contact the PBGC regarding their claim to any pension benefit. As of January 30, 2000 the site had registered 57,170 inquires. PBGC's booklet is JIM O'BRIEN, GERONTOLOGY INSTITUTE, FINDING A LOST PENSION BENEFIT (1999). Pension Benefit Guar. Corp., *Pension Search Directory*, *at* http://search.pbgc.gov (updated Apr. 19, 2001). *See also* Johnson, *supra* note 15.

18. Stephanie Gallagher, *A $300 Billion Lost and Found*, KIPLINGER'S PERS. FIN. MAG., *available at* http://www.kiplinger.com/magazine/archives/1998/august/ffaug98.html (Aug. 1998); *see, e.g.*, Tenn. Treasury Dep't, Unclaimed Property Division, *at* http://www.treasury.stat.tn.us/unclaim/index.htm (last visited Feb. 4, 2001).

19. *E.g.* Unclaimedassets.com, United States, *at* http://www.unclaimedassets.com/usa.htm (Jan. 31, 2001) (providing extensive listings to conduct searches for uncashed checks, proceeds from annuities and retirement accounts); *see also* Life Benefits Search, Inc., *at* http://www.lifesearch.net/ (requiring $150 fee for search of insurance companies).

20. Researchers at Kansas State University have revealed that older Americans do not use the internet, due in part to a fear of technology, past negative experiences with computers and a reluctance to try new technology. The study further revealed that those seniors that use the internet do so primarily to obtain medical information, affiliate with reference groups and to keep up with other seniors. *New Research Reveals Why Older People Like or Dislike the Internet,* INTERNET BUS. NEWS, *at* [insert web cite] (Mar. 24, 2000). In addition, senior's use of even the most basic computer equipment such as a mouse or a keyboard is restricted by physical limitations like arthritis that are part of the aging process. Several companies are developing and bringing to the market equipment designed to help seniors overcome physical limitations that prohibit computer access. Paula Felps, *Computer Firms Cater to the Eldery, Disabled with Specialized Device,* THE DALLAS MORNING NEWS, at http://www.dallasnews.com (Apr. 5, 2000). *Compare* Wallys W. Conhaim, *Videotex: Beneficial for the Eldery,* INFOR. TODAY, *at* http://www.infotoday.com (Apr. 1989) (noting computer training is becoming increasingly available to seniors as are networks devoted to seniors); Allan E. Alter, *Old Timers Are Taking Over the Wed,* COMPUTER WORLD, Mar. 1, 1999, at 32 (AARP Study shows senior citizens are the fastest growing segment of Internet users).

have access to the Internet, the resources to retain private location services, has not applied for Social Security Benefits, or applied for Social Security prior to the implementation of the notification program, he or she must learn about owed benefits from another source or face the possibility of never recovering them.

The high value of unclaimed pension benefits has drawn the attention of states previously uninterested in these funds.[21] With corporations spending twenty-five percent of their compensation dollars on employee benefits,[22] and the anticipated increase in the number of Americans over retirement age,[23] it is reasonable to conclude that without a national program that matches unclaimed pension benefits to the rightful owner, these unclaimed pension benefits are likely to increase in value and become even more tempting to state treasuries.

B. ERISA's Sunday Shoes – Section 514's Preemption Power

ERISA's Section 514, its Preemption Clause, provides that unless specifically exempted under Section 514, ERISA supercedes all state laws "insofar as they may now or hereafter relate to any employee benefit plan."[24] Section 514 contains two limiting clauses. The first is the "Savings Clause" that excludes from preemption any state law that "regulates insurance, banking, or securities" and "any generally applicable

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21. Greenblatt, *supra* note 7, at 72.

22. Bailey, *supra* note 3, at 473.

23. U.S. Census Bureau, Natural Population Projections, *at* http://www.census.gov/population/www/projections/natsum-T3.html (last modified Nov. 2, 2000). The United States Census Bureau provides United States Population estimates broken down into various time periods and subcategories of Total, Male and Female populations by rearranging the total population data for ages 55 and over. The expected population trends for these ages is organized in the Appendix. *Id.*

24. 29 U.S.C. § 1144(a) (1999). Section 1003(a) states that except as provided in subsection (b), ERISA applies to "any employee benefit plan if it is established or maintained (1) by any employer engaged in commerce or in any industry or activity affecting commerce; or (2) by any employee organization or organizations representing employees engaged in commerce or in any industry or activity affecting commerce; or (3) by both." *Id.* § 1003(a). Section 1003(b) provides that ERISA shall not apply to any employee benefit plan if the plan is: (1) a governmental plan, (2) a church plan, (3) maintained solely for the purpose of complying with workman's compensation laws or unemployment and disability insurance laws, (4) maintained outside the U.S. for nonresident aliens or (5) is an excess benefit plan. *Id.* § 1003(b). *See also* Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 44-46 (1987); Shaw v. Delta Airlines, Inc., 463 U.S. 85, 91-92 (1983).

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criminal law of a State" or "any State tax law relating to employee benefit plans," or Hawaii's Prepaid Health Care Act.[25] The second clause, known as the "Deemer Clause", protects employee benefit plans from state regulation under the Savings Clause unless the plan is established for the purpose of providing death benefits as "an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies."[26] The Savings and Deemer Clauses preserve the state's powers to regulate insurance and financial services companies that provide investment services to pension plan *while* simultaneously prevent the states from regulating employee welfare benefit or pension plans as financial services companies unless the plan was organized as such an enterprise. The clauses also preclude plan sponsors from declaring their plans to be insurers in order to avoid ERISA's statutory requirements.

Section 514's language has fueled intense litigation to determine its scope.[27] The courts' challenge has been to determine whether individual plans are welfare benefit or pension plans under Section 514 as well as to delineate the precise contours of Section 514's "relate to" language.[28] The distinction ERISA makes between welfare benefit plans and pension plans and the current view of the meaning of the phrase "relate to" in Section 514 is crucial to understanding Posner's decision in *Vega*.

C. What is an Employee Benefit Plan?

The United States Supreme Court defines employee benefit plans to include employee welfare benefit plans and employee pension benefit plans.[29] The inclusion of both types of plans under ERISA is significant because each type of plan attends to wholly different employee financial needs. Employee welfare benefit plans are employer sponsored plans that pay illness, accident and disability benefits, and death, unemployment and

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25. 29 U.S.C. § 1144(b) (1994).

26. *Id.* § 1144(b)(2)(B); *see also Pilot Life*, 481 U.S. at 44-45 (summarizing Savings and Deemer Clauses).

27. Brauch, *supra* note 11, at 290.

28. *See supra* text accompanying note 26.

29. *Shaw*, 463 U.S. at 90-91.

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severance pay to employees.[30] Employee pension benefit plans provide income deferral or retirement income.[31] Because Congress incorporated plans designed to meet different financial needs into the same statute, it is reasonable to conclude that Congress intended to exclude both types of employee benefit plans from any state regulation unless the plan fell under the Deemer or Savings Clause. If this assumption is true, it would appear appropriate that courts apply Section 514 to *per se* preempt all employee benefit plans from state regulation consistent with congressional intent.

However, instead of shutting the door on all state intrusions into the pension field, Congress has allowed states to challenge ERISA preemption by incorporating the "relate to" language into Section 514. The United States Supreme Court recognized the gap when it said that the present formulation "raised the possibility of endless litigation over the validity of state action that might impinge on federal regulation, as well as opening the door to multiple and potentially conflicting state laws hastily contrived to deal with some particular aspect of private welfare or pension benefit plans not clearly connected to the federal regulatory scheme."[32]

D. The Meaning of "Relate To"

Section 514's "relates to" phrase is so ambiguous that courts have struggled to impose order and meaning to this clause.[33] The United States Supreme Court's early view on Section 514 was that Congress explicitly intended to preempt all state laws that placed additional administrative burdens on ERISA Plans, and that the only state statutes that escaped ERISA preemption were laws that fell under the Savings Clause or were related to plans that were otherwise exempt from ERISA preemption powers.[34]

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30. *Id.* at 91, n.5; *see also* Gilbert v. Burlington Indus., Inc., 765 F.2d 320, 325-26 (2d Cir. 1985) (defining unfunded severance pay plan, vacation, apprenticeship or other training programs, day care centers, scholarship funds, prepaid legal services and any benefit listed under Section 186(c) of Title Section 302(c) of the Labor-Management Relations Act as an employee welfare benefit plans and specifically excluding employee pension benefits at retirement or death and the insurance purchased to provide these benefits from definition of an employee welfare benefit plan).

31. Shaw v. Delta Airlines, Inc., 463 U.S. 85, 91, n.5 (1983).

32. *Id.* at 99-100, n.20.

33. *See supra* notes 2-3.

34. Alessi v. Raybestos-Manhattan, Inc., 451 U.S. 504, 522-24 (1981). When resolving the issue of whether a New Jersey law prohibiting pension plans from reducing

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The Court has held that it does not matter whether the state law has a direct or indirect impact on an ERISA Plan because ERISA preempts state laws in either case.[35] The Court has viewed the "relate to" phrase to mean that a state law relates to an ERISA Plan when it "has a connection or reference to such a plan unless there is a good reason to believe Congress intended the language to have some more restrictive meaning" and that it is unnecessary for a state law to be specifically designed to regulate employee benefit plans because such a requirement would ignore the structure of the Savings Clause.[36] The Court reasoned that: [1] if this was not true, Congress would never have bothered to specifically exempt criminal laws from preemption under Section 514 and, [2] the legislative history confirmed that Congress had rejected efforts to narrow Section 514's reach to preclude unceasing state legislation as states hastily passed laws designed to regulate areas not specifically mentioned in ERISA because such laws would destroy national uniformity in the pension plan field.[37] This result coincides with the Court's historical approach of preempting a state law where Congress has explicitly expressed its preemption intention or where there is a conflict between the federal and state statutory schemes.[38]

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benefits to offset a workman's compensation award are preempted under Section 514, the Court held that the New Jersey law was preempted because it imposed an additional administrative burden on an ERISA Plan by eliminating one of the methods ERISA allowed for benefit calculation. *Id.*

35. *Id.* at 525.

36. *Shaw*, 463 U.S. at 97-98. In *Shaw*, the Court was asked to resolve the issue of whether an employer's ERISA welfare benefit plan could discriminate against pregnant female employees by denying them disability benefits while pregnant. *Id.* at 92-93.

37. *Id.* at 98-99 (quoting Representative Dent's description of § 514 as "the crowning achievement of this legislation, the reservation to Federal authority the sole power to regulate the field of employee benefit plans" and noting that Senator Williams characterized § 514 as "extremely vague" and "too broad").

38. Rice v. Santa Fe Elevator Corp., 331 U.S. 218, 229-30 (1947) (explaining the Court's refusal to exercise blanket federal preemption over historic state powers unless: [1] Congress clearly prohibited the State power or [2] the two systems proved irreconcilable within the regulated field); *see also* Cippollone v. Ligget Group, Inc., 505 U.S. 504, 516 (1992) (citing Malone v. White Motor Corp, 435 U.S. 497, 504 (1978) (quoting Retail Clerks v. Schermerhorn, 375 U.S. 96, 103 (1963))); Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 45 (1987) ("The purpose of Congress is the ultimate touchstone." (quoting Allis-Chalmers Corp. v. Lueck, 471 U.S. 202, 208 (1985)). *See generally* United States v. Turkett, 452 U.S. 576, 580 (1981) ("If the statutory language is unambiguous, in the absence of a 'clearly expressed legislative intent to the contrary, that language must

E. Avoiding Per Se Exemption Under Section 514.

More recently, however, the Court has been increasingly reluctant to preempt state laws based on implicit connections between the state and federal statutes.[39] Perhaps because of this reluctance, the Court has refrained from imposing a *per se* preemption under Section 514. The Court has stated that when determining whether a state law directly references an ERISA Plan, courts must determine if the state statute refers to the plan or the plan's benefits, because Congress clearly differentiated between plans and benefits by separating the two words throughout ERISA.[40] The Court found that this evidenced congressional intent to prohibit any direct references to the plan.[41] As a result, a court may preserve a state law that does not directly relate to the plan because Congress only intended to preempt state laws that impact the plan itself.[42]

The Court has allowed additional relief to the states by holding that Section 514 preempts only those portions of state laws that affect an ERISA Plan, a court may not carve up an ERISA Plan and then apply the state scheme to the selected parts.[43] It is the entire ERISA Plan, not the individual parts, that is precluded from state legislation.[44] By combining Section 514's language with Section 206 (d)(1)'s anti-alienation provisions that specifically prohibit the alienation of pension plan benefits while ignoring welfare benefit plans, the Court concluded that Congress did not

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ordinarily be regarded as conclusive.'" (quoting Consumer Prod. Safety Comm'n v. GTE Sylvania, Inc., 447 U.S. 102, 108 (1980))); Gibbons v. Ogden, 22 U.S. (9 Wheat.) 1 (1824) (showing that state and federal powers are split: [1] where Congress exhausted the field for itself and [2] where state and federal laws may coexist without a disabling conflict that prevents or impedes the application of the federal law; courts must resolve conflicts between state and federal Statutes by determining whether a clear and unmistakable repugnancy or hostility exists between the two schemes when operating in a particular field).

39. Caleb Nelson, *Preemption*, 20 VA. L. REV. 225, 227 (2000).

40. Fort Halifax Packing Co., Inc. v. Coyne, 482 U.S. 1, 7-8 (1987) ("ERISA's pre-emption provision does not refer to state law relating to 'employee benefits,' but to state laws relating to employee benefit *plans*.") (emphasis added).

41. *Id.* at 8.

42. *Id.* ("Given the basic difference between a 'benefit' and a 'plan,' Congress' choice of language is significant in its pre-emption of only the latter.").

43. Shaw v. Delta Airlines, Inc., 463 U.S. 85, 107 (1983).

44. *Id.*

intend to apply the anti-alienation restriction to welfare benefit plans.[45] Therefore, pension plan restrictions do not control welfare benefit plans.[46] A court may preempt a state law infringing on a pension benefit plan even if the court previously held the law not to be preempted insofar as it applies to a welfare benefit plan because these types of plans are distinct and separable so long as Congress remains silent on the matter.[47] This suggests that the reverse is also true -- a court may preserve a state statute insofar as it applies to a welfare benefit plan even if the act was previously preempted in relation to a pension plan. This result allows courts to divide a sponsor's plan into its component parts, and then preempt a state law insofar as it is incompatible with a specific part. Alternatively, this approach allows courts to preserve state laws where there is no incompatibility with ERISA so long as the state acts apply to a particular plan type, and so long as Congress remains silent on the issue.[48]

The functional equivalent to partitioning an ERISA Plan into its distinct plans is the division of a state law into its component parts. Therefore, when a state law has two distinct parts, such that one portion mentions ERISA and the other is one of general applicability, courts may apply the generally applicable law to a specific benefit where preemption of the state act will result in an injustice.[49] The division of state laws into

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45. Mackey v. Lanier Collection Agency & Serv., Inc., 486 U.S. 825, 836-37 (1988). In *Mackey* the Court held that § 514 did not preempt Georgia's general garnishment law allowing collection of child support and alimony payments from welfare benefit plan participants. Further, where Congress intended to bar the alienation or assignment of benefits it specifically mentioned the ban on pension plan benefits but did not mention welfare benefit plans. *Id.* at 827-28.

46. *Id.*

47. *Id.*

48. John Hancock Mut. Life Ins. Co. v. Harris Trust & Sav. Bank, 510 U.S. 86, 98 (1993) ("Instead, we hold, ERISA leaves room for complementary or dual federal and state regulation, and calls for federal supremacy when the two regimes cannot be harmonized or accommodated."); *see also* Consumer Prod. Safety Comm'n v. GTE Sylvania, Inc., 447 U.S. 102, 108 (1980) ("If the statutory language is unambiguous, in the absence of a 'clearly expressed legislative intent to the contrary, that language must ordinarily be regarded as conclusive.").

49. *Mackey*, 486 U.S. at 829-35. Preemption relates to the plan itself, and not the benefit. *See also* Anderson v. Metro. Life Ins. Co., No. 96-AR-2703-S, 1997 U.S. Dist. LEXIS 2834, at *2-5 (N.D. Ala. Jan. 3, 1997) (noting that while some "super-duper" ERISA preemption may still exist, the appellate bench is increasingly aware that narrow constructions of ERISA that prevent mistreated beneficiaries from achieving realistic or adequate relief subverts congressional intent).

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their component parts allows state courts to execute judgments against a plan participant where it is clear Congress did not intend to forbid the state action or failed to provide a means for collecting judgments against a participant even if it means the participant may not receive the owed benefit.[50] This is not at odds with the general trend of Section 514 preemption analysis because it is the will of Congress that is the touchstone of all preemption analysis. Unless a party can demonstrate that Congress intended to work an injustice, a court may prevent the injustice.[51]

The Court opened the door even wider for Section 514 challenges in following a now famous footnote:

> Some state actions may affect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law "relates to" the plan. *Cf. American Telephone and Telegraph Co. v. Merry,* 592 F.2d 118, 121 (CA2 1979) (state garnishment of a spouse's pension income to enforce alimony and support orders is not preempted). The present litigation plainly does not present a borderline question, and we express no views about where it would be appropriate to draw the line.[52]

While the positioning of this sentiment may suggest that it is a judicial afterthought, it may also indicate the Court's willingness to hear arguments that a particular state act is not subject to ERISA's preemption power because it is a borderline case. By refusing to provide any guidance as to what constitutes a too tenuous, remote or peripheral connection to an ERISA Plan, the Court may have found a way to preserve state interests even if these interests are not protected by the Savings Clause. The question the Court left unanswered was how to recognize a borderline case.

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50. *See Mackey*, 486 U.S. at 831-34; *see, e.g.*, Tenneco, Inc. v. First Va. Bank of Tidewater, 698 F.2d 688, 690 (4th Cir. 1983) (holding that a judicial exception applies for spousal and child support payments).

51. Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 45-46 (1987).

52. Shaw v. Delta Airlines, Inc., 463 U.S. 85, at 100 n.21 (1983).

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F. What is a Borderline Case?

The Circuit Courts have developed a multi-part test to recognize when a state law is too tenuous, remote or peripheral a connection with an ERISA Plan to warrant preemption.[53] The test requires a court to determine:

1) if the state law is a traditional exercise of the state power, and
2) if the state law affects the ERISA Plan only incidentally, and
3) if the state law affects the relationship between the principal ERISA Plan entities.[54]

The first point reflects the United States Supreme Court's well established view that there is no *per se* judicable conflict between federal and state laws unless the simultaneous operation of both laws in the same field causes an irreconcilable conflict between the two acts.[55] The second requirement merely restates the Court's early views of Section 514's preemption powers.[56] Finally, the third requirement expands the ERISA preemption inquiry by requiring a court to determine the impact a state law has on the principals who are "employer, the plan, the plan fiduciaries and the beneficiaries."[57] The requirement to consider the impact on any plan principal's relationships comports with the United States Supreme Court's holdings because it is the relationship between the plan's principals that ERISA intends to protect from unwarranted external influence.[58] Congress determined that protecting the relationship between the plan's principals requires eliminating inconsistent or conflicting laws that impact ERISA Plans.[59] Therefore, where a state law requires a plan sponsor to adopt a

53. Firestone Tire & Rubber Co. v. Neusser, 810 F.2d 550, 555 (6th Cir. 1987) (citing other Circuits and listing factors to be considered when determining ERISA preemption cases).

54. *Id.* at 555-58.

55. Gibbons v. Ogden, 22 U.S. (9 Wheat.) 1 (1824).

56. *See supra* text and accompanying notes pp. 11-15.

57. *Firestone*, 810 F.2d at 556.

58. *See* 29 U.S.C. § 1001 (1994). Section 1001(a) states that ERISA is intended to protect the continued well being of employees and their beneficiaries covered under employee benefit plans that have become a major factor in the economy due to the "activities of their participants, and the employers, employee organizations, and other entities by which they are established and maintained." *Id.* Section 1001(b) includes the activities of fiduciaries under the regulatory scheme. *Id.*

59. Fort Halifax Packing Co. v. Coyne, 482 U.S. 1, 8-9 (1987).

particular benefit or plan structure to meet state requirements, or to develop a plan capable of meeting multiple and differing state laws, the state law(s) must be preempted.[60] The only exception to this rule is where a state law requires a one time payment or otherwise limited benefit that is contingent on an event that may never occur. In such cases the state law will stand so long as it is not directly related to the ERISA Plan or does not require the employer to adopt a particular benefit.[61] In short, the United States Supreme Court's primary goal is to ensure that ERISA Plans are not forced to sponsor inefficient benefit plans that exist only to satisfy patchwork state regulatory schemes.[62] Therefore, if a lower court preserved such a state law and certiorari was granted, the United States Supreme Court would most likely reverse the lower court's decision because it disrupts the uniform administration of an ERISA Plan by altering the relationship between the plan's principals.

The development of the United States Supreme Court's and the lower courts' views of Section 514's preemption powers reflects the Court's desire to avoid the unsatisfactory results inherent in a *per se* preemption of all state laws that have even the most remote and tenuous connection to ERISA. By recognizing the existence of borderline cases, the Court appears to indicate that courts should consider challenges to Section 514's preemption power so long as the state law does not unduly burden an ERISA Plan with any requirement that would not otherwise be present without the state law.

II. THE FACTS, PROCEDURAL HISTORY, ARGUMENTS AND HOLDINGS

A. The Facts

Commonwealth Edison Company (ComEd) is a large Illinois public utility that sponsors the Commonwealth Edison Service Annuity Fund (Plan) organized for the sole purpose of paying retirement benefits to plan

60. *Id.* at 10-13; *see also* De Buono v. NYSA-ILA Med. and Clinical Servs. Fund, 520 U.S. 806, 814-15 (1997) (holding that where the existence of a pension plan is not a critical element in the state cause of action or where the state law does not expressly refer to an ERISA Plan, the plan at bar was not one Congress intended for preemption); Alessi v. Raybestos-Manhattan, Inc., 451 U.S. 504, 524-25 (1981) (concluding that a state law relates to an ERISA pension plan where the state law eliminates a method for calculating benefits).

61. *Fort Halifax Packing Co.*, 482 U.S. at 8-9.

62. *Id.* at 10.

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participants.[63] In 1998, the Plan was paying retirement benefits to over 9,750 plan annuitants residing in forty-four states.[64] The Plan's assets are held in a single pool so that no individual participant has a dedicated account in his or her name.[65] When a Plan participant is eligible for a payment, an annuity payment is calculated according to the Plan's benefit formula.[66] Once payments begin, the participant becomes a Plan annuitant and receives regular bimonthly payments from the Plan either by check or through a direct deposit into the annuitant's bank account.[67] The Plan's checking account, known as the Annuity Fund (Fund), issues the benefit checks and is maintained at adequate levels to support the issued payments.[68] If an issued check is not cashed within one year, the money is returned to the Fund.[69] Failure to cash a check within a year does not mean, however, that the annuitant loses his right to his benefit; the Fund normally honors claims regardless of when the claim is presented.[70]

The uncashed checks that are returned to the Fund increase the amount of money that is available to the Fund for paying benefits and is a factor in the actuarial calculations performed by the Plan to determine the amount of contributions that must be transferred from the Plan to the Fund to ensure sufficient money is available to support the issued benefit payments.[71] Because the returned funds are added back into the unallocated Plan assets and earn interest at the Plan's rate of return, the Plan's assets will increase and may reach a point where the Plan is "fully funded" so that the Plan becomes self-sustaining and ComEd may stop

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63. Commonwealth Edison Co. v. Casillas, No. 97-C-0006, 1998 U.S. Dist. LEXIS 7236, at *3-4 (N.D. Ill. May 8, 1998). Organized under Illinois state law, ComEd is headquartered in Chicago, and employs 16,800 workers. ComEd sponsors, funds, administers, and serves as the Plan's administrator and fiduciary. *Id.* at *3.

64. *Id.* at *4.

65. *Id.* These funds are commonly termed "pooled funds," "unallocated pension plans" or "unallocated funds."

66. *Id.*

67. *Id.* at *4-5.

68. *Id.* at *5.

69. *Id.*

70. *Id.* at *5-6.

71. Brief of The Secretary of Labor as Amicus Curiae at 3, *Casillas*, 1998 U.S. Dist. LEXIS 7236 at *3.

making its required Plan contributions so long as the Plan remains fully funded.[72]

The controversy at issue in *Vega* arose when the State of Illinois attempted to use the Illinois Unclaimed Property Act (IUPA) to capture $125,000 in checks owed to plan beneficiaries that had gone unclaimed for five or more years.[73] In attempting to control the unclaimed checks, Illinois set up a classic Section 514 preemption battle that was first heard in federal district court.

B. The District Court, Commonwealth Edison v. Casillas[74]

In the District Court, the Plaintiff, ComEd argued that ERISA preempted the IUPA's ability to capture the unclaimed benefits held in trust by the Plan because if the IUPA applied, the unclaimed payments forwarded to Illinois would reduce the funds that are available to Plan participants.[75] ComEd further contended that paying Illinois the unclaimed pension plan benefits violated ERISA's anti-alienation rule.[76] ComEd said that its position was supported by the Secretary of Labor's *amicus curiae* construction of Section 514's "relates to" clause as encompassing the IUPA.[77]

The State of Illinois failed to see how the IUPA was preempted by ERISA because its "actions with respect to the IUPA affect the plan in a tenuous, remote manner."[78] Citing precedent from the Second Circuit[79]

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72. JOHN H. LANGBEIN & BRUCE A. WOLK, PENSION AND EMPLOYEE BENEFIT LAW § 2 (2d ed. 1995). ERISA details complicated rules governing the amortization and application of unexpected returns and favorable plan experience. So long as the plan adheres to these rules in reaching the full funding limit, the employer may stop funding the plan having reached the maximum limit on its obligation to the plan, and thus making the retention of unclaimed funds important to plan funding calculations. *Id.*

73. Commonwealth Edison Co. v. Vega, 174 F.3d 870, 871-73 (7th Cir. 1999).

74. This case first appeared in the federal court system as Commonwealth Edison Co. v. Casillas, No. 97-C-0006, 1998 U.S. Dist. LEXIS 7236 (N.D. Ill. May 8, 1998). On appeal the case name changed to Commonwealth Edison Co. v. Vega, 174 F.3d 870 (7th Cir. 1999) reflecting the replacement of Frank C. Casillas as Director of the State of Illinois Department of Financial Institutions with Sarah D. Vega.

75. *Casillas*, 1998 U.S. Dist. LEXIS 7236, at *6-7.

76. *Id.* at *7.

77. *Id.*

78. *Id.*

79. *Id.* at *8 (citing Aetna Life Ins. Co. v. Borges, 869 F.2d 142 (2nd Cir. 1989)).

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and the State of Michigan,[80] Illinois argued that because the IUPA is a law of general applicability that "fails to have a connection with any ERISA plan[s]",[81] the IUPA was not preempted by Section 514. As *amicus curiae* for Illinois, the National Association of Unclaimed Property Administrators said that Illinois's custody of the unclaimed benefit checks would not reduce the benefits owed to the Plan's annuitants and that allowing the Plan to use the unclaimed checks to offset its funding obligation is a prohibited transaction under ERISA.[82]

Holding that the IUPA was preempted, Judge Manning focused on the issue to the appropriate weight that the court should give to the Secretary of Labor's statutory construction and followed the United States Supreme Court's guidance that so long as the Secretary's construction "does not do violence to the purpose and wording of the regulation or otherwise cross into forbidden terrain, courts should defer to it."[83] Judge Manning held the Secretary's construction reasonable because: [1] the IUPA's capture of Plan benefits was more than a tenuous impact on the Plan; [2] allowing the IUPA to reach plan benefits would subvert congressional intentions to prevent patchwork state laws from controlling employee pension plans; and [3] in reaching plan benefits, the IUPA would impose its procedures on the Plan, the annuitants and their beneficiaries which would override both the Plan's and ERISA's regulations.[84] Judge Manning concluded her opinion by stating

> this court's task is not to divine the best possible interrelation between ERISA and the IUPA. As the Eleventh Circuit remarked when concluding that ERISA preempted Florida's Unclaimed Property Act 'although the opposite conclusion might also be reasonable, [the agency's] determination is entitled to deference' if it also is reasonable.[85]

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80. *Id.* (citing Attorney Gen. v. Blue Cross & Blue Shield of Mich., 424 N.W. 2d 54 (1988)).

81. *Id.* at *7-8.

82. *Id.* at *8

83. *Id.* at *26-30 (citing Martin v. Occupational Safety & Health Review Comm'n, 499 U.S. 144, 150 (1991) and noting that "the well known standard set forth in *Chevron U.S.A. v. National Resources Defense Council, Inc.*, 467 U.S. 837 (1984), applies.").

84. *Id.* at *28-29.

85. *Id.* at *29 (The Eleventh Circuit decision referred to is Blue Cross and Blue Shield of Fla. v. Dep't of Revenue and Fin., 791 F.2d 1501, 1506 (11th Cir. 1986)).

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Judge Manning's opinion followed the United States Supreme Court's well established principle that the administering agency's construction is controlling unless it is malicious or unwarranted in the law or facts, and that a court need not reject such construction simply because it is not the construction the court would reach upon review of the statute.[86] By allowing the Secretary's construction to control the issue, Judge Manning rejected Illinois's argument that the IUPA imposed a tangential impact on the Plan and Fund and thus should be allowed to capture the unclaimed benefits.[87] Judge Mannings' rhetorical strategy was powerful in this respect because it avoided the necessity for the court to provide a detailed supporting reason that could be refuted on appeal. Nevertheless, the State of Illinois was not satisfied with the result and appealed to the Seventh Circuit.

C. *The Seventh Circuit: Enter Commonwealth Edison Co. v. Vega*[88]

Judge Posner reduced the issue to its simplest element -- greed:

> The state wants this money. The plan wants to retain it. ComEd wants the plan to retain it too for even though money in the plan cannot be kicked back to ComEd unless and until the plan is terminated and is determined to be overfunded, [citation omitted], the more money there is in the plan, the less money ComEd will be required to contribute to it to make sure that the plan has enough to meet its obligations. The parties are thus fighting over who gets to keep the

86. Zenith Radio Co. v. United States, 437 U.S. 443, 450 (1978) ("To sustain [an agency's] application of [a] statutory term, we need not find that its construction is the only reasonable one, or even that it is the result we would have reached had the question arisen in the first instance in judicial proceedings.") (alterations in original); *see also* Chevron U.S.A., Inc. v. Natural Res. Def. Council, Inc., 467 U.S. 837, 842-44 (1984) ("If the statute is silent or ambiguous with respect to the specific issue, the question for the court is whether the agency's answer is based on a permissible construction of the statute." The Court also held that the only limitation on giving controlling weight to an agency's interpretation is a court's finding the construction is "arbitrary, capricious or manifestly contrary to the statute" and possessed of a malicious action on the agency's part.).

87. *Commonwealth Edison Co.*, 1998 U.S. Dist. LEXIS 7236, at *7.

88. 174 F.3d 870 (7th Cir. 1999).

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> interest on this money -- the plan, and perhaps ultimately ComEd or the state.[89]

At oral argument the weakness of the State's position was exposed when the State's attorney commented that it was immaterial to Illinois whether the IUPA required the Plan to turn over the benefits after two weeks or five years.[90] Judge Posner seized upon Illinois's indifference to the timing of the delivery of the unclaimed benefit checks under the IUPA as conclusive proof that the IUPA is a blind behind which Illinois was hiding its true objective of taking over an ERISA Plan.[91] If Illinois intended to protect the annuitant's owed pension benefits from uncertain projections and a vagarious financial marketplace as it claimed under the guise of the timing scheme clearly mandated in the IUPA, then the timing of when funds fell under the IUPS's umbrella would make a difference.[92] The disastrous impact of the comment by the State's Attorney is evident in Judge Posner's conclusion that Illinois's claim that the IUPA's custody of the unclaimed benefits will provide increased security for annuitants is flawed. He reasoned that any additional security is offset by Illinois reputation as a late payer, the increased delays in obtaining benefits, and a loss of the interest earned by the money.[93] If Judge Posner had construed the IUPA as Illinois argued, he would not have reached this conclusion and would not have remarked on the loss of interest to the Plan that ultimately affects the actuarial projections that determines ComEd's funding obligations to the Plan. By reducing the issue in the case to a fight over interest, Judge Posner slammed the door shut on Illinois's claim to the IUPA is a law of general applicability rather than an assault aimed at taking over the Plan's administration. After sealing its doom by revealing its indifference to the timing of benefits, Illinois could not escape Judge Posner's holding "that a state cannot take over the operation of an ERISA

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89. Commonwealth Edison Co. v. Vega, 174 F.3d 870, 872-73 (7th Cir. 1999). The court also stated that the contest was over "the confiscation of interest and the usurpation of administration." *Id.* at 873-74.

90. *Id.* at 874.

91. *Id.* ("In such a case it would be blindly obvious that the state was taking over the administration of an ERISA Plan; it is only a little less obvious when the period is longer.").

92. *Id.* (describing Illinois characterization of state custody of the unclaimed pension benefits as increasing the security of the benefits because the state has a higher credit rating than ComEd and because actuarial projections upon which the plan bases its reserve funds are not certain).

93. *Id.*

plan no matter how forcefully it argues that it can do a better job than the plan's trustees and administrators."[94]

Judge Posner also rejected Illinois's arguments by holding that although the IUPA did not specifically refer to ERISA Plans, it was directly and substantially related to ERISA Pension Plans.[95] In determining the IUPA's practical effect, Judge Posner held that Illinois would become a plan administrator under the IUPA because the unclaimed checks were a plan asset until the checks were cashed. This means that once Illinois controlled the unclaimed benefits, annuitants would have to apply to the State to obtain their pension benefit.[96] Judge Posner said the consequences of this arrangement for all ERISA pension plans results in "numerous variations in the amount of time before the state takes over the money."[97] Because such an arrangement forces annuitants to apply to Illinois to obtain their pension benefit, the State will have stepped into the Plan's administrative shoes and therefore committed an act expressly prohibited by ERISA.[98] With an eye toward the potential impact on such State action on all ERISA Plans, Judge Posner had addressed not only the instant case but the potential encroachment upon similar ERISA Plans.

D. Illinois's Petition for Certiorari

Illinois next filed a Petition for Writ of Certiorari with the United States Supreme Court that was denied without comment.[99] Illinois continued to maintain that the IUPA is an act whose sole purpose is to take abandoned property into the state's "protective custody" where Illinois forever holds the property so as to safeguard and protect it until the real owner steps forward to claim the money."[100] The two reasons Illinois

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94. *Id.*

95. *Id.* at 873.

96. *Id.*

97. *Id.*

98. *Id.* at 875.

99. Brief for Appellant at ii, Topink v. Commonwealth Edison Co., 528 U.S. 873 (1999) (No. 99-102), *cert. denied,* 68 U.S.L.W. 3228 (U.S. Oct. 4, 1999) (No. 99-102) The writ for certiorari is filed as *Topinka* but the case is listed as *Topink* in LEXIS-NEXIS. Page ii of the writ states that the petitioner is listed as Judy Baar Topinka, the State Treasurer of Illinois, because on July 1, 1999, all functions and powers to enforce the IUPA were transferred by statute to the State Treasurer thus compelling the change in the petitioner. *Id.*

100. Brief for Appellant at 3, *Topink* (No. 99-102).

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advanced for the Court to grant certiorari were: (1) to resolve a split between the Seventh Circuit and (2) because the Seventh Circuit decided the case in a manner that was "wholly inconsistent" with the ERISA Preemption Analysis mandated by the Court "while at the same time disregarding Illinois's public policy concerning the disposition of abandoned property, a legitimate public concern that arises from the absence of a contrary or applicable federal policy."[101]

Illinois first argued that because of a Second Circuit holding regarding unclaimed checks from a welfare benefit plan, Court action was required to resolve a split between the circuits. Illinois said the Second Circuit's decision meant that state escheat laws are not preempted by ERISA insofar as an unclaimed property act applies to "uncollected employee benefit checks because state escheat laws are a traditional state police power and because ERISA does not specifically provide for the administration of unclaimed property, such laws have no effect on an employee's benefit and may actually help the plan annuitant protect his benefits."[102]

Second, Illinois contended that the Seventh Circuit's decision in *Vega* "runs afoul of established law requiring a presumption against preemption and deference to state policy."[103] Illinois claimed that no other court had ever so completely disregarded public policy as the Seventh Circuit did in viewing the matter as a contest over interest payments.[104] Illinois contended that the Seventh Circuit's blatant disrespect of Illinois's rights required reversal because the Court had already held that a State has the power to assume the role of a conservator of unclaimed funds to protect the interests of owners of dormant accounts by taking the account into

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101. *Id.* at 7.

102. *Id.* at 8-9 (citing Aetna Life Ins. Co. v. Borges, 869 F.2d 142 (2d Cir. 1989)). In *Borges* the court held that in a welfare benefit plan providing group health and accident insurance for employees through contracts with employers, ERISA does not provide a procedure for the collection of unclaimed benefits or a time limit for collecting such benefits. The trigger for ERISA preemption is the law's effect on the ERISA Plan's primary administrative functions, laws that alter eligibility and amounts of benefits paid or directly impact the administration of the plan because such laws create the patchwork legal requirements ERISA prohibits. The Second Circuit said that the economic and administrative impact on the plan at bar, although substantial, was similar to that of a garnishment law and was therefore indirect and not sufficiently substantial to trigger preemption. *Borges*, 869 F.2d at 147-48.

103. Brief for Appellant at 12, *Topink* (No. 99-102).

104. *Id.*

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state custody whereupon, the obligation of the original holder of the funds is discharged.[105] Illinois also argued in the alternative that to allow an ERISA Plan to retain the unclaimed property to gain the interest on the property would give the ERISA Plan a charmed existence by providing it with a benefit allowed to no other holder of unclaimed property.[106] Simply put, Illinois argued that Judge Posner had erred by failing to understand the relationship between state laws, congressional purpose, annuitant rights, and ERISA.

Illinois misunderstood Judge Posner's holding, given the nature and operation of unclaimed property acts and how application of these acts to an ERISA Plan directly and adversely impacts such plans and leads to their takeover by the State. Because Judge Posner voiced his concern in *Vega* for the universe of ERISA Plans, it is informative to examine the correctness of his holding by considering the ramifications of a contrary decision.

III. JUDGE POSNER CORRECTLY PREEMPTED THE IUPA AND ALL STATE UNCLAIMED PROPERTY ACTS

A. A New World

In the absence of any federal law to the contrary, the states have the right to control unclaimed property.[107] If Judge Posner had ruled in

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105. *Id.* at 13 (citing and quoting Anderson Nat'l Bank v. Luckett, 321 U.S. 233, 241 (1944)).

106. *Id.*

107. Delaware v. New York, 507 U.S. 490, 497-98 (1993) ("States as sovereigns may take custody of or assume title to abandoned personal property as *bona vacantia*, a process commonly (though somewhat erroneously) called escheat") (citations omitted). No serious controversy can arise between States seeking to escheat 'tangible property, real or personal,' for "it has always been the unquestioned rule in all jurisdictions that only the State in which the property is located may escheat." Texas v. New Jersey, 379 U.S. 674, 677 (1965). On the other hand, intangible property "is not physical matter which can be located on a map," and frequently no single State can claim an uncontested right to escheat such property." Id. *See also* Christanson v. King County, 239 U.S. 356 (1915) (explaining right of states to escheat property of decedents is well established in American Commonwealth an exclusive state right); Cummius v. Reading School District, 198 U.S. 458, 469-476, (1905) (explaining power to escheat property is a governmental function and to conclude that it does not rest with the state of Pennsylvania is without merit unless can show that a constitutional limitation restrains that power.); Hamilton v. Brown, 161 U.S. 256, 263-264

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Illinois's favor, he would have shifted the controlling authority and custodianship over unclaimed pension funds to the individual states. The impact upon ERISA pension plans of such a decision is best understood by considering how these plans would most likely operate if states had control over unclaimed pension benefits. To see this impact imagine now a world in which States controlled unclaimed funds would most likely operate. Imagine now the work facing plan administrators and counsel faced with the task of managing an ERISA Plan's unclaimed pension benefits in a post-IUPA environment.

B. Which Law?

Because individual state laws would now control the unclaimed benefits, the threshold problem counsel would be required to resolve is which state law controls the unclaimed benefits. The determination of which state controls the funds requires plan administrators to meet an external standard that was set forth by the United States Supreme Court.[108] Under the Court's methodology, the plan administrator must: (1) determine the precise relationship between the debtor and creditor under the law that created the property, then (2) determine the state that has first right to the property according to the rightful owner's last known address held by the plan, and finally (3) if there is no known last address, forward the funds to the state in which the debtor is incorporated.[109] The plan administrator's problem is exactly how to determine the relationship between the plan participants, the plan and the state.

The relationship between the three parties is a function of ERISA and the ERISA plan because ERISA is the law that created the property at issue.[110] Therefore, to determine the relationship between the debtor, the ERISA plan and the creditor (the plan annuitant), the plan administrator must look to the provisions of ERISA and the ERISA Plan. Because

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(1896) (escheat may not take place without an act of the state legislature because in the absence of any controlling federal law the disposition of property is a state function).

108. *Delaware*, 507 U.S. at 498 (1993) (establishing the rules that holders of unclaimed property must follow to determine where to file unclaimed property reports thus establishing the applicable state act).

109. *Id.* at 499-500 (stating that point number 2 is the primary rule, point number 3 is the secondary rule and that the primary rule must fail before the secondary rule may be applied).

110. *Id.* at 499 ("First, we must determine the precise debtor-creditor relationship as defined in the law that creates the property at issue.").

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ERISA is silent on what constitutes a distribution or transfer of plan assets, the plan administrator must apply the provisions of each individual state's law to the ERISA plan to determine the distribution relationship.[111]

C. Where is the Annuitant?

Assuming the plan administrator correctly establishes the relationship between the plan and the participant or the participant's beneficiary, the plan administrator must decide where to file the unclaimed report. The Court's primary rule awards the property to the state of the creditor's last known address.[112] If the plan's records fail to show a last known address, the report must be filed in the state in which the "debtor is incorporated."[113] To meet the Court's directive, the plan administrator must adhere to the requirements of all of the state laws in which the plan holds a last known address of the annuitant owning an unclaimed benefit. Because the Court did not qualify the address rule with a time limit,[114] the plan administrator must meet the dormancy period of each state. Thus, the plan administrator must file on time, over multiple time periods, in accordance with the laws of several states and in compliance with the due diligence and record requirements of each state.

The due diligence clauses found in each state's act demand the property holder to fulfill differing statutory notification requirements when attempting to locate the property's owner prior to reporting the property as unclaimed.[115] These requirements are predicated on a number of conditions including the value of the property, the elapsed time, an instruction to exercise due diligence when attempting to locate the owner, or may require that written notices be sent to the property's rightful owner at specific times as defined in the statute.[116]

In addition to the due diligence and reporting requirements, the plan administrator must keep careful records because the states will audit plans to determine if the plan has reported all of the unclaimed property it is

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111. Shinehouse v. Guerin, No. 95-7070, 1996 U.S. Dist. LEXIS 6680, at * 10 (E.D. Pa. May 14, 1996).

112. *Delaware*, 507 U.S. at 499-500.

113. *Id.*

114. *Id.*

115. *Id.*

116. Greenblatt, *supra* note 7, at 52-72 (showing all state due diligence requirements).

holding to the state.[117] The Uniform Act provides that states may require the holder of unclaimed property who has not filed an unclaimed property report, or has filed an unclaimed property report the state believes is "inaccurate, incomplete, or false" to file a verified report in a form specified by the state.[118] The Uniform Act further requires the suspected property holder to open his books to state inspectors at a reasonable time and upon reasonable notice to determine the holder's compliance with the act.[119] The examination may be conducted "even if the person believes he is not in possession of any property that must be reported, paid, or delivered under this [Act]" and may be conducted by an outside contractor hired by the state.[120] The Uniform Unclaimed Property Act provides that the report filed by the property holder must include certain information and must be verified.[121]

D. Interest and Expenses

In its writ for certiorari, Illinois complained that the Seventh Circuit completely disregarded public policy by focusing on which party was to enjoy the benefit of the interest generated by the unclaimed benefits.[122] The Illinois argument expresses the common states' view of unclaimed property acts as custodial laws under which states take custody of unclaimed property for the owner's benefit.[123] Despite such noble intentions, the truth is that a state's ability to claim and use the interest on

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117. *Id.* (showing requirements for record keeping and noting a likely step-up of enforcement efforts).

118. UNIF. UNCLAIMED PROP. ACT § 20(a) (1995).

119. *Id.* § 20(b). The Act requires that books, records, working papers, and documents compiled or obtained by the property holder, an agent, transfer agent, business or financial association are subject to inspection. *Id.* This language appears to open to inspection not only the Plan's books but those of anyone associated with the Plan including the investment managers.

120. *Id.*

121. *Id.* § 7 (requiring holder of property presumed abandoned to make a report and specifying the contents of the report); *See* UNIF. UNCLAIMED PROP. ACT § 17 (1981) (requiring person holding tangible or intangible property presumed abandoned to make a report and specifying the contents of the report and the calendar dates when the reports are due).

122. Appellant Brief at 12-13, *Topink* (No. 99-102); *see also infra* text pp. 30-34 and accompanying notes.

123. Louisiana Health Serv. and Indem. Co. v. Tarver, 635 So. 2d 1090, 1092 (La. 1994).

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unclaimed intangible property provides the state with a far more profitable and compelling reason to aggressively pursue unclaimed property. If the issue is mere custodianship, it makes more sense for states to avoid the cost of holding these benefits by allowing pension plans to hold these benefits under ERISA's strict fiduciary and reporting standards. States defend their right to the interest on unclaimed intangible property by arguing that unclaimed property should benefit all citizens and not just the property holder.[124] Illinois claimed that if ComEd's Plan was allowed to retain the interest, the Plan would gain the use of interest not allowed any other holder of unclaimed property and in doing so would achieve a charmed status not allowed under ERISA.[125] Throughout its arguments, Illinois conveniently failed to mention its own plans for the interest.[126]

Moreover, the problem with Illinois's plan is that the imposition of any state charge against the unclaimed pension benefit that reduces the pension benefit creates a new conflict with ERISA because under § 502(a)(3), a plan participant may sue the plan for any act or practice that violates ERISA or the plan's terms.[127] Since the reduction of benefits violates ERISA, the annuitant whose pension benefit is reduced by a state charge most likely will have an actionable right to sue the ERISA Plan for the state's action under § 502. The companion question the courts will eventually face is whether an annuitant has the right to sue the state in a state forum to recover the amounts subtracted by the state under its statute from her pension benefit.

The United States Supreme Court has held that ERISA § 502(a) is the exclusive legal avenue for ERISA Plan participants seeking to remedy improper claim processing and that allowing participants to file state claims for actions allowed under § 502 defeats ERISA's purpose.[128]

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124. *Id.*; *see also* Earl v. McKay Dee Credit Union, 958 P.2d 234, 235 (Utah 1998) (stating that until the state locates the property owner, "the state is allowed to put [the property] to use" to avoid a windfall to the holder); Merrill v. Okla. Tax Comm'n, 831 P.2d 634, 638 (Okla. 1992) (stating that Oklahoma requires the state treasurer to establish a trust fund for unclaimed property. The Oklahoma Tax Commission must periodically determine the amount to retain in the trust and transfer all amounts in excess of the necessary reserve to the state treasury into the states' General Fund.).

125. Brief for Appellant at 13, *Topink* (No. 99-102).

126. *Id.*

127. LANGBEIN & WOLK, *supra* note 72, at 685-87 (listing remedies provided under ERISA § 502).

128. Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 52 (1987).

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Section 502 also provides for: (1) criminal penalties for reporting and disclosure violations, (2) notification to every employee whose benefit has been denied, (3) reasonable opportunity for review of claim denial decisions (4) suits for the recovery of benefits due under the plan, enforcement of a participant's rights under the plan, or to clarify future plan benefits and, (5) breach of a fiduciary duty.[129] ERISA remedies include injunctive relief against a plan or plan administrator, declaratory judgments as to the right to a benefit or removal of a fiduciary.[130] Section 502 further provides for the imposition of "other appropriate equitable relief",[131] but does not define exactly how far an aggrieved annuitant may go in enforcing her rights under an ERISA Plan, especially one that has followed a state's unclaimed property act to the annuitant's disadvantage. The implication is that if ERISA provides the exclusive remedy, a plan annuitant shortchanged by a state must sue in federal court to recover his ERISA benefits without any clear guidelines as to what remedies are actually available to the aggrieved annuitant.

E. The Old Round Moon Was Just Too Round

If Judge Posner had ruled in favor of the IUPA, ERISA Plans would have been forced to satisfy the numerous state unclaimed property act provisions. The post-IUPA world would have been one of confusion and continual litigation to resolve the inevitable questions that will arise as each unclaimed benefit is calibrated according to the facts and circumstances of a particular annuitant's situation. Because plan administrators would have been forced to meet the varying requirements of different states under the United States Supreme Court's primary and secondary tests to determine where to report unclaimed property, the administrative burdens on ERISA Plans may reasonably be expected to increase dramatically. If Judge Posner had failed to preempt the IUPA, the resulting state legal requirements would, more likely than not, have resulted in the states stepping into the shoes of the ERISA Plans – an action precisely prohibited by ERISA.[132] In the post-IUPA world, states would be happy to direct the benefit calculation in their favor because

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129. *Id.* at 53.

130. *Id.*

131. LANGBEIN & WOLK, *supra* note 72, at 685-87 (listing remedies provided under ERISA § 502).

132. Commonwealth Edison Co. v. Vega, 174 F.3d 870, 873, 875 (7th Cir. 1999).

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experience has shown that most benefits are never claimed.[133] ERISA Plans would face an ongoing attack as the states calculated the benefits and subtracted service charges and other fees from the unclaimed pension benefit. If a plan administrator failed to deliver the unclaimed property, cash-starved states would most likely audit the plan's and any associated party's books and assess fines and perhaps criminal penalties against both the plan and the plan administrator.

Although Illinois attempted to find support in the Second Circuit's holding in favor of Connecticut's claims to the uncashed checks from a medical insurance plan, the argument missed the mark because the case was about a welfare benefit plan.[134] The United States Supreme Court separated pension and welfare benefit plans into two distinct categories so that the state laws applicable to one are not necessarily applicable to the other.[135] From the outset, Illinois failed to understand the difference between welfare benefit and pension plans and missed the Second Circuit's acknowledgment that pension plan benefits are a matter of exclusive federal concern.[136] Because Illinois ignored the differences between pension plans and welfare benefit plans and thus failed to develop an argument linking the two, it was a simple matter for Judge Posner to dismiss Illinois's argument based on the Second Circuit's holding because when a state takes title to the unclaimed pension benefit, the benefit no longer belongs to the annuitant.[137]

Judge Posner correctly recognized that even though the IUPA does not directly mention ERISA, the IUPA does substantially and directly relate to ComEd's ERISA Plan because of the impact on the benefit and the requirement that the annuitant must now seek payment from the state.[138] The Illinois Supreme Court reached this same conclusion when it said that once the unclaimed property is delivered to the state, the holder's liability

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133. Fahner v. Chicago Transit Auth., 468 N.E.2d 1316, 1318 (Ill. App. Ct. 1984) ("The Act protects the rights of unknown owners and gives the benefit of the use of the unclaimed property, most of which experience shows will never be claimed, to the State rather than the holders.").

134. Appellant Brief at iii, 7, *Topink* (No. 99-102) (citing Aetna Life Ins. Co. v. Borges, 869 F.2d 142 (2d Cir. 1989); *see also Borges*, 869 F.2d at 143 (insurance company was paying an employee's claim for medical benefits).

135. *See supra* text pp. 17-22 and accompanying notes.

136. *Borges*, 869 F.2d at 144.

137. *Vega*, 174 F.3d at 874.

138. *Id.* at 873.

to the owner ends.[139] Because Illinois common law prohibits the state from depriving a person of his remedies to enforce a right, which the state has no power to destroy unless the state provides an opportunity to protect the right, Illinois cannot claim unclaimed pension benefits unless Illinois allows the annuitant to enforce all of his ERISA rights when the annuitant claims the money from the state.[140] Since Illinois law requires the state to replace an old right with a new right,[141] had Judge Posner allowed Illinois to apply the IUPA to control the Plan's unclaimed pension benefits, including its language against failure to communicate with the plan and failure to avoid a federal tax penalty,[142] Illinois would have entered the private pension plan business because it would have to replace the annuitant's lost rights to elect a particular payment and to enjoy the accumulated interest on his payments with an equal right. This raises the question of just how much enforcement did Illinois really intend? If Illinois intended a selective enforcement against ERISA plans by only collecting unclaimed checks, Illinois would have failed to protect the annuitant against the uncertain financial markets and actuarial calculations because these two factors do not impact payments that are already calculated. If Illinois retained the interest earned on these accounts, there would be nothing to protect from uncertain markets because ComEd's plan is a defined benefit plan.[143] Judge Posner saw through Illinois's protectionist argument and concluded that any benefits the state could offer the owners of unclaimed pension benefits were outweighed by the disadvantages.[144] If Illinois enforced the whole of the IUPA, then its own common law would require it to enter the pension plan benefit field, an event that even the Second Circuit most likely would have preempted.[145]

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139. Country Mut. Ins. Co. v. Knight, 240 N.E.2d 612, 613 (Ill. 1968).

140. Hogan v. Bleeker, 193 N.E.2d 844, 848-49 (Ill. 1963).

141. *Id.* at 849.

142. UNIF. DISPOSITION OF UNCLAIMED PROP. ACT, 765 ILL. COMP. STAT. 1025/7 (2000) (providing that property is assumed abandoned if no activity or communications regarding the property has occurred within the past 5 years, and for the deduction of actual costs for the administration of the account not to exceed 8% of the value of the property remitted).

143. *Vega*, 174 F.3d at 874.

144. *Id.*

145. Aetna Life Ins. Co. v. Borges, 869 F.2d 142, 145-46 (2d Cir. 1989) (The most effective way to achieve ERISA's purpose is to establish "a uniform administrative scheme, which provides a set of standard procedures to guide processing of claims and

Illinois's only way out of this mess would be to haphazardly pass laws every time the IUPA was challenged by the plan, plan annuitants or the federal government. This would generate the patchwork pattern of laws that ERISA, the United States Supreme Court, the Seventh and the Second Circuit have held as preemptable under Section 514.[146]

Any remaining doubt as to the correctness of Judge Posner's holding that the IUPA directly and substantially relates to ComEd's ERISA Plan,[147] is addressed by the requirement that an ERISA Plan's Summary Plan Description (SPD) include an explanation of the plan's provisions including "the participant's benefits, rights and obligations in simple language."[148] The SPD must contain certain information including the plan's provisions for claiming benefits and disputing benefits.[149] It stands to reason that if an annuitant must seek his benefit from the state, that the applicable sections of the state act including any service charges, fees, interest calculations and disbursements to the state must be explained in the SPD.[150] Because employees are allowed to depend upon the SPD as their primary source of information about the plan, an employer seeking to avoid litigation as a result of what is contained in his SPD must ensure the document is accurate, which means she must include all relevant information about the unclaimed property acts.[151] Exactly where the employer's obligations under the SPD would begin and end most likely have become a matter for the courts had Judge Posner not preempted the IUPA.

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disbursements of benefits. Such a system is difficult to achieve, however, if a benefit plan is subject to differing regulatory requirements in differing States." (quoting Fort Halifax Packing Co. v. Coyne, 482 U.S. 1, 9 (1987))). The *Borges* Court's analysis of the cases cited in its decision revealed "that laws that have been ruled preempted are those that provide an alternative cause of action to employees to collect benefits protected by ERISA." *Borges*, 869 F.2d at 146.

146. *Borges*, 869 F.2d. at 145 (quoting Fort Halifax Packing Co. v. Coyne, 482 U.S. 1 (1987); *see also* FMC v. Holliday, 498 U.S. 52, 60 (1990) (stating that ERISA preempts whenever a patchwork scheme will introduce inefficiencies into a benefit program).

147. *Vega*, 174 F.3d at 873.

148. STEPHEN J. KRASS, THE PENSION ANSWER BOOK 1999, 18-1 (1999).

149. *Id.* at 18-3.

150. *Id.*

151. *Id.* at 18-4 (noting that an employer may be bound by a statement in the SPD even if it differs from the Plan's language).

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F. The Slippery Slope

What we have seen throughout this Note is the slippery slope of litigation that will result from allowing state unclaimed property acts to touch ERISA pension plans. It is this new wave of litigation that provides us with the final reason Judge Posner correctly preempted the IUPA and all unclaimed property acts under ERISA. One of the fears Congress expressed during its debates over Section 514 was the possibility that the House version would result in endless litigation "over the validity of state action that might impinge on federal regulation, as well as opening the door to multiple and potentially conflicting state laws hastily contrived to deal with some particular aspect of private welfare or pension plans not clearly connected to the Federal regulatory scheme."[152] If the fear of endless litigation was so strong as to warrant mention by the Court nine years after ERISA was enacted, how can we reasonably conclude that the fear of endless litigation has passed or that Congress would approve the idea of endless litigation today? By preempting the IUPA, Judge Posner advanced the purposes of ERISA by removing a major opportunity for the states to undo Congress's cherished goal of national uniformity in the field[153] and avoided the dreaded endless litigation Congress so rightfully feared in 1974. Consistent with the congressional intent for creating ERISA, Judge Posner correctly decided that pension plan benefits are not subject to state unclaimed property acts.

CONCLUSION

This Note entered the ERISA preemption thicket to argue that Judge Posner was correct in holding in *Vega* that the IUPA is preempted under Section 514. Judge Posner correctly understood the true impact of the IUPA, and more importantly the ramifications for ERISA had he not preempted the IUPA. The problem he faced was more than the preemption of a single state act, it was the question of how to deal with an entire

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152. Shaw v. Delta Airlines, Inc., 463 U.S. 85, 99-100 n.5 (1983).

153. Gilbert v. Burlington Indus., Inc., 765 F.2d 320, 327 (2d Cir. 1985) ("As noted, the plaintiffs here were employed in 16 different states. The policy favoring national uniformity in the field therefore, strongly supports preemption."). *Compare* Commonwealth Edison Co. v. Vega, 174 F.3d 870, 873 (7th Cir. 1999) (explaining that the ComEd Plan is used in 44 States). *See also* Aetna Life Ins. Co. v. Borges, 869 F.2d 142, 144-45 (2d Cir. 1989).

system of state laws founded on a uniform act advancing a recognized state right that has been altered to meet individual state needs. It is a problem inherent in our aging population. If America's pension plan system fails to ensure vested benefits are paid to the rightful owner, then this nation fails its pensioners just as surely as it fails them when it fails to adequately finance medical care. The legal community must take the lead in encouraging federal, state and private agencies to cooperate in developing an effective notification system that will ensure all unclaimed benefits held by ERISA Plans are paid to the rightful annuitant or his beneficiaries. Judge Posner's decision in *Vega* should encourage a comprehensive national effort toward this end.

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APPENDIX

ANTICIPATED NATIONAL AGING TRENDS 2000–2050

Numbers in Thousands

As of	Age 55-64	Age 65-74	Age 75-84	Age 84+
7/1/2000	23,991	18,189	12,335	4,313
7/1/2005	29,690	18,461	12,943	4,968
7/1/2010	35,429	21,154	12,775	5,786
7/1/2015	39,919	26,307	13,256	6,397
7/1/2020	42,108	31,462	15,508	6,764
7/1/2025	40,095	35,603	19,598	7,441
7/1/2030	37,305	37,722	23,667	8,930
7/1/2035	37,016	36,172	27,115	11,487
7/1/2040	39,118	33,904	28,990	14,284
7/1/2045	41,745	33,874	28,048	17,221
7/1/2050	43,644	36,014	26,632	19,352

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DOE V. MUTUAL OF OMAHA INSURANCE CO.: THE ADA DOES NOT REGULATE THE CONTENT OF INSURANCE POLICIES, BUT WHAT HAVE CAMERAS, BRAILLE BOOKS OR WHEELCHAIRS GOT TO DO WITH IT?

*Lori Bloch Izzo**

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D. DOES THE MCCARRAN-FERGUSON ACT RENDER THE ADA'S ANTI-DISCRIMINATION PROVISIONS INEFFECTIVE OR DOES THE ADA DIRECTLY RELATE TO THE BUSINESS OF INSURANCE?.... 307

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INTRODUCTION

Imagine that you are a self-employed person who has contracted the human immunodeficiency virus ("HIV") that causes Acquired Immune Deficiency Syndrome ("AIDS"). You are fortunate enough to have obtained independent health insurance coverage. The policy, however, contains a cap on the lifetime benefits available for AIDS-related treatment. Although your insurance policy limits AIDS-related coverage to $25,000 or even $100,000, you are uncertain *whether* that amount is sufficient and *when* you will reach the limit imposed by the policy.[1] Therefore, in addition to the impact that the virus already has on your daily life, including the scheduling of major life activities such as eating and sleeping around your medical regimen, you must also worry about exhausting your limited insurance coverage and being unable to pay for treatment when you will need it the most. Consequently, you feel compelled to make medical decisions that compromise your best interests. You decide to become a "human guinea pig," by submitting to clinical trials in order to obtain free medication, and you limit the frequency of medical tests that determine the progression of your disease. You suspect that the cap in the health insurance policy restricting AIDS-related treatment must violate the Americans with Disabilities Act of 1990 ("ADA"),[2] the sweeping, anti-discrimination statute designed "to provide a clear and comprehensive national mandate for the elimination of

1. It is estimated that average lifetime healthcare costs for AIDS-related illnesses have increased from initial estimates of $55,000 to more than $155,000. Nancy R. Mansfield, *Evolving Limitations on Coverage for AIDS: Implications for Health Insurers and Employers under the ADA and ERISA*, 35 TORT & INS. L.J. 117, 117 (1999) (citing David R. Holtgrave & Steven D. Pinkerton, *Updates of Cost of Illnesses and Quality of Life Estimates for Use in Economic Evaluations of HIV Prevention Programs*, 16 J. ACQUIRED IMMUNE DEFICIENCY SYNDROME & HUM. RETROVIROLOGY 54 (1997)).

2. Pub. L. No. 101-336 (1990) (codified as amended at 42 U.S.C. §§ 12101-12213 (1994)).

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discrimination against individuals with disabilities."[3] However, according to the Seventh Circuit, your suspicion would be wrong.

According to Judge Posner and the Seventh Circuit in *Doe v. Mutual of Omaha Insurance Co.*,[4] Title III of the ADA does *not* regulate the content of insurance policies including caps on AIDS-related treatment. By extension, the Seventh Circuit held that Title III does not prohibit an insurer from including terms and conditions in health insurance policies that provide different levels of coverage to individuals based on disability. Judge Posner specifically held that Title III "does not require a seller to alter his product to make it equally valuable to the disabled and to the non-disabled, even if the product is insurance."[5] In addition, the Seventh Circuit ruled that the McCarran-Ferguson Act bars a disability-based insurance claim under the ADA.[6] The court held that the state preemption statute leaves the business of insurance regulation to individual states, since the ADA does not *specifically relate* to the business of insurance.[7]

This Note addresses whether the Seventh Circuit correctly held that insurance policies, which provide different levels of coverage for AIDS-related illnesses, do not violate Title III of the ADA. Part I discusses the issues presented by Title III claims and examines the critical federal case law interpreting these issues, given that *Doe* was decided against a background of very unsettled law. Part II discusses the conflicting interpretations of Title III applied by the district and appellate courts in *Doe*. Part III analyzes the majority's reasoning in the Seventh Circuit and concludes that the court incorrectly found that Title III does not apply to the content of insurance policies. Based on the overall goal of the ADA, the plain meaning of Title III, its legislative history, and the regulations and interpretive guidance issued by the Department of Justice ("DOJ") and the Equal Employment Opportunity Commission ("EEOC"), the court should have held that placing AIDS-related caps in health insurance policies violates the ADA's Title III.

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3. 42 U.S.C. § 12101(b)(1) (1994).

4. 179 F.3d 557 (7th Cir. 1999) (overruling the holding of the district court in *Doe v. Mutual of Omaha Insurance Co.*, 999 F. Supp. 1188 (N.D. Ill. 1998)).

5. *Id.* at 563.

6. *Id.*

7. *Id.* at 563-64.

I. BACKGROUND

The ADA provides two avenues under which an insured can challenge discriminatory practices in insurance coverage, namely Title I[8] (employment-related discrimination) and Title III[9] (discrimination related to public accommodations). Under Title I, discriminatory practices are prohibited against all qualified disabled individuals in all aspects of the employment relationship including "compensation . . . and all other terms, conditions, and privileges of employment."[10] According to the EEOC, designated by Congress to issue regulations and interpretive guidance related to Title I,[11] discrimination is prohibited in all aspects of employment including fringe benefits regardless of whether the employer actually administers the plan.[12] Given that employers fund a majority of health care in this country,[13] many plaintiffs bring insurance coverage-related discrimination claims under Title I of the ADA.

In addition, claims related to discrimination in insurance coverage are brought under Title III's public accommodation provision. Title III claims include challenges to discriminatory insurance coverage in cases of employment-related insurance, as well as insurance policies purchased directly from insurance agencies. As a first step, the insurer must come under Title III's public accommodation provision in order for the insured to present a valid claim. Public accommodations are private entities that are open to the general public, and are included in an exclusive listing of twelve categories provided in Title III.[14] Insurance offices are *specifically*

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8. 42 U.S.C. §§ 12111-12117 (1994).

9. *Id.* §§ 12181-12189.

10. *Id.* § 12112(a).

11. *Id.* § 12116 (authorizing EEOC to issue regulations implementing Title I).

12. 29 C.F.R. § 1630.4(f) (1998).

13. *See, e.g.*, Nancy R. Mansfield et al., *Insurance Caps on AIDS-Related Healthcare Costs: Will the ADA Fill the Gap Created by ERISA?*, 14 GA. ST. U. L. REV. 601, 602 (1998) (citing Eric C. Sohlgren, Note, *Group Health Benefits Discrimination Against AIDS Victims: Falling through the Gaps of Federal Law—ERISA, the Rehabilitation Act and the Americans with Disabilities Act*, 24 LOY. L.A. L. REV. 1247, 1300 (1991)).

14. 42 U.S.C. § 12181(7) (1994).

> Public accommodation. The following private entities are considered public accommodations for purposes of this subchapter [42 U.S.C. §§ 12181-12189], if the operations of such entities affect commerce –

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listed as places of public accommodation, under subsection (F), which includes service establishments that are covered under the public accommodation provision.[15] Therefore, in *Doe*, where self-employed individuals purchased their policies *directly* from an insurance company, the insureds brought suit only under Title III.

The federal courts have disagreed over the proper interpretation of Title III's anti-discrimination text as applied to public accommodations on two important issues. The first question concerns whether physical structures open to the public are the only businesses covered by Title III. The second issue deals with the specific Title III requirements, after it is determined that the particular business operates a place of public accommodation. Specifically, the second component concerns whether Title III is limited to protecting *physical access* to goods and services offered by places of public accommodation *or* whether the statute *extends*

(A) an inn, hotel, motel, or other place of lodging, except for an establishment located within a building that contains not more than five rooms for rent or hire and that is actually occupied by the proprietor of such establishment as the residence of such proprietor;

(B) a restaurant, bar, or other establishment serving food or drink;

(C) a motion picture house, theater, concert hall, stadium, or other place of exhibition or entertainment;

(D) an auditorium, convention center, lecture hall, or other place of public gathering;

(E) a bakery, grocery store, clothing store, hardware store, shopping center, or other sales or rental establishment;

(F) a laundromat, dry-cleaner, bank, barber shop, beauty shop, travel service, shoe repair service, funeral parlor, gas station, office of an accountant or lawyer, pharmacy, *insurance office*, professional office of a health care provider, hospital, or other service establishment;

(G) a terminal, depot, or other station used for specified public transportation;

(H) a museum, library, gallery, or other place of public display or collection;

(I) a park, zoo, amusement park, or other place of recreation;

(J) a nursery, elementary, secondary, undergraduate, or postgraduate private school, or other place of education;

(K) a day care center, senior citizen center, homeless shelter, food bank, adoption agency, or other social service center establishment; and

(L) a gymnasium, health spa, bowling alley, golf course, or other place of exercise or recreation.

Id. § 12181(7)(A)-(L) (emphasis added).

15. *Id.* § 12181(7)(F).

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beyond access to the content of goods and services offered by places of public accommodation. The second issue was the primary concern in *Doe*, since it was not disputed that the insurance company qualified as a public accommodation under Title III by selling insurance policies directly to the general public.

Several circuit courts have addressed the first issue regarding whether the defendant must be located in an actual *physical structure* that is open to the public in order to be a public accommodation covered under Title III, as well as the related question: whether a claimant must be *physically present* inside a place of public accommodation to be entitled to non-discriminatory treatment. The First Circuit in *Carparts Distribution Center, Inc. v. Automotive Wholesaler's Ass'n of New England, Inc.*,[16] concluded that Congress did not intend Title III of the ADA to impose a strict requirement that the claimant actually enter a physical structure to be protected by its anti-discrimination provisions. The court in *Carparts* reasoned that a travel service, which is specifically listed as a public accommodation under Title III, provides services to people who typically do not enter an actual physical structure. Congress, therefore, could not have intended for a physical structure to be a mandatory requirement.[17] The court explained, "[i]t would be irrational to conclude that persons who enter an office to purchase services are protected by the ADA, but persons who purchase the same services over the telephone or by mail are not. Congress could not have intended such an absurd result."[18] This line of reasoning has been followed in several recent district court decisions.[19]

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16. 37 F.3d 12 (1st Cir. 1994), *rev'g* 826 F. Supp. 583 (D.N.H. 1993).

17. *Id.* at 19.

18. *Id.*

19. Chabner v. United of Omaha Life Ins. Co., 994 F. Supp. 1185 (N.D. Cal. 1998), *aff'd on other grounds*, No. 98-17060, 2000 WL 1276794 (9th Cir. Sept. 11, 2000); Cloutier v. Prudential Ins. Co. of Am., 964 F. Supp. 299 (N.D. Cal. 1997); World Ins. Co. v. Branch, 966 F. Supp. 1203 (N.D. Ga. 1997), *vacated as moot per curiam*, 156 F.3d 1142 (11th Cir. 1998); Lewis v. Aetna Life Ins. Co., 982 F. Supp. 1158 (E.D. Va. 1997); Kotev v. First Colony Life Ins. Co., 927 F. Supp. 1316 (C.D. Cal. 1996); Doukas v. Metro. Life Ins. Co., 950 F. Supp. 422 (D.N.H. 1996).

In *Chabner*, the Ninth Circuit stated: "summary judgment for Chabner was appropriate. We do not, however, base our decision on the ADA. We instead rest our decision on California law, which provides Chabner with the remedy he seeks for the misconduct he has alleged." *Chabner*, 2000 WL 1276794, at *1.

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However, the Third and Sixth Circuits have taken an opposing view, concluding that Title III is limited to protecting access to actual physical structures.[20] Specifically, in *Parker v. Metropolitan Life Insurance Co.*,[21] the Sixth Circuit's en banc panel disagreed with *Carparts* and held that "[a] benefit plan *offered by an employer* is not a good offered by a place of public accommodation. As is evident by § 12187(7), a public accommodation is a physical place."[22] The court explained that "the First Circuit disregarded the statutory canon of construction, *noscitur a sociis* . . .[t]he clear connotation of the words in § 12181(7) is that a public accommodation is a physical place. Every term listed in § 12181(7) and subsection (F) is a physical place open to public access."[23]

In *Lenox v. Healthwise of Kentucky, Ltd.*,[24] the Sixth Circuit reaffirmed its decision in *Parker*, where a plaintiff argued that her health insurance policy violated Title III of the ADA by denying coverage for heart transplants while including coverage for other types of transplants.[25] The Sixth Circuit denied her Title III claim, reasoning that:

> [The plaintiff] is complaining about the mix of goods and services offered by an insurance company. Her complaint relates solely to the fact that the Healthwise policy does not cover heart transplants but does cover other transplants. The fact that the plan indicated that Lenox could direct questions to Healthwise's office and the fact that she was required to send her application form to Healthwise's office are immaterial. They do not demonstrate the existence of any barrier to her accessing Healthwise's physical facility. Nor do they indicate the existence of a barrier to her taking advantage of the goods and services that are available to individuals at Healthwise's physical facility.[26]

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20. Parker v. Metro. Life Ins. Co., 99 F.3d 181 (6th Cir. 1996), *aff'd en banc*, 121 F.3d 1006 (6th Cir. 1997), *cert. denied*, 118 S. Ct. 871 (1998); Lenox v. Healthwise of Ky., Ltd., 149 F.3d 453 (6th Cir. 1998); Ford v. Schering-Plough Corp., 145 F.3d 601 (3d Cir. 1998).

21. 121 F.3d 1006 (6th Cir. 1997).

22. *Id.* at 1010 (emphasis added).

23. *Id.* at 1014.

24. 149 F.3d 453 (6th Cir. 1998).

25. *Id.* at 455.

26. *Id.* at 457.

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The Third Circuit aligned itself with the Sixth Circuit by reaching the same conclusion in *Ford v. Schering-Plough Corporation*.[27] In *Ford*, the court held that a disparity between disability benefits for mental versus physical disabilities did not violate Title III. The court noted that "[t]he litany of terms, [included in 42 U.S.C. § 12181(7)] refer to places with resources utilized by physical access. . . . [W]e do not find the term 'public accommodation' or the terms in 42 U.S.C. § 12181(7) to refer to non-physical access or even to be ambiguous as to their meaning."[28]

In *Doe*, the policies were purchased *directly* by self-employed individuals who were solicited by an insurer dealing with the general public. Therefore, the *Doe* court directed its attention to the second issue posed by the anti-discrimination requirements of Title III: whether the statute merely requires physical *access* to goods and services offered by places of public accommodation, or whether it extends to the actual *content* of those goods and services. Accordingly, the Seventh Circuit in *Doe*, while holding that Title III prohibits a business qualifying as a public accommodation from *refusing* to sell goods or services to a disabled person due to a disability, declined to extend the anti-discrimination provision protections to the *contents* of goods and services.[29]

Similarly, the First Circuit in *Carparts* discussed whether Title III's reach extended to the content of goods and services, but ultimately declined to decide the issue since the "nature of the record and the way the issues are addressed in the appellate briefs make it imprudent to do so."[30] In dicta, the First Circuit posed an extension of Title III to the substance of goods or services offered by places of public accommodation by stating:

> One who simply reads the Committee Report describing the operations of Title III could easily come away with the impression that it is primarily concerned with access in the sense of either physical access to a place of public accommodation or something analogous, such as access provided through telephone lines, messengers or some other medium. At the same time, there is nothing in that history that explicitly precludes an extension of the statute

27. 145 F.3d 601 (3d Cir. 1998).

28. *Id.* at 614.

29. Doe v. Mut. of Omaha Ins. Co., 179 F.3d 557, 559-64 (7th Cir. 1999).

30. Carparts Distrib. Ctr., Inc. v. Auto. Wholesaler's Ass'n, 37 F.3d 12, 20 (1st Cir. 1994).

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> to the substance of what is being offered. Suppose, for example, a company that makes and distributes tools provides easy access to its retail outlets for persons with every kind of disability, but declines to make even minor adjustments in the design of the tools to make them usable by persons with only quite limited disabilities.[31]

Meanwhile, the Sixth Circuit in *Parker,* while ruling that Title III did not govern the content of a long-term disability policy *offered by an employer*, stated that "Title III regulates the availability of the goods and services the place of public accommodation offers as opposed to the contents of goods and services offered by the public accommodation."[32] By denying the extension of Title III's anti-discrimination provision to questions involving content, the Sixth Circuit noted that it was disagreeing with two district court rulings.[33] Specifically, the Sixth Circuit in *Parker* expressed its disagreement with the court in *Doukas v. Metropolitan Life Insurance Co.*,[34] where the district court reasoned that "[t]he broad wording and diversity of these 'specific prohibitions,' [in § 12182(b)(2)(A)] are a strong indication that Title III was intended to extend beyond mere access or availability of a good or service."[35] In addition, the Sixth Circuit expressly disagreed with the district court in *Kotev v. First Colony Life Insurance Co.*,[36] where the district court concluded that Title III was not limited to the mere denial of physical access to places of public accommodation.[37]

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31. *Id.* at 19-20.

32. Parker v. Metro. Life Ins. Co., 121 F.3d 1006, 1012 (6th Cir. 1997).

33. *Id.* at 1012 n.4.

34. 950 F. Supp. 422 (D.N.H. 1996).

35. *Id.* at 426.

36. 927 F. Supp. 1316 (C.D. Cal. 1996).

37. *Id.* at 1321. Several other district courts have concluded that in order to support the overall goal of the ADA and the plain meaning of Title III, the Act regulates the content of goods and services provided by a place of public accommodation. Chabner v. United of Omaha Life Ins. Co., 994 F. Supp. 1185 (N.D. Cal. 1998), *aff'd on other grounds*, No. 98-17060, 2000 WL 1276794 (9th Cir. Sept. 11, 2000); Cloutier v. Prudential Ins. Co. of Am., 964 F. Supp. 299 (N.D. Cal. 1997); World Ins. Co. v. Branch, 966 F. Supp. 1203 (N.D. Ga. 1997), *vacated as moot per curiam*, 156 F.3d 1142 (11th Cir. 1998).

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II. DOE V. MUTUAL OF OMAHA INSURANCE CO.

A. Facts of the Case

The plaintiffs, Chicago residents John Doe and Richard Smith,[38] purchased health insurance policies from Mutual of Omaha, which sold insurance directly to the public at various office locations.[39] The policies contained limits on the benefits available to individuals suffering from AIDS or AIDS-related conditions (ARC).[40] Under the terms of their policies, Doe had a lifetime AIDS-related benefit of $100,000, while Smith's lifetime limit for recoverable AIDS-related benefits was $25,000.[41] By comparison, the policies provided benefits for other medical care with a lifetime maximum of one million dollars.[42] Additionally, the million-dollar benefit was eligible for reinstatement provided that the insured did not incur any expenses for two consecutive calendar years.[43]

According to medical guidelines published by the National Institutes of Health, the most effective manner to treat HIV is through early medical intervention, including anti-retroviral therapy to reduce the level of HIV.[44] Since expenses related to the treatment of HIV are included under the cap for AIDS, the coverage limits impeded the ability of the plaintiffs to obtain and continue their therapies and related treatment.[45] The AIDS caps forced the plaintiffs to make adverse medical treatment decisions, such as enrolling in clinical drug trials in order to receive free medication and to

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38. "John Doe" and "Richard Smith" are fictitious names granted by the court in order to protect the plaintiffs' privacy. Doe v. Mut. of Omaha Ins. Co., Order No. 98 C 0325, n.1 (N.D. Ill. Feb. 19, 1998).

39. Doe v. Mut. of Omaha Ins. Co., 999 F. Supp. 1188, 1190 (N.D. Ill. 1998).

40. *Id.*

41. *Id.; see also* Nancy R. Mansfield et al., *Insurance Caps on AIDS-Related Healthcare Costs: Will the ADA Fill the Gap Created by ERISA?*, 14 GA. ST. U. L. REV. 601 (1998). "AIDS treatment is not as costly as some diseases that are routinely covered throughout the disease's duration. Rather, public fear over how AIDS is transmitted, its degree of contagion, and its association with a disapproved life-style have made it a cost-cutting target . . . ." *Id.* at 602.

42. *Doe*, 999 F. Supp. at 1190.

43. *Id.*

44. *Id.*

45. *Id.*

avoid utilizing benefits under their expense caps.[46] Enrollment in the clinical drug trials came at the expense of their personal health.[47] Smith was enrolled in an unsuccessful trial involving the reduction of drug dosages to determine its impact in suppressing viral load.[48] The lower dosage resulted in increased viral loads and Smith subsequently resumed the recommended dosage.[49] The plaintiffs also reduced visits to their physicians and they have foregone recommended viral load tests in order to reduce medical expenses.[50] After the plaintiffs reach their limits under their health insurance policies, they will not have insurance benefits for their future treatments associated with the disease.[51]

B. The District Court Decision

The plaintiffs claimed disability discrimination regarding the AIDS-related benefit caps in their policies in violation of Title III of the ADA and the Illinois Insurance Code ("IIC").[52] The district court granted the defendant's motion to dismiss the claim under the IIC, since there was no private right of action implied under the state statute.[53] However, the court held that the plaintiffs adequately stated a claim that the caps constituted discrimination under Title III of the ADA.[54] The court interpreted the text of Title III broadly stating that, "limitation of Title III's scope to the question of discriminatory access is at odds with the plain language of Title III, relevant legislative history and the Department of Justice's interpretive guidance."[55] The court concluded that "the plain language of Title III manifests a congressional intent to ensure 'full and equal enjoyment' of the goods and services themselves and an equal

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46. Brief for Plaintiffs-Appellees at 5-6, Doe v. Mut. of Omaha Ins. Co., 179 F.3d 557 (7th Cir. 1999) (No. 98-4112).

47. *Id.*

48. *Id.* at 6.

49. *Id.*

50. Declaration of John Doe at 4-5, Doe v. Mut. of Omaha Ins. Co., 999 F. Supp. 1188 (N.D. Ill. 1998) (No. 98 C 0325).

51. Doe v. Mut. of Omaha Ins. Co., 999 F. Supp. 1188, 1191 (N.D. Ill. 1998).

52. *Id.* at 1190.

53. *Id.* at 1197-98.

54. *Id.* at 1197.

55. *Id.* at 1193.

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opportunity to 'participate in or benefit from' goods or services offered by a place of public accommodation."[56]

First, under the plain meaning of the statute, the court held that the policy caps could be viewed as discriminatory under any of Title III's specific prohibitions,[57] stating:

> The AIDS/ARC caps could alternately be viewed as a discriminatory denial of the "full and equal enjoyment" of goods or a service; as a discriminatory denial of an equal opportunity to benefit from goods or a service; as the discriminatory denial of an opportunity to benefit from goods or a service; or as the provision of goods or a service different from that provided to others.[58]

Thus, in order to give full effect to the plain language of Title III, the court deemed the statute applicable to the content of insurance policies.[59]

Second, the court found the legislative history of the ADA to comport with a broad interpretation of the statute. "[T]he text of both House and Senate reports acknowledges the applicability of the ADA's anti-discrimination provisions to insurance policies."[60] In particular, the following language in a Senate report was persuasive to the court: "[u]nder the [ADA], a person with a disability cannot be denied insurance or be subject to *different terms or conditions* of insurance based on disability alone, if the disability does not pose increased risks."[61] Similarly, the court acknowledged the following language in a House report stating,

> [T]he [insurance] plan may not refuse to insure . . . or limit the amount, extent, or kind of coverage available to an individual, or charge a different rate for the same coverage solely because of a physical or mental impairment, except where the refusal, limitation, or rate differential is based on sound actuarial principles or is related to actual or reasonably anticipated experience.[62]

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56. *Id.*

57. *Id.*; *see also infra* text accompanying notes 137-40, quoting 42 U.S.C. § 12182(a), (b)(1)(A)(i) – (iii) (2000).

58. *Doe*, 999 F. Supp. at 1193 (citing 42 U.S.C. § 12182(a), (b)(1)(A)(i)-(iii)).

59. *Id.*

60. *Id.*

61. *Id.* at 1193-94 (quoting S. REP. NO. 101-116, at 84 (1989) (emphasis added)).

62. *Id.* at 1193 (quoting H.R. REP. NO. 101-485, pt. 2, at 136-37 (1990), *reprinted in* 1990 U.S.C.C.A.N. 419-20).

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Third, the court held that the Department of Justice's interpretive guidance, promulgated through their regulations and technical assistance manual, should be given deference and provided persuasive support that Title III applies to the content of insurance policies.[63] In support of its conclusion, the court highlighted language from the DOJ's regulations suggesting that the ADA "reach[es] insurance practices by *prohibiting differential treatment* of individuals with disabilities in insurance offered by public accommodations unless the differences are justified."[64] In addition, the court referenced the DOJ's technical assistance manual, which provides "[i]nsurance offices are places of public accommodation and, as such, may not discriminate on the basis of disability in the sale of insurance contracts or in the *terms or conditions* of the insurance contracts they offer."[65]

The district court stated that it was joining a growing number of district courts throughout the country holding that Title III's scope extends to the content of insurance policies.[66] Similarly, the district court rejected the Sixth Circuit's limitation on the scope of Title III in *Parker v. Metropolitan Life Insurance Co.*[67] The court stated that "[t]he *Parker* court did not comment on the statutory text. The plain meaning of [the discrimination provisions in Title III] belies the *Parker* court's narrow conclusion."[68]

In addition, the district court determined that the safe harbor provision in Title V served to reinforce the conclusion that Title III reaches the

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63. *Id.* at 1194.

64. *Id.* at 1194 (quoting 28 C.F.R. ch. 1, pt. 36, App. B at 619 (1996) (emphasis added)).

65. *Id.* (quoting Title III Technical Assistance Manual § III-3.11000 (Nov. 1993) (emphasis added)). Congress has delegated authority to the DOJ to promulgate binding regulation, 42 U.S.C. § 12186(b), and to issue a technical assistance manual providing guidance concerning the ADA's requirements, 42 U.S.C. § 12206(c)(3). *Id.* at 1194 n.6.

66. *Id.* at 1194 (referring to: Chabner v. United of Omaha Life Ins. Co., 994 F. Supp. 1185 (N.D. Cal. 1998), *aff'd on other grounds,* No. 98-17060, 2000 WL 1276794 (9th Cir. Sept. 11, 2000); Cloutier v. Prudential Ins. Co. of Am., 964 F. Supp. 299 (N.D. Cal. 1997); World Ins. Co. v. Branch, 966 F. Supp. 1203 (N.D. Ga. 1997*), vacated as moot per curiam*, 156 F.3d 1142 (11th Cir. 1998); Kotev v. First Colony Life Ins. Co., 927 F. Supp. 1316 (C.D. Cal. 1996); Doukas v. Metro. Life Ins. Co., 950 F. Supp. 422 (D. N.H. 1996); and Baker v. Hartford Life Ins. Co., No. 94 C 4416, 1995 WL 573430 (N.D. Ill. Sept. 28, 1995)).

67. 121 F.3d 1006 (6th Cir. 1997); *see also Doe*, 999 F. Supp. at 1193.

68. *Doe*, 999 F. Supp. at 1193.

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content of insurance policies.[69] According to the safe harbor provision, "the challenged underwriting practice or risk classification does not violate the ADA if it accords with 'sound actuarial principles, reasonably anticipated experience, or bona fide risk classification,' or does not otherwise constitute a 'subterfuge to evade the purposes of the ADA.'"[70] Accordingly, the court rejected the defendant's argument that the safe harbor provision served to exempt the insurance industry from the reach of Title III. Instead, the district court deemed that the insurance provision manifested Congress' intent to subject insurers to the full scope of the anti-discrimination prohibitions in the ADA.[71] Therefore, the safe harbor provision was not found to exempt the insurer from the ADA's broad reach into the content of insurance policies.[72]

The district court also rejected the defendant's argument that the state preemption for insurance regulation provided by the McCarran-Ferguson Act precluded application of the ADA to insurance policy content. Mutual of Omaha argued that Title III of the ADA did not satisfy the Act's clear statement test, which specifies that a federal statute must be construed as inapplicable to the business of insurance, unless the statute provides otherwise.[73] The court ruled that the ADA *specifically relates to* the business of insurance for purposes of the McCarran-Ferguson Act, since the safe harbor provision specifies that insurance underwriting practices cannot be used to evade the purposes of the ADA.[74] The court determined that the ADA as a whole contained sufficient references to the issue of insurance, including Title III (referring to an insurance office as a place of public accommodation) and Title V (containing the safe harbor and

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69. *Id.* at 1194.

70. *Id.* at 1195 (citing World Ins. Co. v. Branch, 966 F. Supp. 1203, 1208-09 n.6 (N.D. Ga. 1997)).

71. *See id.* at 1195; *see also* Chabner v. United of Omaha Life Ins. Co., 994 F. Supp. 1185, 1190 (N.D. Cal. 1998) ("If Title III were meant only to prevent insurance companies from denying persons with disabilities equal access to the physical plants of insurance offices, there would have been no need for Congress to include the safe harbor provision dealing with underwriting practices."); Kotev v. First Colony Life Ins. Co., 927 F. Supp. 1316, 1322 (C.D. Cal. 1996) ("insurers would not need this 'safe harbor' provision ... if insurers could never be liable under Title III for conduct such as the discriminatory denial of insurance coverage."). See discussion of the Safe Harbor provision *infra* Part III.B.

72. *See Doe*, 999 F. Supp. at 1195.

73. *Id.*

74. *Id.* (citations omitted).

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subterfuge references).[75] In addition, the court determined that the defendant did not identify any Illinois state law that would be invalidated, impaired, or superceded by Title III, since Illinois insurance law forbids discriminatory insurance practices unless the "discrimination is based on sound actuarial principles or is related to actual or reasonably anticipated experience."[76] The court stated, "[w]here there is no conflict between the federal statute and state law, as in this case, the McCarran-Ferguson Act does not bar application of federal law."[77]

Finally, the court rejected Mutual's argument that the caps do not constitute discrimination on the basis of a disability, but are merely a permissible distinction in the level of benefits provided to one category compared to other categories of disabilities.[78] Mutual of Omaha cited three appellate cases that rejected the premise that providing unequal benefits for individuals with mental versus physical disabilities constitutes discrimination.[79] However, the district court found the three cases to be inapposite to the case at bar. In *Doe*, the ADA claim focused on the singling out of a group of individuals with a particular disability for inferior coverage versus the treatment levels afforded to the non-disabled group.[80] The court noted that the *Parker* court distinguished the differentiation of discrimination between broad categories of individuals with different disabilities versus the discrimination prohibited by the ADA, namely discrimination between the disabled and the non-disabled.[81] The district court concluded that the Mutual of Omaha policies subjected the plaintiffs to different terms and conditions than those imposed on non-disabled individuals.[82] For example, if the plaintiffs contracted pneumonia, coverage would be denied after the cap was reached since it would be deemed a complication of AIDS and therefore an AIDS-related condition. However, coverage for treatment of pneumonia for non-

75. *Id.*

76. *Id.* at 1195-96 (quoting 215 ILCS 5/364 (West 1997)).

77. *Id.*

78. *See id.*

79. *Id.* (referring to: Parker v. Metro. Life Ins. Co., 121 F.3d 1006, 1015-16 (6th Cir. 1997); EEOC v. CNA Ins. Cos., 96 F.3d 1039, 1044 (7th Cir. 1996); and Modderno v. King, 82 F.3d 1059, 1061 (D.C. Cir. 1996)).

80. *Id.* at 1196.

81. *Id.* (citations omitted).

82. *Id.*

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disabled individuals would be provided up to the $1 million limit.[83] Therefore, the court concluded that the plaintiffs' allegations of differential treatment on the basis of AIDS were sufficient to state a cognizable claim under Title III of the ADA.[84]

C. The Seventh Circuit Decision

At the appellate level, the insurer appealed the district court ruling that AIDS-related treatment caps in two of its health insurance policies violated the public accommodations provision under Title III of the ADA.[85] The insurer stipulated that it "has not shown and cannot show that its AIDS caps are or ever have been consistent with sound actuarial principles, actual or reasonably anticipated experience, bona fide risk classification, or state law."[86] Mutual also conceded that, under the ADA, AIDS is a disabling condition from the onset of HIV infection, consistent with the recent Supreme Court ruling in *Bragdon v. Abbott*.[87] Mutual's sole argument was that the ADA simply does not regulate the content of insurance policies.[88]

1. The Majority Opinion

Judge Posner interpreted the anti-discrimination provision under Title III, section 302(a), as follows:

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83. *Id.*

84. *Id.* at 1196-97.

85. Doe v. Mut. of Omaha Ins. Co., 179 F.3d 557, 558 (7th Cir. 1999).

86. *Id.* *But see* Reply Brief of Defendant-Appellant at 16-17 n.16, Doe v. Mut. of Omaha Ins. Co., 179 F.3d 557 (7th Cir. 1999) (No. 98-4112) (contending that the plaintiffs required an "extraordinarily burdensome discovery, requesting all documents relating to Mutual's actuarial data, underwriting practices, or any actual or reasonably anticipated experience concerning differences in coverage related to AIDS and ARC *and all other medical conditions* for which Mutual provides coverage under *all policies it issues*."). Id. Since Mutual insures approximately 15 million individuals and provides coverage for between 14,000 to 21,000 medical conditions, the insurer estimated the request to entail tens of thousands of man-hours for its employees. The company therefore determined that it had three possible options: 1) comply with the request; 2) face further sanctions by the court; or 3) agree to a stipulated final judgment. Mutual chose the third alternative and in this case only waived its right to produce evidence to show the consistency of its AIDS limits with sound actuarial principles, actual or reasonably anticipated experience, or bona fide risk classification. *Id.*

87. *Doe*, 179 F.3d at 558; *see also* Bragdon v. Abbott, 524 U.S. 624, 642-45 (1998).

88. *Doe*, 179 F.3d at 558.

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> The core meaning of th[e] provision, plainly enough, is that the owner or operator of a store, hotel, restaurant, dentist's office, travel agency, theater, Web site or other facility (whether in physical space or in electronic space...) that is open to the public cannot exclude disabled persons from entering the facility and, once in, from using the facility in the same way that the nondisabled do.[89]

However, according to Judge Posner, the implementation of the anti-discrimination provision requires proper interpretation in each instance.[90] For example, the owner or operator of a camera store cannot refuse to let in the disabled and once inside may not refuse to sell its cameras to them on the same terms as nondisabled customers.[91] Similarly, a dentist cannot refuse to fill a cavity of an individual with AIDS unless he can demonstrate a direct threat to health or safety.[92] Further, an insurance company cannot refuse to sell an insurance policy to a person with AIDS.[93] However, a store is not required to alter its inventory in order to sell goods like braille books, which are specially designed for disabled individuals.[94] Therefore, Judge Posner determined that the case could not be resolved simply by reference to the language of Title III, section 302(a), since interpretation of the case's unique circumstances was necessary.[95]

After interpreting the plain meaning of the anti-discrimination provision as ambiguous, Judge Posner stated that, "[t]he common sense of the statute is that the content of the goods or services offered by a place of public accommodation is not regulated."[96] He logically determined that if Congress had intended to impose such a tremendous burden on the retail sector of the economy and such a vast supervisory responsibility on the federal court system, it would have established a clearer intention and imposed detailed standards regarding proper inventory composition.[97] If

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89. *Id.* at 559 (citations omitted).

90. *Id.* at 559-60.

91. *Id.* at 559; *see also* 28 C.F.R. § 36.202 (1999).

92. *Doe*, 179 F.3d at 559; *see also* Bragdon, 524 U.S. at 648-55.

93. *Doe*, 179 F.3d at 559; *see also* 28 C.F.R. § 36.104 (1999).

94. *Doe*, 179 F.3d at 559; *see also* Lenox v. Healthwise of Ky., Ltd., 149 F.3d 453, 457 (6th Cir. 1998); 28 C.F.R. § 36.307 (1999).

95. *See Doe*, 179 F.3d at 559-60.

96. *Id.* at 560.

97. *Id.*

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this burden were imposed on retail establishments, the only defense available to the retailer would be that the modification of the seller's practices necessary to provide equal access to the disabled "would fundamentally alter the nature of . . . [the seller's] services."[98] In any event, the "fundamental alteration" defense would probably not apply in many cases including the instance of a bookstore that does not stock or sell braille books.[99] Judge Posner was concerned that extending the reach of Title III to regulate the content of goods and services would place retailers in violation of the ADA for refusing to reconfigure a service to make it as valuable to disabled individuals versus nondisabled customers.[100]

Judge Posner refused to distinguish the AIDS caps from the refusal to stock cases despite the fact that the caps include treating the complications of AIDS. Judge Posner reasoned that this is not a difference in treatment due to the fact that one person is disabled and the other is not, since the essential point is that HIV does not directly cause illness.[101] HIV weakens the body and destroys the immune system, which causes the body to fall prey to these diseases.[102] Judge Posner concluded that "[a]n AIDS cap would be meaningless if it excluded the opportunistic diseases that are the most harmful consequences of being infected by the AIDS virus."[103] The AIDS caps cover the cost of fighting the virus and trying to keep the immune system intact plus the costs of treating the opportunistic diseases after the individual is classified as having AIDS and the immune system has eroded.[104] In effect, Judge Posner concluded that *the opportunistic diseases are not really the same disease*, when faced by a person who does not have HIV, since they are either more lethal to a person with AIDS or they are rare infectious diseases that are unique to individuals with AIDS.[105]

Judge Posner's examination of the "safe harbor" provision under Title V caused him to reject the plaintiff's argument that the insurance provision has no function if Title III's anti-discrimination provisions do not regulate

98. *Id.* at 560 (quoting 42 U.S.C. § 12182(b)(2)(A)(ii)).
99. *Id.*
100. *See id.*
101. *Id.*
102. *Id.* at 560-61.
103. *Id.* at 561.
104. *Id.*
105. *Id.*

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the content of insurance policies. Judge Posner concluded that the plaintiff's reasoning was incorrect, since if it were true it would imply that Title III regulates not only the contents of insurance policies but also the content of other goods and services because Title III is not limited to insurance.[106] Judge Posner stated that it would be a prima facie violation of Title III section 302(a) if Mutual were to refuse to sell insurance policies to individuals infected with AIDS.[107] Consequently, Judge Posner implicitly adopted an intent-based approach to the subterfuge provision by implying that Mutual would run afoul of the limitation only if the insurer intended to discriminate against AIDS-infected individuals by adopting the caps to deter them from purchasing the policies.[108]

Judge Posner supported his position that the ADA regulates the access but not the content of goods and services to the disabled by relying on the Act's legislative history, which included a hypothetical that refusing to sell an insurance policy to a blind person would violate the ADA.[109] However, since he was unable to locate anything in the language or history of the statute suggesting that it would be unlawful for an insurer to deny the expense of the blind person learning braille, Posner concluded that there was an inherent difference under the ADA between the two propositions.[110] Judge Posner also dismissed the importance of the DOJ's Technical Assistance Manual, yet admitted that it contained broader language than either the statute or its legislative history or regulations, forbidding insurers to discriminate on the basis of disability in the sale, terms, or conditions of insurance contracts.[111] However, he ultimately concluded that the DOJ Manual "basically . . . just parrots the statute and the regulation and does not indicate a focused attention to coverage limits."[112]

Although the DOJ filed an amicus curiae brief emphasizing the distinction and supporting the plaintiff's interpretation of the ADA, the Seventh Circuit concluded that it was unclear how much deference the court *must show* to the DOJ's informal pronouncements, including the

106. *Id.* at 561-62.
107. *Id.* at 562.
108. *Id.* at 561.
109. *Id.* at 562.
110. *Id.* at 562-63.
111. *Id.*; *see also* Technical Assistance Manual, § III – 3.11000 (Nov. 1993).
112. *Doe*, 179 F.3d at 562-63.

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Technical Assistance Manual and its amicus curiae brief.[113] Although the court acknowledged that some amount of deference is appropriate, it should not be very great since the DOJ "has unaccountably failed to address a fundamental issue on which the brief takes a radical stance."[114] The court deemed that a more public and systematic procedure than filing an amicus brief would be necessary in order to justify displacing insurance regulation from the states into the federal courts.[115] Judge Posner was reluctant to have the federal courts assume the role of "super-actuary" in determining sound risk management procedures.[116] Therefore, Judge Posner held that Title III "does not require a seller to alter his product to make it equally valuable to the disabled and to the nondisabled, even if the product is insurance."[117]

According to the Seventh Circuit, the suit was also barred by the McCarran-Ferguson Act, which forbids construing a federal statute to "impair, or supersede any law enacted by any [s]tate for the purpose of regulating the business of insurance . . . unless such Act specifically relates to the business of insurance."[118] Judge Posner concluded, contrary to the district court's finding, that direct conflict with state insurance law is not required; the interpretation must merely interfere with the state's regulation over the industry.[119] The Seventh Circuit stated that:

> [s]tate regulation of insurance is comprehensive and includes rate and coverage issues . . . so if federal courts are now to determine whether caps on disabling conditions (by no means limited to AIDS) are actuarially sound and

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113. *Id.* at 563.

114. *Id.*

115. *Id.*

116. Brief of Defendant-Appellant at 7-8, Doe v. Mut. of Omaha, 179 F.3d 557 (7th Cir. 1999) (No. 98-4112).

117. *Doe*, 179 F.3d at 563. Posner concluded that this result is consistent with all other appellate courts that have considered this or related issues. *Id.* *See also* Rogers v. Dep't of Health & Envtl. Control, 174 F.3d 431, 436 (4th Cir. 1999); Ford v. Schering-Plough Corp., 145 F.3d 601, 612-14 (3d Cir. 1998); Lenox v. Healthwise of Ky., Ltd., 149 F.3d 453, 457 (6th Cir. 1998); Parker v. Metro. Life Ins. Co., 121 F.3d 1006, 1010-14 (6th Cir. 1997) (*en banc*); Vaughn v. Sullivan, 83 F.3d 907, 912-13 (7th Cir. 1996); Modderno v. King, 82 F.3d 1059, 1065 (D.C. Cir. 1996).

118. *Doe*, 179 F.3d at 563 (quoting 15 U.S.C. § 1012(b)).

119. *Id.* at 563; *see also* Humana Inc. v. Forsyth, 525 U.S. 299, 308-09 (1999); Autry v. Northwest Premium Servs., 144 F.3d 1037, 1039-44 (7th Cir. 1998); Dep't of the Treasury v. Fabe, 508 U.S. 491, 508-09 (1993).

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> consistent with principles of state law they will be stepping on the toes of state insurance commissioners.[120]

The Seventh Circuit looked at individual parts of the ADA when it concluded that the McCarran-Ferguson Act bars an interpretation of Title III section 302(a), but not Title V section 501(c), since that section specifically relates to insurance.[121] Accordingly, Judge Posner feared that forcing the federal courts to interpret Titles III and V of the ADA would place the federal courts into the heart of state insurance regulation.[122] Judge Posner concluded that Title III section 302(a) was limited to a *simple prohibition* of discrimination and was not meant to impair state regulation of the insurance industry; therefore McCarran-Ferguson's reverse preemption comes into play only when Title III is interpreted as broadly as required in order for the plaintiffs to prevail.[123]

Although Judge Posner reversed the decision of the district court, he stated that the plaintiffs might still have a remedy under state law if they could prove that the policies violated state law and sound actuarial practices. Judge Posner did not view federal law as being "the only source of valuable rights."[124]

2. The Dissenting Opinion

Judge Evans reframed the main issue in the case from whether the ADA regulates the content of insurance policies to whether "an insurer can discriminate against people with AIDS, refusing to pay for them the same expenses it would pay if they did not have AIDS."[125] Due to the expansive, protective nature of the ADA, designed to eliminate discrimination against individuals with disabilities, he concluded that Mutual's policies violated the Act.[126] In addition, Judge Evans refuted Judge Posner's analogy comparing the insurer to a camera store forced to stock cameras specifically designed for the disabled, deeming it off-point. Judge Evans advanced a better analogy: "a store which lets disabled

120. *Doe*, 179 F.3d at 564 (citations omitted).
121. *Id.*
122. *Id.*
123. *Id.*
124. *Id.* at 564-65.
125. *Id.* at 565.
126. *Id.*

customers in the door, but then refuses to sell them anything but inferior cameras."[127]

The dissent conceded that the ADA's safe harbor would allow the insurance company to treat the insureds differently if the disparity were consistent with Illinois law or could be justified by sound actuarial principles or claims experience.[128] However, the insurer conceded that the caps did not fall under the safe harbor provision; therefore the dissent concluded that the defendant was unable to take advantage of its shield.[129]

Judge Evans refuted Judge Posner's reasoning that the disputed policies do not discriminate solely based on the insured's HIV status due to the unique nature of AIDS. Judge Posner suggested that there are a unique set of symptoms or afflictions that are AIDS-related conditions, making it easy for the insurance company to determine whether the treatment is covered under the cap.[130] However, the policies do not elaborate on what specific illnesses would fall under the exclusions, nor does the medical community have a definitive list of AIDS-related conditions.[131] The practical effect of this scenario is that coverage for certain expenses is determined solely on whether the insured has AIDS. Since the ADA is supposed to mandate that discrimination against the disabled should be eliminated, the statute should effectively "right the wrong" committed by Mutual according to Judge Evans.[132]

Judge Evans also disagreed with the majority regarding their analysis of the McCarran-Ferguson Act, focusing once again on the manner in which the primary issue was framed.[133] According to Judge Evans, the decision concerned exactly what the majority deemed as permissible, namely whether an insurer may refuse to deal with disabled persons on the same terms as nondisabled persons.[134] According to Judge Evans, the majority was concerned with the federal courts' encroachment on the domain of the state insurance commissioners by acting as super-actuaries. However, the insurer's stipulation has effectively taken this issue out of

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127. *Id.*
128. *Id.*
129. *Id.*
130. *Id.*
131. *Id.*
132. *Id.* at 565-66.
133. *Id.* at 566.
134. *Id.*

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the equation.[135] Therefore, Judge Evans concluded that the policies' caps violated the ADA since the safe harbor provision was not an issue in the case due to the defendant's stipulation and, more importantly, since an insurer cannot decide whether to pay expenses based solely on whether the insured has AIDS.[136]

III. CRITIQUE OF THE COURT'S ANALYSIS

A. Is the Plain Language of the Statute Sufficient to Decide Whether Title III Regulates the Content of Goods and Services?

Title III of the ADA, detailing the prohibition of discrimination against the disabled by places of public accommodation, contains general and specific anti-discrimination provisions as well as a listing of prohibited activities. The general provision under Section 302(a) provides that "[n]o individual shall be discriminated against on the basis of disability in the *full and equal enjoyment* of the goods, services, facilities, privileges, advantages, or accommodations *of any place* of public accommodation by any person who owns, leases . . . or operates a place of public accommodation."[137]

Section 302(b)(1)(A) of Title III provides further guidance regarding what constitutes a discriminatory practice by listing generally prohibited activities including: (1) denying participation to the disabled; (2) offering participation in unequal benefits to the disabled; and (3) providing separate benefits to disabled individuals. The following activities are prohibited:

> (i) Denial of participation
>
> It shall be discriminatory to subject an individual or class of individuals on the basis of a disability . . . directly, or through contractual, licensing, or other arrangements, *to a denial of the opportunity* of the individual . . . to participate in or benefit from the goods [or] services . . . of an entity.[138]

135. *Id.*
136. *Id.*
137. 42 U.S.C. § 12182(a) (2000) (emphasis added).
138. *Id.* § 12182(b)(1)(A)(i) (emphasis added).

> (ii) Participation in unequal benefit
>
> It shall be discriminatory to afford an individual or class of individuals, on the basis of a disability . . . directly, or through contractual, licensing, or other arrangements with *the opportunity to participate in or benefit from* a good [or] service, . . . that is *not equal to* that afforded to other individuals."[139]
>
> (iii) Separate benefit
>
> It shall be discriminatory to provide an individual or class of individuals, on the basis of a disability . . . directly, or through contractual, licensing, or other arrangements with a good [or] service . . . *that is different or separate from* that provided to other individuals, unless such action is necessary to provide the individual or class of individuals with a good [or] service . . . that is as effective as that provided to others.[140]

In addition, the specific anti-discrimination provisions of Title III expand upon the general provision to provide detailed prohibitions of discriminatory conduct under Section 302(b)(2)(A) of Title III. The relevant specific prohibitions are as follows:

> For purposes of subsection (a) of this section, discrimination includes —
>
> (i) the imposition or application of eligibility *criteria that screen out* . . . an individual with a disability . . . from fully and *equally enjoying* any goods, services, facilities, privileges, advantages, or accommodations, unless such criteria can be shown to be necessary for the provision of the goods [or] services . . . being offered;[141]
>
> (ii) a failure to make reasonable modifications in policies, practices, or procedures, when such modifications are necessary to afford such goods [or] services, . . . to individuals with disabilities, unless the entity can demonstrate that making such modifications would

139. *Id.* § 12182(b)(1)(A)(ii) (emphasis added).
140. *Id.* § 12182(b)(1)(A)(iii) (emphasis added).
141. *Id.* § 12182(b)(2)(A)(i) (emphasis added).

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> fundamentally alter the nature of such goods, services, facilities, privileges, advantages, or accommodations.[142]

Judge Posner concluded that the case could not be decided entirely by reference to the plain meaning of the language in Title III's general anti-discrimination provision.[143] However, in reaching his conclusion, Judge Posner relied solely on the general anti-discrimination provision contained in Title III section 302(a).[144] The Seventh Circuit considered neither the surrounding text from the specific anti-discrimination provisions[145] nor the prohibited activities[146] specifically listed in Title III. However, the meaning of Title III's discrimination prohibitions must be gleaned from the totality of the provisions. The combination of the following references in Title III provides a powerful message that the ADA addresses the content of goods and services:

> 1) In the general rule, there is a prohibition against discriminatory denial of the "full and equal enjoyment" of goods or services.[147]
>
> 2) In the general prohibition of activities section, there is an explicit "denial of the opportunity to participate in or benefit from" a good or service; a prohibition against affording an opportunity to benefit from a good or service that is "not equal to that afforded" to others; and, a prohibition against providing a good or service that is "different or separate from" that provided to others.[148]

Inclusion of an AIDS-related cap in a health insurance policy denies *full and equal enjoyment* of a service to AIDS-infected individuals. Since the cap on the policy denies insurance coverage to AIDS-afflicted patients after the threshold has been reached, they are denied the opportunity to have the peace of mind that is afforded to others by maintaining adequate levels of health insurance coverage. Therefore, they have effectively *been denied the benefit of the full and equal enjoyment* of the insurance service due to their disability. Further, the policy limitations applicable only to

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142. *Id.* § 12182(b)(2)(A)(ii).

143. *See supra* text accompanying note 137.

144. 42 U.S.C. § 12182(a) (2000); *see also supra* text accompanying note 137.

145. 42 U.S.C. § 12182(b)(2)(A)(i)-(ii) (2000); *see also supra* text accompanying notes 141-142.

146. 42 U.S.C. § 12182(b)(1)(A)(i)-(iii) (2000); *see also supra* text accompanying notes 138-140.

147. 42 U.S.C § 12182(a) (2000).

148. *Id.* § 12182(b)(1)(A)(i)-(iii).

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AIDS patients qualify as the discriminatory *denial of an opportunity to benefit from a service provided to others*. Since insurance coverage for many conditions is provided to non-AIDS patients, while coverage for the *same treatment* is not provided to AIDS patients based solely on their disability, the insurer is not providing the same coverage for the disabled and the non-disabled. Therefore, the insurers are denying AIDS-afflicted patients the *opportunity to benefit from a service provided to others*. Alternatively, AIDS caps on the policies qualify as affording an opportunity to benefit from a good or service that is "*not equal to that afforded*" to others not infected with the virus. Finally, the policy limits single out AIDS patients by providing a good or service that is "*different or separate from*" that provided to others.

If the content of goods or services is not implicated in Title III, then why does the statute include a reference to "full and equal enjoyment" and words such as "not equal to" or "different or separate from" that indicate an intent to compare and contrast the attributes or utility of the goods or services? The totality of Title III's anti-discrimination provisions indicate that the Act intended to go beyond mere questions of access to goods and services of a public accommodation to the issue of contents through the inclusion of words that clearly measure the utility of the items to the disabled. If the intent of Congress were to limit the claims of discrimination to issues of simple *access*, then the deliberate focus of the statute on the inequality aspects and the distinctness or separateness of the goods or services would be superfluous. Therefore, Judge Posner should have further probed the text of the prohibited activities in Title III before concluding that the plain meaning of the language did not adequately address the issue regarding whether the anti-discrimination provisions extended to the regulation of the content of insurance policies.

B. Does the ADA's Title V "Safe Harbor" Provision Deem that the Contents of Insurance Policies Are Covered Under Title III?

Title V of the ADA includes a stipulation referred to as the "safe harbor" provision, which seeks to clarify when an insurer's practices fall under the umbrella of the ADA's non-discrimination provisions. The provision, ADA § 501(c), provides the following:

> Insurance
>
> Subchapters I through III of this chapter and Title IV of this Act *shall not be construed to prohibit or restrict –*

> (1) *an insurer*, hospital or medical service company, health maintenance organization, or any agent, or entity that administers benefit plans, or similar organizations from *underwriting risks, classifying risks, or administering such risks* that are based on or *not inconsistent with [s]tate law*; or
>
> (2) a person or organization covered by this chapter from establishing, sponsoring, observing, or administering the terms of a bona fide benefit plan that are based on underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with [s]tate law; or
>
> (3) a person or organization covered by this chapter from establishing, sponsoring, observing, or administering the terms of a bona fide benefit plan that is not subject to [s]tate laws that regulate insurance.
>
> Paragraphs (1), (2), and (3) shall *not be used as a subterfuge* to evade the purposes of subchapter I and III of this chapter.[149]

This provision has been interpreted by the courts in one of two ways -- either as verification of Congress' intent to ensure a broad exemption for insurance companies from the reach of the anti-discrimination provisions contained in Titles I and III[150] or as manifestation of the opposite intent, namely to subject insurers to the full breadth of the ADA's anti-discrimination prohibitions.[151] In this case, the Seventh Circuit has taken the first position, namely that the safe harbor provision was designed for the exclusive benefit of the insurance industry, rendering insurance

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149. *Id.* § 12201(c)(1)-(3) (1999) (footnote omitted) (emphasis added).

150. *See* Ford v. Schering-Plough Corp., 145 F.3d 601 (3d Cir. 1998). "[R]equiring insurers to justify their coverage plans elevates this court to the position of super-actuary. This court is clearly not equipped to become the watchdog of the insurance business, and it is unclear exactly what actuarial analysis the defendants would have to produce to disprove the charge of 'subterfuge'[.]" *Id.* at 612.

151. *See* Chabner v. United of Omaha Life Ins. Co., 994 F. Supp. 1185 (N.D. Cal. 1998); *see also* Pallozzi v. Allstate Life Ins. Co., 198 F.3d 28 (2d Cir. 1999). "We . . . hold that Title III does regulate the sale of insurance policies in insurance offices, subject to the limitations of the safe harbor provision in Section 501(c) of Title V. . . . [W]e base our holding on the statutory text -- which . . . unambiguously covers insurance underwriting in at least some circumstances . . . ." *Id.* at 33.

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coverage the province of state regulators versus a matter to be considered under the ADA.[152] Judge Posner concluded that the provision "is *obviously intended* for the benefit of insurance companies rather than plaintiffs and it may seem odd therefore to find the plaintiffs placing such heavy weight on what is in effect a defense to liability."[153] According to Judge Posner:

> The insurance industry may have worried that [Title III] would be given just the expansive interpretation that the district court gave it in this case, and so the industry may have obtained the rule of construction in section 501(c) just to backstop its argument that [Title III] regulates only access and not content.[154]

Accordingly, the Seventh Circuit determined that the business of insurance regulation should be left exclusively to the states.

Other courts, however, have interpreted the provision to indicate that Titles I and III apply to insurers with the safe harbor provision setting the standard for the court's review. In *Kotev v. First Colony Life Insurance Co.*,[155] the district court concluded, "[the defendant] has not explained why insurers would need this 'safe harbor' provision under Title III if insurers could *never be liable* under Title III for conduct such as the discriminatory denial of insurance coverage."[156] Meanwhile, the district court in *Chabner v. United of Omaha Life Insurance Co.*,[157] explained that "the 'safe harbor' provision of the ADA for insurers would be rendered utterly meaningless if the court did not hold that Title III applied to insurance underwriting practices."[158] At the appellate level, the Second Circuit in *Pallozzi v. Allstate Life Insurance Co.*,[159] stated, "[i]f the ADA were not intended to reach insurance underwriting *under any circumstances*, there would be no need for a safe harbor provision exempting underwriting practices that are consistent with state law."[160]

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152. Doe v. Mut. of Omaha Ins. Co., 179 F.3d 557, 561-62 (7th Cir. 1999).
153. *Id.* at 562 (emphasis added).
154. *Id.*
155. 927 F. Supp. 1316 (C.D. Cal. 1996).
156. *Id.* at 1322 (emphasis added).
157. 994 F. Supp. 1185 (N.D. Cal. 1998).
158. *Id.* at 1190.
159. 198 F.3d 28 (2d Cir. 1999).
160. *Id.* at 32 (emphasis added).

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Judge Posner was reluctant to reach the relatively narrow conclusion posited by the plaintiffs that Title III regulates the content *of insurance policies*, since this interpretation would also signify the more expansive reading that Title III regulates the content of *all other* goods and services.[161] Judge Posner was influenced by the defendant's argument concerning the enormous impact that such a ruling would have on the United States economy, pursuant to the defendant's cautionary warning:

> Even more telling, however, the District Court's erroneous construction of ADA Title III goes far beyond health insurance. *What is truly at stake in this case transcends the insurance industry and threatens to effect a sea change in the provision of every good and service throughout the American economy.* The District Court effectively has held that all businesses that deal with the public must, in order to avoid running afoul of the ADA, provide goods and services *tailored for every disability.* Although this may sound extraordinary, . . . the content of every good and service offered by every place of public accommodation must be changed or altered so that all disabled persons achieve the same enjoyment of the good or service as non-disabled persons.[162]

By broadening the issue to include all goods and services, the defendant successfully deflected attention away from the insurance industry.

The real issue, however, concerns the *intentional* placement of a clause in an insurance contract that singles out individuals with a recognized disability for differential treatment where the insurer cannot defend its disparate treatment based on actuarially- or historically-based justifications. In this case, limiting the utilization of medical services based solely on whether the individual has a particular disability *intentionally* restricts the level of enjoyment achieved by the disabled. In the case of other types of goods and services, it should be relatively clear if a seller has *intentionally* provided an inferior good or service to a disabled individual. When it is not clear, then it should be up to the court to determine on a case-by-case basis whether Title III has been violated. In

161. Doe v. Mut. of Omaha Ins. Co., 179 F.3d 557, 562 (7th Cir. 1999).

162. Brief of Defendant-Appellant at 8, Doe v. Mut. of Omaha Ins. Co., 179 F.3d 557 (7th Cir. 1999) (No. 98-4112) (emphasis added).

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situations where the seller must *fundamentally* alter the nature of goods or services provided in order to accommodate the request, the statute clearly provides that a violation of Title III has *not* occurred.[163] Where a relatively minor alteration of the good or service would effectively allow the disabled individual to experience "full and equal enjoyment" under Title III, then it is up to the court to weigh the projected incremental costs versus the intended benefits. Judge Posner's theories governing the importance of economic principles in the formulation of the law should provide adequate guidance concerning the economic efficiency of a particular modification.

Why is the safe harbor provision included in the Act if the ADA has absolutely no role to play in ensuring that the insurance industry meets its anti-discrimination provisions under any circumstances? By its terms, the safe harbor provision only serves to insulate the insurers if their plans or policies "are based on or not inconsistent with state law." Accordingly, the safe harbor provision does *not* operate as a carte blanche denial of liability for insurers to construct any type of plan. Insurers are required by the plain meaning of Title V to act in compliance with state insurance laws. Further, they may not use their ability to underwrite, classify or administer risks allowed under this section "as a subterfuge to evade the purposes of [Title] III."[164] Thus, the safe harbor provision also serves to limit insurers' actions under certain circumstances. Therefore, the ADA's safe harbor provision affords the federal courts a regulatory role in ensuring that insurers do not run afoul of the actuarially based standards established and administered by the states, or that insurers do not abuse the leeway provided by the safe harbor to evade the anti-discrimination provisions.

Judge Posner also rejected the plaintiffs' argument that the legislative history of the ADA confirmed the applicability of Title III to the substance of insurance policies.[165] In refuting the text of the legislative history, "which the plaintiffs hopefully call "definitive," to section 501(c)[,]"[166] Judge Posner dismissed without substantive comment the House and Senate Reports highlighted by the insureds. Yet the House Report stated:

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163. 42 U.S.C. § 12182(b)(2)(A)(ii) (2000).
164. *Id.* § 12201(c) (2000).
165. *See Doe*, 179 F.3d at 562.
166. *Id.*

> [W]hile a plan which limits certain kinds of coverage based on classification of risk would be allowed under [Section 501(c)], the plan may not refuse to insure, or refuse to continue to insure, or *limit the amount, extent, or kind of coverage available* to an individual, or charge a different rate for the same coverage solely because of a physical or mental impairment, except where the refusal, limitation, or rate differential is based on sound actuarial principles or is related to actual or reasonably anticipated experience.[167]

And the Senate Report stated:

> Virtually all states prohibit unfair discrimination among persons of the same class and equal expectation of life. The ADA adopts this prohibition of discrimination. Under the ADA, a person with a disability cannot be denied insurance or be subject to different *terms or conditions* of insurance based on disability alone, if the disability does not pose increased risks.[168]

These excerpts from the legislative history explicitly demonstrate that Congress contemplated application of the ADA to the content of insurance policies under certain circumstances.[169]

In addition, the Department of Justice's interpretive guidance, promulgated through their regulations, the appendix to their regulations, and their technical assistance manual, conclude that Title III applies to the content of insurance policies.[170] The Justice Department's regulations indicate that the ADA "reach[es] insurance practices by prohibiting differential treatment of individuals with disabilities in insurance offered

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167. H.R. REP. NO. 101-485, pt. 2, at 136-37 (1990), *reprinted in* 1990 U.S.C.C.A.N. 419-20 (emphasis added).

168. S. REP. NO. 101-116, at 84 (1989) (emphasis added).

169. Several district courts have relied on the ADA's legislative history to support the application of Title III to the content of insurance policies. *See* Chabner v. United of Omaha Life Ins. Co., 994 F. Supp. 1185, 1191 (N.D. Cal. 1998); Kotev v. First Colony Life Ins. Co., 927 F. Supp. 1316, 1322-23 (C.D. Cal. 1996); Doukas v. Metro. Life Ins. Co., 950 F. Supp. 422, 428 (D.N.H. 1996).

170. The district court in *Kotev* relied on the DOJ's regulations and interpretive comments to support the application of Title III to the content of insurance policies. *See* Kotev v. First Colony Life Ins. Co., 927 F. Supp. 1316, 1322-23 (C.D. Cal. 1996).

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by public accommodations unless the differences are justified."[171] In addition, the DOJ's technical assistance manual states that "[i]nsurance offices are places of public accommodation and, as such, may not discriminate on the basis of disability in the sale of insurance contracts or in the *terms or conditions* of the insurance contracts they offer."[172]

Yet, the Seventh Circuit held that the regulations issued by the Department of Justice were not indicative of Congress' intent to extend the ambit of Title III to the content of insurance policies.[173] According to Judge Posner, "[t]he Department's regulations interpreting the [ADA] are entitled to Chevron deference, [per] Bragdon v. Abbott, . . . but, as we have just seen, do not compel the interpretation for which these plaintiffs contend."[174] Judge Posner rejected the plaintiffs' interpretation since he noted an inherent difference in refusing to sell an insurance policy to a person with AIDS or attaching a condition in the policy designed to deter the individual from purchasing the policy versus offering policies that include caps based on the disability.[175] While acquiescing that the Technical Assistance Manual contained broader language than the statute, regulations or legislative history, Judge Posner dismissed the Manual's interpretation since it did "not indicate a focused attention to coverage limits."[176] Therefore, in his interpretation of the technical assistance manual, Judge Posner effectively ignored the prohibition against varying the "terms or conditions" of insurance coverage based on a disability. Judge Posner did not address the critical question: why does a cap on insurance coverage based solely on an individual's personal disability *not qualify* as a material term or condition of an insurance contract?

The court also commented that it was unsettled as to how much deference should be given to an agency's informal policy pronouncements, including technical assistance manuals and amicus curiae briefs.[177] Although the Department of Justice filed such a brief in this case, the court refused to defer to the guidance, which was directly on point, offered in the

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171. 28 C.F.R., Ch. 1, pt. 36, app. B § 36.212 at 638.

172. The Americans with Disabilities Act, Title III Technical Assistance Manual § III-3.11000 (Nov. 1993) (emphasis added).

173. Doe v. Mut. of Omaha Ins. Co., 179 F.3d 557, 562-63 (7th Cir. 1999).

174. *Id.* at 563.

175. *See id.*

176. *Id.* at 562-63.

177. *Id.* at 563.

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brief.[178] The court concluded that the Justice Department advanced a radical position in the brief, whereas the department had not adequately addressed the issue in its formal regulations.[179] According to Judge Posner, "[d]isplacing the regulation of the insurance industry into the federal courts is a sufficiently far-reaching interpretive stride to justify us in requiring the Department to invite deference by a more deliberative, public, and systematic procedure than the filing of an amicus curiae brief."[180]

The Seventh Circuit's view regarding the proper amount of deference which should be accorded to the DOJ's regulations and technical assistance manual is at odds with the position espoused by the United States Supreme Court in *Bragdon v. Abbott*.[181] In *Bragdon*, the Court deferred to the Department of Justice's regulations, the technical assistance manual, and the appendix to the department's regulations.[182] Specifically, the Supreme Court stated, "[a]s the agency [the DOJ] directed by Congress to issue implementing regulations, . . . [pursuant to] 42 U.S.C. § 12186(b), to render technical assistance explaining the responsibilities of covered individuals and institutions, § 12206(c), and to enforce Title III in court, § 12188(b), the Department's views are entitled to deference."[183]

In Title V's "safe harbor" provision, Congress added a disclaimer that the right to adequately underwrite and insure risks "shall not be used as a *subterfuge* to evade the purposes of Titles I and III."[184] Ambiguity exists, however, concerning Congress' intended meaning of the term 'subterfuge' in Title V. Several district courts have emphasized the significance of actuarial data or the application of actual or reasonably anticipated risk experience to provide adequate justification for discriminatory provisions in insurance policies in order to overcome the burden of proof in the subterfuge clause.[185] In *World Insurance Co. v. Branch*,[186] the court

178. *Id.*

179. *Id.*

180. *Id.*

181. 524 U.S. 624 (1998). *But see* Sutton v. United Air Lines, Inc., 527 U.S. 471, 482-82 (1999) (where the Supreme Court ignored the EEOC regulations under the ADA on the grounds that they were inconsistent with the plain meaning of the statute).

182. *Bragdon*, 524 U.S. at 646-47.

183. *Id.* at 646.

184. 42 U.S.C. § 12201(c) (emphasis added).

185. Chabner v. United of Omaha Life Ins. Co., 994 F. Supp. 1188, 1194-96 (N.D. Cal. 1998); Cloutier v. Prudential Ins. Co. of Am., 964 F. Supp. 299, 304-07 (N.D. Cal.

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stated that the safe harbor provision provides "that insurance practices are protected to the extent they are in accord with sound actuarial principles, reasonably anticipated experience, or bona fide risk classification."[187] The court concluded, "because access to adequate health care is often integral to a disabled individual's ability to participate in society, the court cannot imagine that an insurer could arbitrarily cap the benefits payable with respect to a particular disability without running afoul of this stated purpose."[188]

Although appearing to give the subterfuge limitation rather minimal consideration in the majority opinion, the Seventh Circuit seems to adopt the view that the limitation is based on an intent-based test.[189] Accordingly, Judge Posner states that the insurer would "run afoul of the 'subterfuge' limitation . . . if, for example, it had adopted the AIDS caps to deter people who know they are HIV positive from buying the policies at all."[190] Therefore, the court implied that insurers should not be held liable under the ADA absent proof of intent to discriminate against insureds due

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1997); Kotev v. First Colony Life Ins. Co., 927 F. Supp. 1316, 1322-23 (C.D. Cal. 1996); Doukas v. Metro. Life Ins. Co., 950 F. Supp. 422, 427-28 (D. N.H. 1996).

186. 966 F. Supp. 1203, 1206-07 (N.D. Ga. 1997), *vacated on other grounds*, 156 F.3d 1142 (11th Cir. 1998) (rescinding the insurance policy, thereby vacating the district court's ruling regarding a Title III violation due to an AIDS cap in the policy).

187. *Id.* at 1208. The court stated that this principle was consistent with the legislative history of the ADA, which provides that:

> [The safe-harbor provision] is intended to afford to insurers . . . the same opportunities they would enjoy in the absence of this legislation to design and administer insurance products and benefit plans in a manner that is consistent with basic principles of insurance risk classification. This legislation assures that decisions concerning the insurance of persons with disabilities which are not based on bona fide risk classification be made in conformity with non-discrimination requirements.

H.R. REP. NO. 485, pt. 2, at 137-38, pt. 3, at 70 (1990), *reprinted in* 1990 U.S.C.C.A.N. 303, 445.

In addition, the Report of the House Committee on the Judiciary concluded: "[i]n sum, the ADA requires that underwriting and classification of risks be based on sound actuarial principles or be related to actual or reasonably anticipated experience." H.R. REP. NO. 485, pt. 3, at 71.

188. *World Ins. Co.*, 966 F. Supp. at 1208.

189. Doe v. Mut. Of Omaha Ins. Co., 179 F.3d 557, 562 (7th Cir. 1999).

190. *Id.*

to their disability.[191] Under this scenario, the plaintiff would have the burden of proving that the business justification was pretextual -- an almost impossible hurdle to overcome in the absence of direct evidence.[192]

Although the Department of Justice has been designated by Congress as the agency responsible for implementing regulations under Title III,[193] reference to the EEOC's interpretation of discrimination in health insurance as applied to Title I provides persuasive guidance on the definition of subterfuge. Although Judge Posner was not persuaded that the Justice Department's regulations and related materials provided sufficient support to extend Title III's reach to the content of insurance coverage and he found the text of the safe harbor provision ambiguous, he could have located direct support for the proposition by reviewing guidance promulgated by the EEOC. Although the EEOC is authorized by Congress to issue interpretive guidance under Title I,[194] it is an acceptable practice for a court to expand its interpretive search to other agency's views on the same issue within the same Act. The Supreme Court in *Bragdon* implicitly adopted this approach while analyzing whether HIV infection was a physical impairment under Title III, since it drew "guidance from the views of the agencies authorized to administer other sections of the ADA."[195] Accordingly, the Supreme Court examined the definitions of physical impairment issued by the EEOC (Title I); the Attorney General (Title II, subtitle A); and the Secretary of Transportation (Titles II and III's transportation-related provisions) in addition to reviewing the administrative guidance issued by the Justice Department under Title III. The Supreme Court noted that "[i]n the EEOC's view,

191. The Seventh Circuit's view takes the position espoused by the Supreme Court in *Public Employees Retirement Sys. of Ohio v. Betts*, 492 U.S. 158 (1989), based on the same term in the Age Discrimination in Employment Act ("ADEA").

192. An advocate for an intent-based subterfuge test lists the following ways for an employee to prove pretext: by direct evidence of discriminatory intent, such as oral or documentary admissions; by demonstrating that the underwriting guidelines or decisions have no rational basis; or by proving that the limitation or exclusion clearly violates state laws. *See* Daniel A. Engel, *The ADA and Life, Health, and Disability Insurance: Where is the Liability?*, 33 TORT & INS. L.J. 227, 241-42 (1997).

193. 42 U.S.C. § 12186(b).

194. *Id.* § 12116 (authorizing EEOC to issue regulations implementing Title I).

195. Bragdon v. Abbott, 524 U.S. 624, 647 (1998).

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impairments . . . such as HIV infection, are inherently substantially limiting," before the Court reached the same conclusion.[196]

In 1993, the EEOC issued interim guidance on the application of the ADA to disability-based discrimination in health insurance under Title I.[197] Since the EEOC has not issued final regulations on the topic, the interim guidance continues to have a significant role in interpreting Title I regarding health insurance issues. The EEOC's interim guidance provides that, "[a] term or provision is "disability-based" if it singles out a particular disability (e.g., deafness, *AIDS*, schizophrenia), a discrete group of disabilities (e.g., cancers, muscular dystrophies, kidney diseases), or disability in general (e.g., non-coverage of all conditions that substantially limit a major life activity)."[198] Once the provision is determined to be a disability-based distinction, the employer must prove that the differentiating feature is not used as a subterfuge to evade the purpose of the ADA.[199] Subterfuge is interpreted by the EEOC as "disability-based disparate treatment that is not justified by the risks or costs associated with the disability."[200]

The EEOC provides a non-exclusive list of five ways that an employer may demonstrate that the disability-based distinction is *not* a subterfuge:

> 1) The employer may prove it has not engaged in the alleged disparate treatment. It can show that it imposes

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196. *Id.* (citing 29 CFR § 1630.2 (j)(1997)).

197. EEOC, No. N-915.002, *Interim Enforcement Guidance on the Application of the Americans with Disabilities Act of 1990 to Disability-Based Distinctions in Employer-Provided Health Insurance* (June 8, 1993) [hereinafter *EEOC Guidance*].

198. EEOC Guidance § III.B. EEOC Guidance provides the following example of a disability-based distinction:

> R Company's new self-insured health insurance plan caps benefits for the treatment of all physical conditions, except AIDS, at $100,000 per year. The treatment of AIDS is capped at $5,000 per year.... The lower AIDS cap is a disability-based distinction. Accordingly, if R is unable to demonstrate that its health insurance plan is bona fide and that the AIDS cap is not a subterfuge, a violation of the ADA will be found.

Id.

199. EEOC Guidance § III.C. According to the EEOC Guidance, it is proper to require the insurer to bear the burden of proving entitlement under section 501(c) since they have the "greatest access to the relevant facts." *Id.*

200. EEOC Guidance § III.C.2.

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similar limits on catastrophic conditions other than AIDS.[201]

2) The employer can prove that the disparate treatment is "justified by legitimate actuarial data, or by actual or reasonably anticipated experience, and that conditions with comparable actuarial data and/or experience are treated in the same fashion."[202] Therefore it is not sufficient to show that coverage of the condition merely increases the overall cost to the plan, the employer must also demonstrate that other conditions are treated in the same manner. Therefore cost savings derived through limitations on coverage cannot be borne solely by HIV-infected individuals.

3) The employer can prove that the limitation is "necessary ... to ensure that the challenged health insurance plan satisfies the commonly accepted or legally required standards for the fiscal soundness of such an insurance plan."[203]

4) The employer may prove the practice is necessary to "prevent the occurrence of an unacceptable change either in the coverage of the health insurance plan, or in the premiums charged for the health insurance plan."[204] The change must be so drastic that it would effectively render the plan non-competitive with health plans offered by other employers in the community.

5) Or the employer must prove that the treatment does not produce "*any* benefit," when denial is to a disability-specific treatment. If the employer provides coverage for other treatments that do not provide a benefit, then the employer may be in violation of the ADA.[205]

Insurers have objected to the EEOC's stringent justifications in order to refute a claim that a disability-based distinction is a subterfuge to avoid the anti-discrimination provisions in Title I. Some commentators have

201. *Id.* § III.C.2.a.
202. *Id.* § III.C.2.b.
203. *Id.* § III.C.2.c.
204. *Id.* § III.C.2.d.
205. *Id.* § III.C.2.e.

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found the EEOC's business justifications so excessive that they effectively provide either no defense or establish impossible burdens of proof for the insurer.[206] However, the requirements comport with sound business practices used to evaluate risk versus return. In addition, insurance companies are not unsophisticated enterprises; they employ specially trained actuaries and have access to large databases of historical data.

Some courts interpreting Title I have chosen not to defer to the EEOC's interpretive guidance.[207] Instead, they adopted the Supreme Court's interpretation of "subterfuge" in the Age Discrimination in Employment Act ("ADEA").[208] Interpretation of the subterfuge provision according to *Betts* places the burden of proof on the plaintiff and only prohibits the adoption of a discriminatory provision when there is "*intentional discrimination*"[209] compared to the EEOC's threshold inquiry regarding an actuarial or experience-based justification. This intent-based interpretation was explicitly rejected by the EEOC based on the legislative history of the ADA.[210] According to the EEOC, "both the language of the ADA, expressly covering 'fringe benefits,' and the Act's legislative history, rejecting the concept of a 'safe harbor' for pre-ADA plans, make plain congressional intent that the Betts approach *not be applied* in the context of the ADA."[211]

Therefore, the Seventh Circuit's holding that Title V's safe harbor provision does not determine that the contents of insurance policies are covered under Title III conflicts with the rationale behind the inclusion of the provision within the Act, the legislative history of the provision and the administrative guidelines issued by the Justice Department and the EEOC.

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206. Engel, *supra* note 192, at 240.

207. Ford v. Schering-Plough Corp., 145 F.3d 601, 614-15 (3d Cir. 1998); Krauel v. Iowa Methodist Med. Ctr., 95 F.3d 674, 678-79 (8th Cir. 1996); Modderno v. King, 82 F.3d 1059, 1063-65 (D.C. Cir. 1996).

208. Public Employees Ret. Sys. of Ohio v. Betts, 492 U.S. 158 (1989).

209. *Id.* at 181-82.

210. EEOC Guidance § III.B. n.10.

211. *Id.* (emphasis added).

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C. *Is the Distinction Between Content and Access Illusory: Should the Court's Analogies Based on Non-Insurance Products Control the Outcome of the Case?*

In *Doe*, Judge Posner highlights various analogies (including cameras, braille books, and wheelchairs) to show that Congress never intended the ADA to apply to the content of goods and services.[212] Pursuant to the following discussion, insurance is a unique product, given the amorphous nature of the item, the lack of available alternatives, and its heavy regulation, which can be differentiated from the other types of goods and services listed by Judge Posner. Therefore, his use of analogies illustrating requirements for sellers to modify their inventory to make their products equally valuable to disabled customers remains unpersuasive. It is still possible for the ADA to regulate insurance caps without reaching the situations presented by Judge Posner; therefore, his "slippery slope" argument is without merit.

In concluding that the meaning of Title III is "a matter of interpretation rather than compelled by a simple reading,"[213] Judge Posner offers cases and hypotheticals that fall on either side of the line. According to Judge Posner, the examples either violate or comply with the anti-discrimination provisions of the ADA's Title III.[214] However, the examples do not provide a reasonable basis for comparison purposes. The hypotheticals do not provide relevant analogies to a case where an insurer *deliberately* places an exclusionary provision in an insurance policy to cap coverage for AIDS-related treatment.

For example, the fact that a camera store clearly violates Title III of the ADA by refusing to let in or sell its cameras to disabled customers[215] has nothing to do with underwriting life insurance policies. Likewise, the examples of a bookstore that refuses to sell braille books to the blind[216] or a furniture store that refuses to sell wheelchairs to the disabled[217] are not useful comparisons. In those instances the retailers would presumably not be required to comply with these requests since the alterations would

212. Doe v. Mut. of Omaha Ins. Co., 179 F.3d 557, 559-60 (7th Cir. 1999).
213. *Id.* at 560.
214. *See supra* text accompanying notes 91-94.
215. *Doe*, 179 F.3d at 559.
216. *Id.* at 560.
217. *Id.*

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substantially alter their normal inventory composition. In addition, the bookstore and furniture store analogies can be distinguished since the braille books and wheelchairs are not provided to anyone in the store regardless of whether they have a disability. However, coverage for AIDS-related complications, such as pneumonia, are routinely provided to people without the disabling condition while coverage is denied to HIV patients based solely on their disability.

Another fundamental reason why the camera, wheelchair, and braille book analogies are so far off the mark is that these are essentially specialty goods that can be purchased elsewhere. Accordingly, there are special medical supply stores that carry a full range of wheelchairs so that an individual would not depend on a regular furniture store to stock the specialty item. Similarly, braille books can be purchased in specialty stores or even over the Internet with a modicum of effort. However, where does an individual with HIV or AIDS go to purchase a health insurance policy? There are no other alternatives because the individual is essentially uninsurable.[218] Once the individual's personal assets are depleted, the government usually takes over the burden of financing their medical costs, thereby documenting the trend toward the "medicaidization" of AIDS.[219]

Another problem associated with the use of these analogies is that the specific good (i.e. the book in the case of the bookstore example) is clearly defined, whereas an insurance policy is an amorphous item. If a bookstore were deemed to sell *information* instead of books, then in order to provide *access* to the information, the store would presumably need to stock and

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218. Alan I. Widiss, *To Insure or Not to Insure Persons Infected with the Virus that Causes AIDS*, 77 IOWA L. REV. 1617, 1719-20 (1992). While this assessment of uninsurability is usually correct, it is not true in all circumstances. Theoretically, anything or anyone should be insurable when there are no constraints as to the cost of adequate coverage. "Accordingly, statements about 'uninsurability' and 'insurability' are more accurate -- though not necessarily fully descriptive of what happens when someone applies for insurance -- if they are framed in terms of access to insurance as standard risks." *Id.* at 1720.

219. Nancy R. Mansfield, *Evolving Limitations on Coverage for AIDS: Implications for Health Insurers and Employers under the ADA and ERISA*, 35 TORT & INS. L.J. 117, 134 (1999). "Medicaid finances a much larger proportion of inpatient care for AIDS patients than for patients with other illnesses. Longer survival times for HIV-positive individuals will increasingly burden the public welfare system if insurance is not available." *Id.* (footnote omitted).

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sell braille books.[220] As the First Circuit noted in *Carparts*, "there may be areas in which a sharp distinction between these two concepts [of access and content] is illusory."[221] The practical effect of capping the insurance policy is to *deny* the plaintiffs' coverage under the policy after they reach their limits. However, since the plaintiffs intend to save their limited coverage for the time when they are unable to work and have depleted their personal resources, they are not even utilizing the limited coverage that they are entitled to under the policies.[222]

Thus, in the case of a bookstore, the line is apparently drawn between refusing to sell the disabled specialty products (not a violation since that "would fundamentally alter the nature of such goods"[223]) versus refusing to let the disabled in the door or once inside refusing to sell them available products (clearly a violation of the ADA). In the insurance context, there is no bright-line test available. Is there really an effective difference between the refusal to provide coverage versus the denial of benefit payments? Judge Posner held that the refusal to sell an insurance policy to a person with AIDS is clearly a violation of Title III. However, he distinguishes that situation from the case at bar since Mutual "was happy to sell health insurance policies" to people with AIDS.[224] The insurer was willing to sell the insurance product to people with AIDS, since it was not

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220. James Nathan Spolar, *I Hear Ya' Knockin', So You Can Come In: The Americans With Disabilities Act Limited to Physical Structures and Individualized Discrimination Under* Parker v. Metropolitan Life Insurance Co., 24 J. CORP. L. 105, 118 (1998).

221. Carparts Distrib. Ctr., Inc. v. Auto. Wholesaler's Ass'n, 37 F.3d 12, 19 (1st Cir. 1994).

222. Brief of Plaintiffs-Appellees at 5-6, Doe v. Mut. of Omaha Ins. Co., 179 F.3d 557 (7th Cir. 1999) (No. 98-4112).

223. 42 U.S.C. § 12182(b)(2)(A)(ii) (1994).

224. Doe v. Mut. of Omaha Ins. Co., 179 F.3d 557, 559 (7th Cir. 1999). *But see* Brief of Plaintiffs-Appellees at 39, *Doe* (No. 98-4112) (contradicting this distinction as illusory).

> Mutual argues that because it provides the same discriminatory policy to all insureds, it has fulfilled Title III's mandate of equal treatment and is not discriminating by providing disparate coverage based on HIV or AIDS. Mutual Br. at 43-44. This is like arguing that a race-based restrictive covenant in a property deed is not discriminatory because all deeds have them. Even if the record established that the same discriminatory terms (*i.e.*, the AIDS Caps) exist in every insured's policy, only those insureds with HIV or AIDS will ever be subject to them.

Id.

at substantial risk (up to the policy limits) for the medical costs associated with the disease. In addition, the insurer was unable to provide the plaintiffs with an advanced list of conditions that it would consider AIDS-related.[225] This gave the insurer complete power to make up the rules as they went along. Judge Posner concluded that the inclusion of policy caps did not make the offer to sell illusory since people with AIDS have medical needs that are unrelated to AIDS.[226] However, since the terms of what is covered is either essentially left open under the discretion of the insurer or determined merely by reference to the disability, in reality very little medical coverage would be deemed non AIDS-related. For example, the insurer admitted that a case of pneumonia would be covered for a person without HIV or AIDS but would be deemed AIDS-related for individuals with AIDS.[227] What about a broken leg – would the insurer deem the condition to be non AIDS-related and pay the full claim? Alternatively, would the presence of the disease require the doctor to perform additional procedures or would the healing process take longer or would there be a greater risk of additional complications which would incur additional medical expenses? Exactly how much the insurer would cover is entirely unclear.

Another example provided as guidance by Judge Posner as a *clear* violation of the ADA is *Bragdon v. Abbott*.[228] Judge Posner affirms that "a dentist cannot refuse to fill a cavity of a person with AIDS unless he demonstrates a direct threat to safety or health."[229] However, in *Bragdon*, the case involved a local dentist who refused to perform the procedure in his office but *offered to perform* the service in a hospital, effectively raising the cost of the medical procedure to the disabled individual.[230] Essentially, the dentist was willing to provide a service that was *unequal* to the one provided to the non-disabled patient, based solely on her disability. The dentist's decision was based on his subjective fear of contagion, not on the objective evaluation of the risk involved based on the latest

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225. Declaration of John Doe at 5, Doe v. Mut. of Omaha Ins. Co., 999 F. Supp. 1188 (N.D. Ill. 1998) (No. 98 C 0325). "I have asked Mutual of Omaha to tell me exactly what expenses will be counted against my lifetime maximum. Mutual of Omaha has told me that I must submit my claims before they will advise me of their determination." *Id.*

226. *Doe*, 179 F.3d at 559.

227. *Id.* at 560.

228. 524 U.S. 624 (1998).

229. *Doe*, 179 F.3d at 559.

230. *Bragdon*, 524 U.S. at 628-29.

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information available to the medical community.[231] Accordingly, there are similarities to the instant case, where the plaintiffs were offered different treatment based solely on their disability, which was not based on sound actuarial principles. Therefore the line between the outright denial of medical services versus providing modified services is not as clear-cut as the Seventh Circuit implies.

Based on these analogies, Judge Posner concludes that common sense dictates that the contents of goods and services offered by public accommodations are not regulated.[232] Judge Posner surmises that if this were the intent of the statute, it would impose such a tremendous burden on the entire retail sector of the economy that Congress would have imposed detailed standards for the federal courts to review.[233] Judge Posner determined that the only available defense to sellers would be the "fundamental alteration" defense that negates the conduct of the seller if the modification "would fundamentally alter the nature of . . . [the seller's] services."[234] Judge Posner refused to acknowledge that an insurance contract is different from the goods in his other analogies by stating, the fact "[t]hat the plaintiffs are asking that a limitation be removed rather than that a physical product be added or altered cannot distinguish these cases."[235] However, an insurance contract is a unique service product due to the lack of available alternatives as well as the tremendous amount of regulation associated with the product. If the insurance industry "bails out" on providing decent coverage for individuals with HIV and AIDS, the only alternate insurer is the government. The use of these analogies deflects attention from the insurance industry to other sectors of the economy that are not remotely implicated in this case.

As an example, a bank loan serves as a commodity more analogous to an insurance policy. First, a "bank" like an "insurance office" is considered a private entity that operates a place of public accommodation under the service entity subcategory in Title III.[236] Also, individuals conduct some percentage of their business with the bank remotely, similar to conducting insurance business. The government heavily regulates the

231. *Id.* at 649-50.
232. *Doe*, 179 F.3d at 560.
233. *Id.*
234. *Id.* (quoting 42 U.S.C. § 12182(b)(2)(A)(ii)).
235. *Id.*
236. *See* 42 U.S.C. § 12181(7)(F) (1994).

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banking industry, like insurance, and the credit approval process has significant similarities to the insurance underwriting process.

In the case of an insurance policy and a bank loan, the underwriter or the loan officer measures risk versus return in deciding whether to issue the policy or the loan and uses this analysis to determine the appropriate price and terms to include in the agreement. In order to determine whether to enter into a contractual relationship, the underwriter or loan officer gathers relevant information from the prospective client. In the case of the insurance underwriter, relevant information includes age, occupation, medical history, *HIV or AIDS status*, etc. The loan officer performing an assessment of credit risk examines relevant information including age, occupation, past credit history, financial assets and liabilities, future cash flow, etc. The insurance underwriter considers HIV or AIDS status as critical information in the risk assessment and selection process. What if the loan officer could consider HIV or AIDS status as important information in determining an assessment of credit risk? Surely it is more risky to lend money to an individual with a terminal illness, who may not be able to work in the future and may not be able to repay the loan. Should the loan officer be able to *deny* the individual's loan application? Or should the loan officer be able to *vary the terms and conditions* of the loan to reduce risk by charging the customer a higher interest rate or by limiting the repayment terms to five years for an HIV-infected person or three years for an AIDS-infected individual? In the bank loan analogy, the same types of issues regarding access and content are implicated. If the loan terms are unfavorable (the interest rate is set too high or the loan term is too short), the resulting product will not be useful to the consumer and the disabled individual will effectively be denied access to the loan. If all the banks or lenders employ similar credit criteria, then the individual will be unable to borrow money.

In this analogy, the courts would be called upon to evaluate the intent of the anti-discrimination provisions of the ADA in the same manner as the case at bar, subject to applicable federal and state banking laws. By ruling that the ADA does not regulate the contents of goods and services, the Seventh Circuit has determined the future course of action for other sectors of the retail economy with potentially devastating results.

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D. Does the McCarran-Ferguson Act Render the ADA's Anti-Discrimination Provisions Ineffective or Does the ADA Directly Relate to the Business of Insurance?

The McCarran-Ferguson Act provides that "[n]o act of Congress shall be construed to invalidate, impair, or supercede any law enacted by any State for the purpose of regulating the business of insurance ... unless such [federal] Act specifically relates to the business of insurance."[237] Under the Act, a federal statute that does not specifically relate to the business of insurance must defer to the insurance regulations imposed by individual states. Understandably, ambiguity attaches to the interpretation of the Act regarding the nature and amount of insurance references that must be present in the ADA for this state preemption statute to prevail. Since the only concrete references to insurance in the ADA appear in Title III, which lists an "insurance office" as a type of public accommodation, and the safe harbor provision in Title V, courts have disagreed over whether the ADA relates sufficiently to the business of insurance to take priority over the McCarran-Ferguson Act.

In *Doe*, Judge Posner rejected the plaintiffs' discrimination claim by concluding that even if the court was incorrect in its analysis of Title III, "the suit must fail anyway, because it is barred by the McCarran-Ferguson Act."[238] Therefore, the Seventh Circuit concluded not only that the federal courts were ill-equipped to determine whether coverage limitations were actuarially sound and consistent with state law, but also that this type of action by the federal courts would interfere with the administration of state law.[239] Relying on the ruling in *Humana Inc. v. Forsyth*, where the Supreme Court stated "[w]hen federal law does not directly conflict with state regulation, and when application of the federal law would not frustrate any declared state policy or interfere with a State's administrative regime, the McCarran-Ferguson Act does not preclude its application[,]"[240] Judge Posner held that the prohibition is triggered if the ADA's interpretation would interfere with the state's insurance regime.

The Second Circuit arrived at the opposite conclusion, namely that the ADA specifically relates to the business of insurance and therefore falls

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237. 15 U.S.C. § 1012(b) (1994).
238. *Doe*, 179 F.3d at 563.
239. *Id.* at 564.
240. Humana Inc. v. Forsyth, 525 U.S. 299, 310 (1999).

outside the prohibition.[241] In reaching this conclusion, the Second Circuit applied the four-step analysis established by the Supreme Court in *Barnett Bank v. Nelson*.[242] The Second Circuit highlighted the fact that neither the Act's language nor purpose requires the federal statute to pertain predominantly to insurance, rather specific detailed references to the insurance industry will be sufficient to call the proposed legislation to the attention of interested parties.[243]

First, the Second Circuit found that the ADA relates to the insurance business since Title III defines an insurance office as a place of public accommodation and Title V, labeled "Insurance," subjects insurance underwriting to the regulatory scope of the ADA under certain circumstances.[244] Second, the court noted that the same provisions, which are explicit and direct in their references to insurance, satisfy step two by demonstrating that the Act specifically relates to insurance.[245] Third, the court determined that the ADA regulates the business of insurance, since it affects matters that go to the core of the Act's concerns, namely the relation between the insured and the insurer and the allocation of risk.[246] Congress contemplated that under certain circumstances, Titles I and III would apply to underwriting practices.[247] Finally, the Second Circuit held

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241. Pallozzi v. Allstate Life Ins. Co., 198 F.3d 28, 34 (2d Cir. 1999).

242. 517 U.S. 25 (1996) (where a unanimous Supreme Court held that the federal statute granting permission to certain national banks to sell insurance in small towns specifically relates to the business of insurance). The Court used the following four-step analysis:

1) Whether the statute relates to the insurance business – whether it has a connection with insurance plans;
2) Whether the statute specifically relates to the insurance business – either explicitly, particularly, or definitely;
3) Whether the statute specifically relates to the business of insurance – whether it affects matters at the core of the Act's concern, such as the relation of insured to insurer and the spreading of risk; and
4) Consideration of the federal statute in light of the Act's purposes – emphasizing that the Act serves to protect state insurance regulation primarily against inadvertent federal intrusion.

See Pallozzi, 198 F.3d at 34 (citing Barnett Bank of Marion County v. Nelson, 517 U.S. 25, 38-39 (1996)).

243. *Pallozzi*, 198 F.3d at 34-35.

244. *Id.* at 34.

245. *Id.*

246. *Id.*

247. *Id.* at 34-35.

that due to the specific references to insurance in Titles III and V, any intrusion by the ADA on state insurance regulation was not inadvertent.[248] Accordingly, the references to insurance in the Act were sufficient to attract the attention of interested parties prior to enactment of the ADA, guaranteeing that Congress focused on the insurance-related effects of its implementation.[249] Based on the application of the four-step analysis, the Second Circuit concluded that the McCarran-Ferguson Act did not bar application of Title III to insurance underwriting.[250] The Second Circuit stated their belief that "the safe harbor provision of Section 501(c) was written by Congress with McCarran-Ferguson in mind, precisely to communicate that message."[251]

Alternatively, the Seventh Circuit reached the conclusion that the ADA does not specifically relate to the business of insurance. The court's analysis appeared to be influenced by a broader policy argument made by the Third Circuit in *Ford v. Schering-Plough Corp.*,[252] where the court declined to be elevated to the "position of a super-actuary," or to "become a watchdog of the insurance business."[253] However, this narrow position ignores the intent of Congress to place minimum standards on insurers through the ADA's anti-discrimination provisions, subject to the clarification provided in the safe harbor provision. Congress clearly stated that the safe harbor provision could not be used as a subterfuge to evade the purposes of Titles I and III. This serves to place a burden on the federal courts to ensure that the insurance industry complies with the anti-discrimination provisions as set forth under Title III.

CONCLUSION

According to the Seventh Circuit in *Doe v. Mutual of Omaha Insurance Co.*, the inclusion of caps limiting coverage for AIDS-related treatment in health insurance policies sold directly by the insurer to the insured does not violate the anti-discrimination provisions of the ADA. Judge Posner did determine, however, that the insurer cannot deny the

248. *Id.* at 35.
249. *Id.*
250. *Id.*
251. *Id.*
252. 145 F.3d 601 (3d Cir. 1998).
253. *Id.* at 612.

insured access to health insurance by refusing to sell an insurance policy to an individual with HIV or AIDS. In reality, however, the impact on disabled individuals seeking to derive benefits from their insurance policies is essentially the same, since the capping of benefits for AIDS-related treatment effectively denies disabled individuals the benefit of adequate health care coverage after the caps have been reached. The Seventh Circuit missed an opportunity to follow several district court opinions and become the first federal circuit court to declare that the contents of insurance policies are subject to the anti-discrimination provisions of the ADA's Title III.[254] In reaching its decision, the court misinterpreted the plain meaning of the statute, its legislative history, and the regulations and interpretive guidance issued by the Department of Justice and the EEOC. Unfortunately, the overarching goal of the ADA "to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities"[255] was clearly overlooked, since the decision allows insurers to set caps for AIDS-related treatment without requiring that the limitation be premised on actuarial or experience based justifications.

In addition, the decision has severe implications for other sectors of the retail economy, since the court has sanctioned the use of discrimination-based criteria to provide inferior goods and services to disabled individuals. As long as the retailers can show that the disabled have equal access to the items, the sellers are given carte blanche authority to vary the terms and conditions of the products and services. Since the

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254. After the decision in *Doe v. Mutual of Omaha*, the Fifth and Ninth Circuits joined the Sixth and Third Circuits, rejecting the argument that Title III of the ADA regulates the content of insurance policies. McNeil v. Time Ins. Co., 205 F.3d 179 (5th Cir. 2000) (holding that Title III does not regulate the content of goods and services offered by public accommodations). The court in *McNeil* stated that: "if we construe Title III to regulate the content of goods and services, there seem to be no statutory boundaries. Based on the language of the statute, we simply see no non-arbitrary way to distinguish regulating the content of some goods from regulating the content of all goods." *Id.* at 187. *See also* Weyer v. Twentieth Century Fox Film Corp., 198 F.3d 1104 (9th Cir. 2000) (holding "that Title III does not address the terms of the policies that [the insurer] sells."). *Id.* at 1115. *But see* Pallozzi, 198 F.3d at 33-35 (interpreting Title III as properly regulating insurance underwriting practices. However, the Second Circuit's holding was limited to the facts of the case, where a *refusal to sell* life insurance policies to an individual with a mental disorder was held to be a violation of Title III).

255. 42 U.S.C. § 12101(b)(1) (1994).

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Supreme Court has denied the plaintiffs' petition for a writ of certiorari,[256] it is up to Congress or another circuit to revisit the issue and to give proper effect to the meaning of the statute.

256. Doe v. Mut. of Omaha Ins. Co., 528 U.S. 1106 (2000).

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FROM THE JOURNALS: INSURANCE LAW ABSTRACTS

*Edited by Jeffrey Thomas**

AUTOMOBILE INSURANCE

Timothy D. Kuo, Note, *Marcus v. Hanover Insurance Co.: The Louisiana Supreme Court Invalidates the "Business Use" Exclusion to Compulsory Automobile Liability Insurance Laws*, 74 TUL. L. REV. 1579 (2000).

This Note explores the impact of the Louisiana Appellate Court's decision in *Marcus v. Hanover Insurance Co.*, which held that the business use exclusion violated public policy when applied to the driver of an insured vehicle in the course of employment. The author contends that, though the decision is not unreasonable, there is nothing in the holding that fully justifies the decision as a matter of public policy. The author surveys the conflict amongst the circuits in Louisiana and examines the detrimental effects that may occur when the exclusion is invalidated, such as the court's disregard for freedom of contract and highly probable rate increases by all insurance carriers.

Michael V. Cory & Lanny R. Pace, *Mississippi Uninsured Motorist Law -- Where Do We Go From Here?*, 69 MISS. L.J. 455 (1999)

This Article attempts to clarify Mississippi uninsured motorist law. The author contends that the confusing state of the law has resulted from the Mississippi Supreme Court's interpretation of the uninsured motorist statute in favor of coverage for insureds. However, in reaching these pro-insured results, the author stresses that the court intrudes on the province of the legislature, erodes the right to contract, and causes insurers to raise premiums to cover their increased liability exposure resulting from these

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decisions. The author attempts to resolve these difficulties in the law by providing a guide for practitioners when faced with common uninsured motorist issues.

John R. Nicholson, Note, *Mahler v. Szucs: An Impediment to Interinsurer Arbitration and Affordable Personal Injury Protection Coverage*, 23 SEATTLE U. L. REV. 213 (1999).

This Note explores the decision of the Washington Supreme Court in *Mahler v. Szuchs* and *Fisher v. Aldi Tire, Inc.* in which the court held that when an individual obtains payments from a personal injury protection insurer and later retains an independent attorney to litigate claims not covered by the PIP policy (e.g., pain and suffering), the insurer is required to pay reasonable attorneys' fees if the insured's attorney recovers its PIP interest from the liability insurer. This duty is imposed even when the insured's attorney collects the insurer's interest against its express will, such as when the insurer has an interinsurer arbitration agreement with the liability insurer to settle claims efficiently without resorting to litigation.

Nicholson argues that not only does the Washington Supreme Court's decision run counter to well-settled precedent at the state supreme court and appellate court levels, but will also promote inefficiency by precluding insurers from selecting the best means of recovering their PIP interests, which may very well be through interinsurer arbitration agreements. Additionally, the author contends that the decision will create an oppressive burden on the general public, who will have to subsidize this recovery of attorneys' fees against insurers by paying higher insurance premiums.

EMPLOYMENT

Steven D. Baderian et al., *Managing Employment Risks in Light of the New Rulings in Sexual Harassment Law*, 21 W. NEW ENG. L. REV. 343 (1999).

This Article discusses United States Supreme Court sexual harassment case law, placing particular emphasis on the Court's recent sexual harassment decisions, *Burlington Industries, Inc v. Ellerth* and *Faraghter*

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v. City of Boca Raton. The authors explain the test for imposing liability on employers under *Ellerth* and *Faraghter.* From these recent decisions and earlier Supreme Court case law, the authors outline steps that employers should take in order to reduce the potential for sexual harassment liability.

Francis Mootz III, *Insuring Employer Liability For Hostile Work Environment Claims: How Changes in Discrimination Law May Affect the Growing Market For Employment-Related Practices Liability Insurance,* 21 W. NEW. ENG. L. REV. 369 (1999).

The Article explores some of the difficulties faced by Employment Practice Liability Insurance (EPL) providers due to the changing nature of employment law and the confusion surrounding the defense of a hostile work environment. The author demonstrates that liability for hostile work environment harassment is grounded in negligence principles, and because of this, employers may have coverage under their General Liability Policies for employment discrimination. Due to the potential overlap in coverage, conflicts arise concerning which policies are primary and which are secondary. Despite this difficulty in predicting coverage, the author concludes that insurers will have to bear the uncertain risk of liability due to hostile environment claims because coverage cannot be avoided under the public policy defense.

ENVIRONMENTAL

Liberty F. Cagange, Note, *The "Sudden" Interpretation:* Northville Industries Corp. v. Union Fire Insurance Co. of Pittsburgh, 16 PACE L. REV. 285 (1999).

This Note examines the interpretation of the term "sudden," in pollution exclusionary clauses of standard Comprehensive General Liability policies by the New York Court of Appeals in *Northville Industries Corp. v. Union Fire.* The pollution exclusion denies coverage resulting from the release, discharge, dispersal or escape of pollutants. An exception applies, however, when the release, discharge, dispersal or escape is "sudden and accidental."

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Cagange argues that the court's definition of "sudden" offers little guidance, though the court correctly ruled that Northville failed to meet its burden of proving that the discharge was "sudden and accidental." Cagange contends a regulatory estoppel theory would be superior to relying on the pollution exclusion for future environmental litigation regarding the same issue.

Evan M. Goldenberg, *The Scope of Insurance Coverage for Pollution Claims in Florida: Full Indemnification for Indivisible Cleanup Costs Caused by Multiple Releases*, 24 NOVA L. REV. 373 (1999).

This Article explores the scope of insurance coverage for pollution suits under Florida law. Goldenberg analyzes "occurrence-based" liability insurance policies, the "pollution exclusion" clauses, and the problem of multiple occurrences. He argues that although pollution exclusion clauses have been narrowly interpreted by the Florida Supreme Court, Florida's lower courts have implied that there exists a temporal limitation to the term "occurrence," that may allow insurers to receive full indemnification for pollution costs where more than one episode of pollution has caused contamination, as is often the case in a suit for pollution contamination. Goldenberg maintains that because the Florida Supreme Court has not ruled on the issue of indemnification for indivisible and multiple cleanup costs, there is a possibility that these costs may be fully indemnified.

Rebecca M. Bratspies, *Splitting the Baby: Apportioning Environmental Liability Among Triggered Insurance Polices*, BYU L. Rev. 1215 (1999)

This Article examines the allocation of insurance coverage for claims brought under the Comprehensive Environmental Responsibility, Compensation and Liability Act (CERCLA), which imposes retroactive strict liability that requires private-sector Potentially Responsible Parties (PRPs) to finance the cleanup of polluted areas. PRPs seek coverage under their Comprehensive General Liability (CGL) policies.

Bratspies examines the history of insurance coverage for environmental injuries, and concludes that a continuous trigger has the effect of maximizing coverage and better reflects the parties' intent. She maintains that courts generally either ground the allocation within the

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horizontal long-tail timeline from the beginning, or treat the long-tail injury as though it occurred entirely within one insurance period. She identifies two forms of horizontal allocation: "Straight-horizontal allocation," which assigns shares of liability on a pro rata basis to all triggered insurance policies, and "weighted-horizontal allocation," which attempts to weight the allocated shares to reflect changing perceptions of risk over time. Bratspies also identifies two forms of vertical allocation: "serial-vertical allocation," which makes insurers jointly and severally liable up to their respective policy limits, and "single-vertical allocation," which limits a policyholder's recovery to the policy limits within one single policy period. Bratspies argues that the strengths of the single-vertical allocation far outweigh its weakness, while the opposite is true of horizontal allocation and of serial-vertical allocation.

Bratspies also examines secondary apportionment used to equitably spread shares of liability to all the triggered policies. For horizontal apportionment, she argues in favor of so-called fill-the-glass secondary apportionment, which requires the primary insurers pay first until primary coverage is exhausted, and then secondary insurers pay until exhausted, and so on up the coverage ladder within each policy period. In vertical allocation, Bratspies considers two methods: policy limits (where shares of liability based on a ratio of each triggered policy limit to the total limits of all the triggered policy) and time-on-the-risk apportionment (where the insurance policies are exhausted vertically-primary, then first-level excess, and so on up the coverage ladder). Bratspies argues that single-vertical allocation followed by time-on-the-risk secondary apportionment promises consistent and equitable result. In horizontal jurisdictions, weighted-primary allocation followed by fill-the-glass secondary apportionment is more reasonable.

Stephanie M. Tita, Note, *And the Wallpaper Comes Crumbling Down: Pollution Exclusion Clause Relieves Insurer of Duty to Defend in Stamford Wallpaper Co. v. TIG Insurance,* 10 VILL. ENVTL. L.J. 517 (1999).

This Note discusses the Second Circuit Court of Appeals interpretation of the insurer's duty to defend its insured for environmental damage claims under the Comprehensive Environmental Response, Compensation and Liability Act of 1980 (CERCLA). The court held that the insurer had no duty to defend the insured because the insured's pollution-related

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activities fell outside the scope of coverage of the Comprehensive General Liability insurance policy. Tita criticizes the court for not providing definitive steps in its duty to defend analysis. As a result, she contends that future litigants will have difficulty in determining whether there is a duty to defend.

Douglas Curran & Richard Green, *Getting Your Liability Insurance Carriers to Honor Their Defense and Indemnification Obligations for Municipal Claims*, 29 STETSON L. REV. 613 (2000).

This Article advises cities and municipalities about obtaining defense and indemnity from insurance carriers for environmental suits. The authors begin by outlining a series of possible defenses insurance companies raise to avoid coverage, and then articulate responses to these defenses. Each of the various defenses and their corresponding responses are then explored in an examination of a case study of Overland Park, Kansas, which obtained a million dollars from its insurers even though the insurers initially refused to defend and indemnify the city.

Janet E. Bender, Note, *Foster-Gardner, Inc. v. National Union Fire Insurance Co.: No Duty to Defend CERCLA Environmental Protection Agency Administrative Proceedings Under the Comprehensive General Liability Policy in California*, 30 MCGEORGE L. REV. 1461 (1999).

This Note examines the California Supreme Court's decision in *Foster-Gardner, Inc. v. National Union Fire Insurance Co.* in which the court determined that the duty to defend under a Commercial General Liability (CGL) insurance policy is not triggered by administrative proceedings brought by the EPA or its state equivalent. The author examines the split in authority as to the meaning of the word "suit" and advocates a "functional equivalent approach" as opposed to the "literal meaning approach" adopted by the California Supreme Court. The author analyzes the arguments made by each side of the *Foster-Gardner* case, discusses the ramifications, and concludes that California would be better served by adopting the "functional equivalent approach".

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HEALTH INSURANCE

Jonathan Andrew Hein, *Caring for the Evolving American Family: Cohabitating Partners and Employer Sponsored Health Care,* 30 N.M. L. REV. 19 (2000).

This Article outlines the need for employer sponsored health care benefits and examines the various corporate-sponsored benefit plans available for domestic partnerships. Hein maintains that such benefit programs enable employers to attract and retain the most qualified workers while providing a significant means of reducing the economic burden presented by the uninsured. In addition, Hein analyzes domestic partnership codes enacted in some municipalities, with a focus on the San Francisco model. This model requires city contractors to provide health care insurance to an employee's traditional and non-traditional family members. Hein concludes that non-traditional families are no longer atypical, and that economic realities and principles of equity should result in employers noting the change in familial structure in their health insurance plans.

Eugene C. Grochowski, *Ethical Issues In Managed Care: Can The Traditional Physician-Patient Relationship Be Preserved In The Era of Managed Care Or Should It Be Replaced By A Group Ethic?*, 32 U. MICH. J.L. REFORM 619 (1999).

This Article examines the conflicts associated with rationing health care and its effects on the traditional physician-patient relationship. While managed care has become the dominant form of health care delivery, it has created serious conflicts because managed care organizations (MCOs) create incentives for physicians to spend less, causing the physician's duty to shift from a single patient to a group of patients within the MCO. Grochowski argues that this violates the ethic of "patients first" and threatens the integrity of the traditional physician-patient relationship.

Although Grochowski recognizes that rationing health care is necessary, he contends that MCOs do not ration properly. The current model, where individual spending decisions are made at the bedside (bedside rationing) is more efficient but violates the traditional physician-patient relationship. Because physicians owe their patients a duty of trust,

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engaging in bedside rationing encourages physicians to spend less money on their patients and prevents full disclosure to patients regarding the financial incentives provided to physicians. Grochowski argues that macro-level plans are preferable, where spending decisions apply to all patients and are a more effective means of rationing new technology and controlling the steep rate of growth of health care expenditures.

Peter J. Hammer, *Questioning Traditional Antitrust Presumptions: Price and Non-Price Competition In Hospital Markets*, 32 U. MICH. J.L. REFORM 727 (1999).

This Article analyzes hospital competition and the claims that hospital mergers reduce costs and lower prices. Hammer provides a historical framework and outlines the radical transformations taking place in the health industry. He distinguishes between the old regime, where hospitals compete almost exclusively along non-price dimensions, and the emerging regime, where there is greater price-based competition. He asserts that problems develop when courts and enforcement agencies base decisions on economic theories and policy assumptions based on the old regime model.

Hammer argues that courts have applied a limited economic analysis when hospitals fall under the Old Regime and that they must develop a better analytic framework for assessing the total welfare effects of merger. Attention should focus on the impact of mergers and economic concentration on non-price competition, and ultimately upon the social value of the resulting non-price attributes.

William M. Sage, *Regulating Through Information: Disclosure Laws and American Healthcare*, 99 COLUM. L. REV. 1701 (1999).

This Article analyzes mandatory disclosure laws in the context of the American health care system. The author asserts that mandatory disclosure has great potential, but that important operational difficulties and non-optimum uses of information have limited the benefits of mandatory disclosure. Sage identifies and critiques four rationales for mandatory disclosure: 1) the "competitive rationale" that disclosure can promote competitive provision of health insurance and medical care, improving transactional and allocative efficiency; 2) the "agency rationale"

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that disclosure can strengthen agency relationships and enforce fiduciary obligations involving both individual health professionals and collective organizations; 3) the "performance rationale" that disclosure can overcome the problem of incomplete information and can improve the performance of the healthcare system; and 4) the "democratic rationale" that disclosure can increase public awareness and political accountability.

Sage discovers that conflicts arise when attempting to achieve all four goals simultaneously. The competition rationale is useful if directed at group purchasers and other information intermediaries as opposed to individual consumers. However, this increases the need to vigorously pursue the agency rationale by more clearly defining and safeguarding agency relationships. The author notes that the performance rationale has the greatest potential to generate significant changes in the health care system. However, the premise underlying this rationale -- that the health care system needs improvement - runs counter to the idea upon which the other rationales are based -- that people are being denied access to a properly functioning system. Finally, in order to further the democratic rationale for disclosure, government agendas and processes must be prevented from tainting disclosed information. Sage concludes that disclosure laws need to be more cohesive, and should focus on market discipline, professional values, and social imperatives.

Mark A. Hall, *Legal Rules And Industry Norms: The Impact Of Laws Restricting Health Insurers' Use Of Genetic Information*, 40 JURIMETRICS J. 93 (1999).

This Article discusses legislation designed to prevent genetic discrimination in health insurance. Hall selects seven states from which to interview representatives from the Department of Insurance, major health insurance providers, genetics clinics, and insurance agents. Genetics clinics are split over whether insurance discrimination based on genetic information has occurred. On the provider side, the author found that the insurance regulators were generally frustrated that they had to spend exorbitant amounts of money to stop something that was not truly happening in the first place. This frustration seemed justified as Hall reported that the agents could not recall any incidents of insurers using genetic information in underwriting practices. However, when asked if they would make use of genetic information that indicated high risk, some

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health insurers responded affirmatively to Hall while others were not sure the information would be relevant given the short-term nature of the business.

The author identifies two potential harms of banning the use of genetic information: adverse selection and preventing individuals with favorable genetic results from proving they are not a risk. Hall concludes that while one could criticize laws banning the use of genetic information for solving a non-existent problem, they should be applauded for codifying a social and moral judgment that these practices are wrong.

Robert H. Jerry, II, *Health Insurers' Use Of Genetic Information: A Missouri Perspective On A Changing Regulatory Landscape*, 64 MO. L. REV. 759 (1999).

This Article discusses a Missouri law passed in 1998 restricting the use of genetic information in health insurance underwriting. Jerry explains how this new law is one addition in an existing broader federal and state framework. On the federal side, he discusses the scope and shortcomings of both the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Americans with Disabilities Act (ADA). On the state side, he gives a survey of the developments and differences in other parts of the country. While Jerry admits that Missouri's new law is not perfect, he feels that Missouri, the federal government, and other states have made an important symbolic gesture by opposing genetic discrimination.

Mark Hall, *The Competitive Impact of Small Group Health Insurance Reform Laws*, 32 U. MICH J.L. REFORM 661 (1999).

This Article considers the effects of several states' small group health insurance reform laws. The author concludes that the health insurance reform laws have not hurt overall competition, although they may have driven some small companies from the market and may have hurt competition in some sparsely populated areas. Hall concludes that the objective of the reforms has largely been unrealized, and suggests that insurance carriers have found ways to circumvent the reforms to continue some forms of risk selection.

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David A. Hyman, *Accountable Managed Care: Should We be Careful What We Wish for?*, 32 U. MICH. J.L. REFORM 785 (1999)

This Article describes the common perception of an "accountability crisis" in managed care, and systematically considers the extent to which alternatives to the tort system have become widely accepted parts of the commercial landscape. Hyman argues that there are at least ten reasons why tort-based accountability is overrated. He also suggests that tort liability is not the only way to deliver accountability. Hyman compares managed care accountability to implied warranties of habitability, the bar admissions process, and shrink-wrap software licenses. He examines the costs and benefits of providing accountability through tort in those situations, and concludes that 'full' accountability may be needed to prevent force, fraud, and duress, but it does not follow that 'full' accountability is necessary or cost-effective, or that every bad outcome requires a regulatory response.

Steven A. Grenier, Comment, *The ERISA Shield Around HMOs Cannot be Justified*, 12 REGENT U. L. REV. 283 (1999-2000).

This Comment discusses ERISA's application to employee benefit plans and the resulting preemption of claims alleging liability for injuries caused by HMO decisions. The author discusses the purpose and goals behind HMOs and ERISA and details the application of ERISA to HMO liability through the U.S. Supreme Court's interpretation of ERISA's use of the words "relate to." The author next outlines a recent line of cases that do not find preemption by ERISA when the HMO steps out of its ERISA-governed duties and assumes the duty of a health care provider making decisions for patients based on medical criteria. He concludes that this trend may be gaining more acceptance among the courts, opening HMOs to suit for negligence when making health care determinations and argues that Congress did not likely intend that two people with identical claims would have different remedy for injuries simply because their insurance plan was or was not employer provided. The author urges courts to rely on the precedents set in the United States Courts of Appeal for the Third, Fourth, Seventh, and Tenth Circuits allowing claims against HMOs acting as health care providers and urges Congress to remedy the confusion arising out of ERISA.

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Peter D. Jacobson & Scott D. Pomfret, *Establishing New Legal Doctrine in Managed Care: A Model of Judicial Response to Industrial Change*, 32 U. MICH. J.L. REFORM 813 (1999).

This Article examines the legal and practical results of the health care industry's transformation from a fee-for-service basis to managed care. The authors argue that due to this change, the country is currently on new ground with respect to the issues of state or private regulation, as well as the extent of liability for a managed care organization sustains as a result of cost-containment measures.

After examining the way courts have initially mishandled litigation involving new industrial innovations and using this legal model as a springboard, the authors contend that current court decisions which shield HMO's from liability are not surprising. They analyze the legal mechanisms by which such shielding occurs, while focusing on the difficulties of ERISA and federal preemption. The authors then argue that a backlash is currently occurring in courts due to the dissatisfaction with health care. This backlash has pressured courts to apply with less frequency federal preemption thus holding HMO's to an increased accountability. It has further placed pressure on Congress to pass a Patients' Bill of Rights, giving injured plaintiffs the opportunity to sue HMO's directly.

William M. Sage & Peter J. Hammer, *Competing on Quality of Care: The Need To Develop a Competition Policy for Health Care Markets*, 32 U. MICH. J. L. REFORM 1069 (1999).

This Article considers problems with applying antitrust principles to health care markets as health care moves from a professionally dominated model to one operating under open market principles. The author expresses concern that as competition begins to inject itself into the health care market, quality of services will suffer as participants compete with each other to offer services at lower prices.

The authors attempt to outline a research agenda that will produce a policy designed to emphasize the maintenance of quality services, and structure oversight of a competitive health care marketplace so as to advance quality and generate appropriate price and quality tradeoffs. They suggest that a proper approach to oversight of the health care market will

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require abandoning some of the principles of antitrust and economics that govern oversight of other markets. A proper framework would identify current features of health care regulation that impede quality competition, examine what types of regulations may facilitate competition, and isolate areas where competition is not likely to be effective in terms of quality. They conclude that the government must seek to balance its role as a protector of public health and a promoter of private market principles.

Jana K. Strain, J.D. & Eleanor D. Kinney, J.D., M.P.H., *The Road Paved with Good Intentions: Problems and Potential for Employer-Sponsored Health Insurance Under ERISA*, 31 LOY. U. CHI. L.J. 29 (1999).

This Article addresses the problems resulting from ERISA's regulation of employer-sponsored health care plans. The authors contend that ERISA, along with other related Federal health insurance legislation, has created a gap between Federal and State regulation of health insurance provided by employers. The authors believe that the Federal legislation extends too far in preempting State regulation without providing sufficient substantive Federal regulations to fill the void.

The authors argue that although federal legislation has created the problem, there is potential for the Federal government to solve the problems. Strain and Kinney discuss the potential for improved enforcement of laws by the Department of Labor and the imposition of a higher standard of judicial review of plan administrator decisions. They also support amending ERISA to include greater consumer protection requirements. The authors suggest a clarification and expansion of tort liability for plan conduct involving the development of federal common law to further the public policy goals of ERISA. Finally, they argue that regulation of stop-loss insurance is a necessary step toward closing the regulation gap created by current legislation.

Eleanor D. Kinney, *Clearing the Way for an Effective Federal-State Partnership in Health Reform*, 32 U. MICH. J.L. REFORM 899 (1999).

This Article considers whether states can successfully accomplish genuine health reform in consideration of the politically charged, complex

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and costly nature of the subject. In particular, Kinney explores the contours of a Federal-State partnership that will move toward the societal goal of universal health coverage, and especially coverage of the uninsured poor. She suggests several legislative and regulatory changes. Kinney asserts that the most practical and immediate steps that Congress could take would be to reform the Employment Retirement Income Security Act of 1973 (ERISA) and provide matching funds for state health insurance programs for the uninsured that allow states great flexibility in designing programs that effectively reach the uninsured within their boundaries.

Judith C. Bronstron, *The Conflict of Interests in ERISA Cases: Can it be Avoided in the Denial of High Dose Chemotherapy Treatment for Breast Cancer*, 3 DEPAUL J. HEALTH CARE L 1 (1999).

This Article discusses the denial of coverage for high dose chemotherapy followed by an autologous bone marrow transplant (HDC-ABMT) by an ERISA plan when a conflict of interest exists. This new treatment results in higher rates of remission for metastatic breast cancer, yet many insurance companies deny the treatment as experimental. The Article explores HDC-ABMT as a treatment, and denials under ERISA when an insurance company both insures and administers the plan. It also examines *Firestone Tire & Rubber Co. v. Bruch*, the case that set the standard of review for denial of ERISA benefits. However, since the Circuit Court of Appeals has created four different ways to apply the standard of review, the author concludes with recommendations to insurance companies on how to avoid the conflict of interest standards.

Timothy Stoltzfus Jost, *Managed Care Regulation: Can We Learn From Others? The Chilean Experience*, 32 U. MICH. J.L. REFORM 863 (1999).

This Article considers the lessons the United States can learn by examining the regulation of private health insurance in Chile. The author explains the history and evolution of Chile's health insurance industry. In Chile, all employees and self-employed persons who contribute to the social security pension system, as well as indigents, are covered by the public health care system unless they elect private insurance coverage.

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Chile's public health care system is currently undergoing complex reforms, demonstrating Chile's commitment to maintaining a public health system as a viable alternative to the private sector.

Private health insurers deal with health care in several ways. Some groups function as traditional insurers, in which beneficiaries have free choice of physicians and are not limited to that company's facilities. Other companies have formed HMO's with particular hospitals, are using point-of-service plan type arrangements with hospitals and managed care plans, or have preferred provider arrangements. Although these private groups have no obligation to accept an application, once a person is insured, they cannot raise the premium unless they raise the rates for all persons in that plan, and the policy must cover the insured, his or her spouse, and children. In addition, private health insurance must supply the services covered by the public system.

There are several lessons the United States can learn by exploring Chile's complex health insurance industry. Chile's system successfully allows significant cross-subsidization to take place between the public and private sectors. Chile has found that, like many other countries, problems such as adverse selection and moral hazard exist. However, tools such as utilization review, statistical review, and caps on coverage have dealt with these problems. Additionally, as long as one is functioning in a market for private insurance and operating under a basic principle of freedom of contract, there are real limits on how much regulation can accomplish. Finally, Chile's experience cautions the United States to be modest in our expectation of regulation, particularly regulation intended to expand access and coverage.

Kathryn Kindell, Comment, *Prescription For Fairness: Health Insurance Reimbursement for Viagra and Contraceptives*, 35 TULSA L.J. 399 (2000).

This Comment argues that insurance companies should provide coverage for Viagra for men and for contraceptives for women when necessary to enable both men and women to have sex at will. The author asserts that drugs which enable sex at will are medically necessary when medically diagnosed impotence renders sexual intercourse impossible or unprotected sexual intercourse creates the risk of unwanted pregnancy. The author notes that many insurers deny coverage because Viagra and

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contraceptives are not viewed as medically necessary but as quality of life treatment. According to the author, as a matter of policy insurers should provide coverage for Viagra because investigation of impotency can result in detection of the underlying disease that may otherwise go undetected. Similarly, coverage for contraceptives is efficient for insurers and society because of the enormous social cost to society resulting from unwanted pregnancy.

Sallyanne Payton, *Introduction: Managed Care -- The First Chapter Comes To A Close*, 32 U. MICH. J.L. REFORM 573 (1999).

This Article provides an introduction to other articles presented in a Symposium. The author examines the view that managed care, in the form of fully-integrated medical care organizations, is a comprehensive solution to the enormously complex problems of the health care sector by bringing to medical care delivery the discipline of private commercial business. The present challenge is to integrate managed care into the fabric of the law without destroying it as a result of adopting normative premises that are inconsistent with managed care itself. The background to this Symposium is that the defeat of the Clinton Health Care Plan did not defeat the idea of managed care, but rather marked the beginning of a dramatic turn to managed care by the private sector.

This introduction provides a brief history of health insurance and managed care plans, the problems with the current state of health care in the United States, as well as the reform initiatives and proposed solutions. It argues that in light of the problems of trying to transform the current health care system into one financed and regulated by government, but operated by commercial businesses, we should look for a way to allow employer-based, customer-led organizations to create a system of universal, portable coverage to meet the needs of the emerging economy. The private sector should be empowered to create medical financing and delivery vehicles that will be more closely aligned with the interest of the customers than are the current commercial managed care organizations. Finally, health care management responsibilities should be assigned to institutions that can work independently, and can manage their local issues through private ordering and private law.

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W. Kip Viscusi, *The Governmental Composition of The Insurance Costs of Smoking*, 62 J.L. & ECON. 575 (1999).

This Article analyzes the costs to states of cigarette smoking. The author presents tables that show the cigarette smoking is self-financing from an economic and insurance perspective because increased medical costs associated with smoking are offset by nursing home savings resulting from earlier mortality and pension costs savings associated with a smoker's premature death. In addition, the excise tax on cigarettes also reduces the economic cost to society. The author also notes that net economic gains in terms of reduced costs are even greater to the federal government than the states. According to the author, the driving force beyond the states' suit against the tobacco industry was gross medical costs rather than financial externalities.

Jacob S. Hacker & Theodore R. Marmor, *How Not To Think About "Managed Care"*, 32 U. MICH J.L. REFORM 661 (1999).

This Article contends that the term "managed care" has no meaning and is a source of linguistic confusion. The authors encourage a discussion of health care reform that elucidates the techniques, organization and incentives that characterize alternative health plans rather than a dialogue based on meaningless labels and categories. Moreover, the Article notes that legislative changes have been aimed at dissatisfaction with selected features of the health care system rather than with the concept of "managed care." Consequently, the authors underscore that once the features of "managed care" become evident the category becomes ambiguous because it is filled with strong political and ideological connotations.

INSURANCE -- GENERAL

Guy William McRoskey, *The Rule in a Contribution Action Between Third Party Insurers Wherein the Plaintiff Insurer Seeks Reimbursement of Defense Costs from the Defendant Insurer After a Collusive Fraud on the Plaintiff Insurer under California Law*, 36 SAN DIEGO L. REV 797 (1999).

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This Article explores the duties imposed on insurers when they are aware that an insured is involved in collusive fraud. The author discusses the growing problem of fraud in the United States and exemplifies the issue with an examination of the "Alliance," a well-known fraud scheme in California. The Article describes the various bad faith acts that an insurer or insured can commit and the various contractual and tort remedies available. It examines the predicament insurers experience when an insured submits defense of a third party suit. The author concludes by discussing the variety of issues surrounding a contribution action seeking defense costs that involves collusive fraud and proposes a rule of law for such cases.

Chris S. Stacy, Comment, *Life of the Triparty: Why Flat-Fee Independent Counsel Might Just Make Everyone (More or Less) Happy*, 19 REV. LITIG. 323 (2000).

This Comment explores the tripartite relationship between the attorney, the insurance company and the insured, and the problems that have arisen from this relationship in connection with third-party auditors who are used to combat rising legal costs. Stacy recognizes impartiality and confidentiality complications that arise with the use of these auditors, and seeks to highlight these issues in the context of the tripartite relationship.

The author first identifies the salient characteristics of the tripartite relationship. Next, the author examines different doctrines for protecting confidential information. The third section highlights various conflicts that implicate the issue of confidentiality. Finally, the author compares two of the methods by which jurisdictions handle those conflicts and offers a solution that voids some of the pitfalls of current approaches. The Comment seeks to redirect discourse between insurers, policyholders and attorneys toward developing principled solutions that fully account for the market results that any solution will certainly entail.

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Joann Henderson, *Bankruptcy Disaster Relief: A Chapter 3 Debtor's Right to Use Insurance Proceeds to Repair or Replace Collateral*, 35 GONZ. L. REV. 21 (1999).

This Article considers a debtor's access to proceeds, particularly insurance proceeds, to repair or replace collateral. The question is essentially one of who owns insurance proceeds in the case of destruction of collateral. If the creditor owns the proceeds, the creditor can veto the debtor's use of the proceeds to repair or replace and can refuse turnover of the proceeds to the estate or demand turnover from the estate. If the debtor owns the proceeds, the creditor is limited to a security interest in the proceeds. The author discusses two theories under which the debtor is considered to own the insurance proceeds, the state law approach and the "substitution theory." Substitution involves the debtor's use of the proceeds through an involuntary "loan." Henderson argues that while debtors may have an increasing need to use insurance proceeds as cash collateral and thus will propose substitution due to a possible restriction of cramdown, it is unlikely that such efforts will be successful.

Lorelie S. Masters, *Punitive Damages: Covered or Not*, 55 BUS. LAW 283 (1999).

This Article describes how courts have dealt with the issue of whether punitive damages awards are insurable. The insurability of such awards depends on the applicable state law. Although some states have resolved this issue legislatively, the majority of courts generally apply a two-prong test to determine the insurability of punitive damages: 1) does the policy language allow for coverage, and 2) does the state's public policy permit punitive damages to be insured. Masters explores how this has been applied in various state courts, and includes a state-by-state survey on the insurability of punitive damages awards. She concludes that the majority of courts allow insurance coverage for some types of punitive damages.

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Ellen S. Pryor & Charles Silver, *Defense Lawyers' Professional Responsibilities: Part I Excess Exposure Cases*, 78 TEX. L. REV. 599 (2000).

This Article, the first of two parts, discusses a defense lawyer's duties when representing an insured who may be liable for an excess judgment or settlement. The authors begin by providing an overview of the major conclusions of their previous related articles. The authors then analyze the different interests and characteristics of the insurer and insured, which give rise to conflicts in cases involving excess exposures.

Pryor and Silver address defense-related duties in excess exposure cases. At the outset they consider the nature and the scope of the lawyer's representation, and they discuss two specific situations where conflicts arise: disagreement regarding the conduct of the defense, and rejection by a carrier of the lawyer's recommendations. This section concludes with practical steps for lawyers to take when they are confronted with conflicts in the latter of the two aforementioned categories.

The next section considers a lawyer's duties regarding settlement in excess cases. The authors explain the conflicts that arise when either the policyholder or the carrier seek to involve the lawyer in settlement. They also note the role that a waiver suggested by the lawyer plays in resolving conflicts where the lawyer can adequately serve the insured.

The final substantive section addresses communication with clients. Pryor and Silver discuss necessary communications and their content. The authors include an appendix containing form letters for defense attorneys in excess exposure cases.

Carol J. Greenhouse, *Fair Play and Substantial Justice? Territory of Coverage Clauses and the Assertion of Personal Jurisdiction Over Insurers*, 51 BAYLOR L. REV. 699 (1999).

This Article considers whether a territory of coverage clause subjects an insurance company to personal jurisdiction in any forum within the coverage area. The circuits are split on this issue. Some hold that an insurance company does not subject itself to the laws of a state by agreeing to defend an insured wherever sued. Other courts contend that the contract is more attractive and profitable with the inclusion of a territory of coverage clause and consequently invoke the protection of the laws of that

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state. Greenhouse contends that the territory of coverage clause meets the minimum contacts test, but maintains that that lower courts should apply a "reasonable analysis" test to make sure that jurisdiction does not offend traditional notions of fair play and justice.

William G. Ross, *An Ironic and Unnecessary Controversy: Ethical Restrictions on Billing Guidelines and Submission of Insurance Defense Bills to Outside Auditors*, 14 NOTRE DAME J.L. ETHICS & PUB POL'Y 527 (2000).

This Article takes issue with state bar associations' ethics committee opinions doubting the wisdom of billing guidelines and submission of insurance defense bills to outside auditors. Ross argues that these mechanisms are necessary to control insurance defense costs and thereby to keep premiums down. He disagrees with assertions that audits and guidelines compromise attorneys' professional judgment, arguing that audits do not normally review substantive decisions, and that the guidelines do not impose "substantive restraint on strategy." Most issues concerning professional judgment can usually be worked out with the insurer.

The Article also disagrees with the ethics committees' confidentiality concerns. It states that legal bills are unlikely to include prejudicial confidential information. Even if they do contain such information, informed consent can be obtained, or other alternatives (such as confidentiality agreements with auditors, refraining from including confidential information in the bills and redaction of confidential information) can be used to minimize confidentiality concerns.

Douglas Richmond, *Trust Me: Insurers are Not Fiduciaries to their Insureds*, 88 KY. L.J. 1 (1999).

This Article contends that insurers are not fiduciaries for their insureds. Richmond argues that language in court opinions, from commentators and even by some insurers characterizing themselves as "fiduciaries" is inaccurate. A fiduciary relationship makes the interests of the beneficiary paramount, but the insurer is not under an obligation to always act in the best interest of the insured. For example, the insurance

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policy gives the insurer the authority to settle even against the insured's wishes. In addition, a fiduciary relationship involves a complete surrender of personal control, but the insured retains a certain amount of control over the defense of the claim. Rather than characterize the relationship as fiduciary, the author contends that the insurance relationship is a special kind of contractual relationship. The author stresses that if the insurance relationship were to include heightened fiduciary duties, insurers would lose their ability to fight unwarranted claims and, in the long run, insurance rates would rise.

Melissa Coulombe Beauchesne, Comment, *Lloyd's of London and Diversity Jurisdiction: Analyzing the Citizenship of a Unique Organization*, 5 ROGER WILLIAMS U. L. REV. 217 (1999)

This Comment addresses the split in the federal circuits as to whether Lloyd's of London should be considered a citizen with respect to diversity jurisdiction. The author reviews current methods of establishing citizenship and provides an explanation of the bounds of diversity jurisdiction. In addition, she discusses how the issue has been treated in the Sixth Circuit and Seventh Circuits. She explains that the Sixth Circuit found that because the principal appears to be undisclosed, only the agent's citizenship is to be considered for the purposes of diversity jurisdiction. In contrast, the Seventh Circuit found that an agency relationship exists within the syndicate and the citizenship of all members must be considered because each member has a substantial interest in the litigation. Beauchesne concludes that a Lloyd's syndicate should take on the citizenship of its subscribing members and states that the rule of unincorporated associations should be applied to a Lloyd's syndicate because it has the primary characteristics of other unincorporated associations.

Rory A. Goode, Comment, *Self-Insurance as Insurance in Liability Policy "Other Insurance" Provisions*, 56 WASH. & LEE L. REV. 1245 (1999).

This Comment considers the application of other insurance clauses when one of the overlapping policies is a non-traditional policy, such as a

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self-insurance policy. After providing a history of self-insurance, as well as its advantages and variations, Goode considers the different treatment which courts have afforded self-insurance as "other insurance." Stressing the need for uniformity, Goode offers a structured analysis for courts to treat the self-insured as an insurer if the self-insured is acting as an insured for another party and it has: 1) agreed to indemnify the tortfeasor; 2) for a specific loss; 3) for consideration.

INSURANCE REGULATION

Allan Kanner, *The Filed Rate Doctrine and Insurance Fraud Litigation*, 76 N.D. L. REV. 1 (2000).

This Article analyzes the application of the filed rate doctrine to insurance companies, which have used it in attempt to escape liability. It examines the inherent conflict in the application of the filed rate doctrine to fraud-based insurance claims in North Dakota in light of North Dakota's insurance regulations, using *Hanson v. Accelerated Life Ins. Co.* as a case study. The filed rate doctrine most often applies to entities which operate as a monopoly, as is the case of most public utilities, and it makes little sense, the author argues, to apply it to the insurance industry.

Kanner weighs the facts of the *Hanson* case against the four factors that courts take into account when deciding whether the filed rate doctrine applies: 1) the impact on the regulating agency, 2) administrative review and remedies that may be available, 3) whether there is meaningful review if the rate increases, and 4) whether the damages are based upon the difference between the filed rate and the rate that would have been charged absent some alleged wrongdoing. In light of these factors, he concludes that the case was properly decided.

Myers N. Massengill II, Comment, *Myint v. Allstate Insurance Co.: The Tennessee Consumer Protection Act and the Insurance Industry*, 30 U. MEM. L. REV. 207

This Comment discusses the Tennessee Supreme Court decision in *Myint v. Allstate Insurance Co.* where the court held that the Tennessee Consumer Protection Act applies to insurance companies. The court

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rejected Allstate's argument that insurance companies are regulated exclusively by the Insurance Practices Act and the bad faith statute. In finding that the Consumer Protections Act applies to insurers, the court noted that the Act's remedies are expressly cumulative and supplementary to all other statutory remedies. Massengill concludes by warning that the application of the Act to insurance companies may cause the comparably low automobile insurance rates paid in Tennessee to rise.

Jeffrey S. Manning, Comment: *Are Insurance Companies Liable Under the Americans with Disabilities Act?*, 88 CAL. L. REV. 607 (1999).

This Comment analyzes the federal circuit split concerning whether insurance companies can be liable under Title III of the Americans with Disabilities Act. The author points out that two questions are at issue. First, what does the ADA intend to do when it prohibits discrimination by businesses that serve the public? The author explains that the debate is over whether Title III requires equal ability to attain the goods offered to the public or equal access to acquire the goods sold to the public. The second issue concerns whether insurers can use categories relating to race and sex in risk classification. On this issue, the author explains that some courts have found these classification fall within the safe harbor, exempting insurance underwriting from the ADA while other courts have interpreted the safe harbor more narrowly as applying only to traditional statistical based actuarial data.

The author argues for a pro-plaintiff interpretation of the ADA as being consistent with the text of the ADA and the underlying intent of the statute. Moreover, the author asserts that interpreting the ADA narrowly and to exempt insurers from its prohibitions against discrimination would be contrary to discrimination policy and would give insurers the ability to arbitrarily discriminate based on an insured's disability.

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LIABILITY INSURANCE

Cynthia A. Muse, *Homeowners Insurance: A Way to Pay for Children's Intentional and Violent Acts?* 33 IND. L. REV. 665 (2000).

This Article examines the scope of insurance coverage provided by Homeowners insurance policies for intentional acts committed by minors. Muse dissects the purposes and exclusions contained in the standard homeowners policy and then details three prevailing judicial tests used to determine coverage for intentional acts. She examines these tests as applied to the four major types of violent acts committed by minors—shootings with firearms, shootings with BB guns, physical assaults and arson. She then assesses the impact of a minor's age on the applicability of coverage in these situations. Muse concludes that although it is doubtful the existence of an insurance policy has any impact on a minor's decision to commit an intentional violent act, excluding coverage for such acts will send a message to parents and society that such acts will not be condoned regardless of the actor's age.

Gregory J. Rokosz, *Princeton Insurance Co v. Chunmuang -- Does the Court's Result Signal a Need for Legislative Reform Broadening Malpractice Insurance coverage for the Benefit of Victims of Physical Sexual Abuse*, 30 SETON HALL L.REV. 133 (1999).

This Article discusses the New Jersey Supreme Court's decision in *Princeton Insurance Co v. Chunmuang,* where the court held that the criminal act exclusion denied coverage to a physician who sexually assaulted his patient during a gynecologic examination. In reaching this result, the author notes that the New Jersey Supreme Court departed from the interpretation of a majority of courts by finding that the insurance policy did provide coverage. Many courts find no coverage because coverage is limited to injuries arising out of professional acts or service. The New Jersey court read the policy provision providing coverage resulting from any "medical incident" to include acts that are not professional in character. The author maintains that public policy should preclude individuals from insuring against their own misconduct, and suggests that the proposed bill in the New Jersey Assembly requiring insurers to provide coverage but allowing them to be subrogated by the

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insured is not an adequate solution because it would increase the cost to insurers to defend and indemnify, raising malpractice premiums for physicians.

Joel Sulkes, Note, *Murphy v. Kuhn: Defining the Insurance Broker's Exposure to Professional Liability Lawsuits in New York*, 43 N.Y.L. SCH. L. REV. 633 (1999).

This Note examines *Murphy v. Kuhn* in which the New York Court of Appeals refused to recognize that insurance brokers have a continuing duty to advise clients with regard to their insurance coverage. The court refused to recognize a "special relationship" between a broker and his client that would impose such a duty. Sulkes analyzes the court's rationale for not applying the special relationship theory to the insurer/broker context. He notes that the court hinted at three "exceptional situations" that might justify imposing a duty of advisement on insurance brokers. Sulkes concludes that, as these exceptional circumstances become less so, there will be an increased likelihood that the special relationship theory will apply to brokers in New York.

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RECENT CASE DEVELOPMENTS

*Jeffrey W. Stempel**

IN ORDER TO HAVE COMPLETE DISCRETION AS TO BENEFIT DETERMINATIONS, ERISA PLAN DOCUMENTS MUST CLEARLY STATE THAT BENEFIT DETERMINATIONS ARE DISCRETIONARY

Herzberger v. Standard Ins. Co., 205 F.3d 327 (7th Cir. 2000).

Much of the Employee Retirement Income Security Act of 1974 (ERISA) deals with retirement benefits, but much of the daily administration of benefit plans involves health insurance coverage provided by employers, often administered through insurance coverage purchased by the employer. Employee beneficiaries and employers or the insurers administering the plan often disagree as to coverage, engendering litigation.

A continuing controversy on this front is the degree of freedom a benefit plan administrator (usually a health insurance company claims adjuster) has in denying such claims. For obvious reasons, employers and insurers prefer to have total discretion so that any benefit denials are final and not subject to successful court challenge. For equally obvious reasons, beneficiaries prefer to categorize a plan as providing coverage subject to certain contractual standards and norms of acceptable health insurance. Courts have had some difficulty in determining, from the plan documents, whether the plan's decision authority is discretionary or circumscribed.

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In *Herzberger*, the Seventh Circuit sought to bring some clarity to its own precedents, issuing an opinion that may be influential in other quarters. Writing for the court, Chief Judge Richard Posner framed the issue as:

> whether language in plan documents to the effect that benefits shall be paid when the plan administrator upon proof (or satisfactory proof) determines that the applicant is entitled to them confers upon the administrator a power of discretionary judgment, so that a court can set it aside only if it was 'arbitrary and capricious,' that is, unreasonable, and not merely incorrect, which is the question for the court when review is plenary ("de novo"). The cases directly on point say 'no,' ruling that the language in the plan documents must confer discretion in clearer terms.

205 F.3d at 329 (citations omitted). Finding some of the case law unclear or arguably in tension, the court issued the *Herzberger* opinion to "clarify our position and reduce the tension." *Id.* at 330. In particular, the court found it "highly desirable to have a uniform national rule" because of the movement of workers and the multi-state operations of employers.

Where plan documents provide no indication of the scope of judicial review, the judicial review will be plenary and determine whether a plan administrator "got it right" under the terms of the coverage provided by the plan. However, because an ERISA plan is a contract between the employer and the employees, the employer is permitted to change the default standard of judicial review from one that is plenary to one that is more deferential, such as the "arbitrary and capricious" standard. But to make this change, the plan documents must be sufficiently clear. Where plan document language is ambiguous, the plan is construed as providing plenary review. As with insurance coverage generally, ambiguity is in effect construed against the drafter of the documents.

However, unless a contract involves something of highly personal taste, such as a commissioned portrait, the widest discretion that can be established is a yardstick of reasonableness. Even where the plan documents do clearly convey discretion to the administrator, the administrator's decisions must be reasonable rather than arbitrary and capricious. Although this standard provides some protection to the worker or beneficiary, it benefits the employer because health coverage issues are often sufficiently close or complicated that both sides can be said to have adopted "reasonable" or "non-arbitrary" positions. As the court put it:

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> The very existence of "rights" under such plans depends on the degree of discretion lodged in the administrator. The broader that discretion, the less solid an entitlement the employee has and the more important it may be to him, therefore, to supplement his ERISA plan with other forms of insurance. In these circumstances, the employer should have to make clear whether a plan confers solid rights or merely the "right" to appeal to the discretion of the plan's administrator.

Id. at 331.

To clarify matters, the *Herzberger* panel, after circulating its draft opinion to the entire Seventh Circuit, issued and "commend[ed] to employers" what it deemed "safe harbor" language for employers to use if they wish to have their plan benefits decisions reviewed under the more deferential arbitrary and capricious standard used with discretionary plans. The court suggested the following language: "Benefits under this plan will be paid only if the plan administrator decides in his discretion that the applicant is entitled to them." *Id.* According to the court: "An ERISA plan that contains such language will not be open to being characterized as entitling the applicant for benefits to plenary judicial review of a decision turning him down." *Id.*

Although future beneficiaries will undoubtedly want to claim that the absence of such "safe harbor" language provides plenary review, the court stated that this was not necessarily a persuasive argument, finding that:

> In some cases the nature of the benefits or the conditions upon it will make reasonably clear that the plan administrator is to exercise discretion. In others the plan will contain language that, while not so clear as our "safe harbor" proposal, indicates with the requisite if minimum clarity that a discretionary determination is envisaged.

Id. Thus, employers appear to have an advantage of either using the "safe harbor" language, which is presumably conclusive, or litigating the issue of the standard established by plan documents containing other language. However, beneficiaries have something of an advantage as well under *Herzberger* in that

> the mere fact that a plan requires a determination of eligibility or entitlement by the administrator, or requires proof or satisfactory proof [or similar provisions] . . . does not give the employee adequate notice that the plan

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> administrator is to make a judgment largely insulated from judicial review by reason of being discretionary.

Id. at 332.

The court also defended the current regime of deference to plan administrators, so long as the plan documents adequately establish the discretion of the administrator.

> An ERISA plan can stipulate for deferential review; it might be entirely rational for an employee to accede to and even prefer such a plan -- it might be cheaper. But the stipulation must be clear, and cannot merely be assumed from language that in the closely related setting of insurance contracts has never been thought to entitle the insurer to exercise a discretionary judgment in determining whether to pay an insured's claim. An employer should not be allowed to get credit with its employees for having an ERISA plan that confers solid rights on them and later, when an employee seeks to enforce the right, pull a discretionary judicial review rabbit out of his hat. The employees are entitled to know what they're getting into, and so if the employer is going to reserve a broad, unchanneled discretion to deny claims, the employees should be told about this, and told clearly.

Id.

In addition, the *Herzberger* court held that the employer was not estopped from denying benefits because it had supported Herzberger's application for social security disability benefits. The two positions were not inconsistent because Herzberger's claim was one for mental health disability under social security and the dispute between Herzberger and her employer was the degree to which mental health benefits were covered under the health provisions of the ERISA benefit plan in question.

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FEDERAL ANTI-INJUNCTION ACT DOES NOT PERMIT POLICYHOLDER TO SUE IN STATE COURT AFTER HAVING LOST IN FEDERAL COURT; INSURER MAY HAVE SECOND LAWSUIT HALTED

New York Life Ins. Co. v. Gillispie, 203 F.3d 384 (5th Cir. 2000).

Because the United States is a federal system where both state governments and the national government share power, there are certain constitutional and statutory restrictions on federal power co-existing with the right of the national government to have supreme or exclusive power in some areas. One example of this tension is the Anti-Injunction Act, 28 U.S.C. § 2283 (2000), which generally forbids federal courts from interfering with ongoing state court proceedings. However, an exception to the Act's general rule provides that federal courts may issue an injunction to halt or limit state proceedings in order to avoid relitigation of matters previously decided in federal court or to otherwise protect the federal courts from undue state interference.

A tenacious life insurance beneficiary recently tested the confines of the Anti-Injunction Act, but was unsuccessful before a unanimous panel of the Fifth Circuit Court of Appeals, which included the states of Texas and Louisiana. The court summarized the facts of the two lawsuits as follows:

> Ronald Gillispie died in 1993. His wife, Sheree Gillispie, is the named beneficiary of a life insurance policy issued to Mr. Gillispie by New York Life Insurance Company. Shortly after Mr. Gillispie's death, Mrs. Gillispie submitted a claim to New York Life alleging entitlement to the proceeds of the policy. New York Life denied the claim, contending the Mr. Gillispie's death was the result of a suicide. Suicide is unambiguously excluded from coverage under the policy.
>
> In 1995, Mrs. Gillispie filed a complaint against New York Life in the United States District Court for the Northern District of Mississippi, alleging breach of contract and bad faith denial of benefits. New York Life moved for summary judgement. Mrs. Gillispie's attorney did not respond to the motion. In early 1996, the court granted New York Life's motion for summary judgment, explicitly

> finding that "all evidence points to the decedent's death as a suicide."
>
> Mrs. Gillispie subsequently hired new counsel to represent her. Her new attorney succeeded in convincing the Chancery Court of Tippah County, Mississippi to order the issuance of an amended death certificate declaring the cause of Mr. Gillispie's death to be accidental. In 1997, Mrs. Gillispie filed another complaint against New York Life, this time in the Circuit Court of Tippah County, Mississippi. The complaint stated the same basic causes of action as had the 1995 federal suit, alleging breach of contract and bad faith denial of benefits.

Gillispie, 203 F.3d at 386.

In response to the second suit in state court, the insurer removed the case to the United States District Court for the District of Mississippi, but the case was remanded to state court for lack of subject matter jurisdiction since the case involved both a Mississippi plaintiff and defendants other than New York Life who were Mississippi residents. New York Life then filed a separate claim in the Mississippi District Court seeking an order enjoining the state court suit, arguing that the second suit was precluded by the decision of no coverage in the first lawsuit, which was res judicata. Mrs. Gillispie argued that the Anti-Injunction Act barred the requested injunction and the trial court agreed.

The Fifth Circuit reversed the trial court, holding that the general rule of the Act was in this case clearly subject to the "relitigation exception" to the Act, which permits a federal court to halt state court proceedings that are repeats of prior federal court adjudication. The Act specifically states that a federal court may nonetheless issue an injunctive order "to protect and effectuate its judgments. 28 U.S.C. § 2283 (2000). According to the court, "[t]his exception 'was designed to permit a federal court to prevent state litigation of an issue that previously was presented to and decided by a federal court.'" *Gillispie*, 203 F.3d at 387 (quoting Chick Kam Choo v. Exxon Corp., 486 U.S. 140, 147 (1988)).

The Fifth Circuit applied a four-part test to determine whether the relitigation exception to the Act was applicable:

> 1. The parties to the later action must be identical to or in privity with the parties to the prior action;

> 2. The judgment issued in the first action must have been rendered by a court that had proper jurisdiction over the matter;
>
> 3. The prior action must have in fact resulted in a final judgment on the merits of the claim (nonfinal, preliminary rulings do not qualify); and
>
> 4. The 'same claim or cause of action must be involved in both suits.'

Id.

In *Gillispie*, the parties to both the federal and Mississippi actions were the same and the federal court in the first case had proper jurisdiction. The federal court's entry of summary judgment for New York Life was a final judgment on the merits of the claim. The Fifth Circuit saw the only colorable issue as being whether the 1995 federal suit and the 1997 state court suit involved the "same claim or cause of action." The Fifth Circuit found the cases to involve the same claim -- whether Mr. Gillispie died from suicide. Consequently, a federal court was empowered to and required to halt the duplicative second case in state court.

Mrs. Gillispie argued that the second action was different because it involved different facts, in particular the change in content of the official death certificate. The court found this distinction unimportant, however, because under the relitigation exception to the Anti-Injunction Act, the court focused on whether the first and second case involved the same *transaction*, not necessarily the exact same evidence. Applying this approach, there was no question that both lawsuits were about the same thing -- the circumstances of Mr. Gillispie's death and whether the life insurance policy provided coverage. *Id.*

MISSISSIPPI SUPREME COURT HOLDS UNINSURED MOTORIST COVERAGE NOT TRIGGERED ABSENT ACTUAL PHYSICAL CONTACT; NO COVERAGE FOR "HIT AND RUN" INCIDENT RESULTING IN DEATH

Massachusetts Bay Ins. Co. v. Allstate Indem. Co. v. Joyner, 736 So.2d 877 (Miss. 2000).

The facts of this case read like something out of bad action movie. On September 19, 1996, on an interstate outside of Jackson, Mississippi, two cars

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are traveling in the left lane. A black sport utility vehicle (SUV) is passing them on the right and finds its path blocked by a slow-moving truck. Rather than braking, the SUV swerves to the left. In the left lane, Evelyn Joyner swerves further left in response. In order to avoid a collision with the SUV, she enters the median of the highway, loses control, flips, and is killed. The other car in the left lane witnesses the tragedy as the black SUV continues speeding on into the night, never to be apprehended.

After Joyner's death, her surviving husband sought uninsured motorist benefits from Allstate (which provided $30,000 in such coverage) and Massachusetts Bay (which had uninsured motorist limits of $200,000). The theory of uninsured motorist coverage is that it provides the coverage that would have been available had the policyholder been able to bring a tort claim against an insured, tortfeasing driver. Normally, of course, drivers do not flee the scene of an accident, and a prospective plaintiff knows who is the alleged tortfeasor and finds out whether that driver has sufficient insurance. To the extent that the tortfeasor driver is uninsured or underinsured, the innocent driver may recover up to applicable policy limits from its uninsured or underinsured motorist coverage.

Hit-and-run drivers have always been a problem for uninsured motorist coverage disputes as well as society. A hit and run driver who escapes is constructively an uninsured motorist because neither he nor his insurance company can be brought before a court. In a typical hit-and-run case involving a collision, insurers normally pay uninsured motorist benefits unless they have significant grounds for suspecting that an accident was fraudulently staged. But what about a "miss-and-run" incident, where the escaping driver did not physically collide with the injured party but otherwise caused the injury? In hit and run cases of this sort, insurers have tended to resist paying claims, partially on general principles ("hit" should mean "hit," rather than "cause a swerve") and partially out of concern that fraud is more likely in the absence of physical impact.

Cases dealing with miss and run incidents are divided. In some states, such as Mississippi, insurers have been successful in codifying a physical impact requirement for uninsured motorist coverage. State law provides that an "uninsured motor vehicle" shall mean a:

> motor vehicle of which the owner or operator is unknown; provided that in order for the insured to recover under the endorsement where the owner or operator of any motor vehicle which causes bodily injury to the insured is unknown, *actual physical contact must have occurred*

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> between the motor vehicle owned or operated by such unknown person and the person or property of the insured.

MISS. CODE ANN. § 83-11-103 (1999) (emphasis added).

Mississippi recently took a strong position in favor of requiring physical impact for coverage, reversing, in a 7-2 opinion, a trial court ruling for the policyholder and entering judgment as a matter of law for the insurer. Despite the sympathetic factual situation and the loss to the Joyner family, the court felt constrained by what it regarded as the clear language of the statute. In so doing, it reaffirmed an approach of judicial restraint regarding the statute, stating that "'[i]t is no answer that upon reflection the legislative enactment may be seen crude, inadequate or even foolish. Where the legislature has enacted upon a subject within its competence, we may not annul or evade what it has done.'" Massachusetts Bay Ins. Co., 763 So.2d at 879 (quoting Anderson v. State Farm Auto Ins. Co., 555 So.2d 733, 734 (Miss. 1990)).

The court also examined the policies in question. The Allstate policy specifically required physical contact for uninsured motorist coverage. The Massachusetts Bay policy did not, but the court found it unambiguous because it stated that its hit-and-run coverage was restricted to "instances in which the unidentified car 'hits' an insured, the insured vehicle or a vehicle in which an insured is riding." Thus, even though there was "no suggestion of the presence of fraud" in Joyner's case, the court found no coverage under either the terms of the policies or the statute.

The dissenters, despite the policy language and the language of the statute, contended that the majority opinion did "not hold water." Unlike the majority, the dissent saw the *Joyner* decision, not as following from statute and precedent, but moving away from Mississippi's traditions of liberal interpretation of insurance policies in favor of the policyholder, and the vindication of public policy favoring compensation to victims of auto accidents.

In particular, the dissent argued for a "reasonable expectations" approach to coverage, even though it did not articulate the "reasonable expectations" doctrine by name. In the dissent's view, a policyholder with uninsured motorist coverage reasonably expects coverage if injured in an accident by an uninsured driver. Evelyn Joyner was killed in an accident caused by a functionally uninsured car (the Black SUV could not be located), and it did not matter to her surviving husband that the cars had not collided. The Joyner family was just as injured and as in need of compensation regardless of whether the cars collided or one car rolled into a ravine.

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The dissent also took what might be termed a functional view of the auto insurance contract rather than a formal view. The formal view, expressed by the majority, reasoned that if the statute and the policy require physical contact, then physical contact is a prerequisite to recovery. The dissent argued that the function of the physical contact requirement was to reduce the chances of fraud. In the *Joyner* case, there was an eyewitness, and it was conceded by the parties that there was no fraud or staging that led to the tragedy. Under these circumstances, reasoned the dissent, it was an elevation of form over substance to deny coverage for the Joyners. To balance the concerns of policyholder and insurer, the dissent suggested a general approach:

> Anytime a car runs off the road and there is no evidence that another car was involved, there should be a presumption that a one car accident occurred. However, that presumption could be rebutted by the testimony of eyewitnesses. This would prevent fraud and at the same time prevent the injustice of prohibiting legitimate claims solely because there was no proof of physical contact.

Id. at 883.

TAXI DRIVER'S SEXUAL ABUSE OF PASSENGER IS INTENTIONAL ACT, NO ACCIDENT AS REQUIRED BY AUTO INSURANCE POLICY; NO COVERAGE

Kim v. Nat'l Indem. Co., 6 P.3d 264 (Alaska 2000).

Alaska's highest court recently added their state to the list of jurisdictions that have taken a hard doctrinal line against coverage of sexual abuse under common liability policies such as automobile, homeowners, or general liability insurance. Since the 1980s, child abuse and other sexual abuse claims appear to have been more frequently litigated, resulting in claims against liability insurers. Despite the unsavory aspects of these cases, tortfeasors, their victims (where the policy benefits have been assigned), or a third party (where a third party may proceed directly against an insurer) have argued that the abuse resulted from negligent supervision or structure, was the product of an unreasonable impulse, or was not intended to cause harm.

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Where the policyholder is an entity that is only vicariously liable, claimants have had some success arguing that the insured's liability stemmed from negligence rather than volitional wrongdoing with intent to injure. Even in these cases, however, an employee or agent of the vicariously liable policyholder is often an "insured," triggering the bar to coverage for injuries "expected or intended from the standpoint of the insured."

Where a claimant policyholder is the active tortfeasor, insurance companies have had great success in defeating claims for coverage. The *Kim* case now puts Alaska squarely within that line of cases. Kim, a taxicab driver, "sexually abused a minor who was a passenger in Kim's cab. When the minor's mother sued the cab driver, Kim looked to his automobile insurer for coverage." 6 P.3d at 266. The insurer disputed coverage and prevailed before both the trial court and the Supreme Court of Alaska, which summarized the policy as follows:

> At the time of the incident, Kim was insured under a commercial automobile insurance policy from National Indemnity Company. Kim had purchased this policy -- a $300,000 single limit policy -- to provide basic insurance for his taxi. The policy provides coverage for "all sums an insured legally must pay as damages because of 'bodily injury' or 'property damage to which this insurance applies, *caused by an 'accident'* and resulting from the ownership, maintenance or use of a covered 'auto'. But the policy excludes coverage for "'[b]odily injury' or 'property damage' *expected or intended* from the standpoint of the 'insured.'" It also excludes coverage for bodily injury or property damage arising out of the "abuse or molestation by anyone of any person while that person is in the care, custody or control of any insured."

Id. (emphasis added).

The *Kim* court found that the injury to the minor passenger was not an "accident" within the meaning of the auto policy because an "accident ordinarily does not include injuries that are intentionally inflicted by the insured." *Id.* at 267. The court also noted that Alaska, like many states, has a general public policy against permitting insurance coverage for intentional acts. The nature of the underlying tort made this a particularly clear case to the court, which stated:

> We agree with the majority rule that "in liability insurance cases involving sexual abuse of children, the intent to cause

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> injury can be inferred as a matter of law." The majority of courts agree with this rule because "the harm to the victimized child is no less serious when the abusive adult's subjective intentions are purportedly 'benign'."
>
> Because we infer an intent to injure as a matter of law from acts of child abuse and molestation, Kim's subjective intent is irrelevant. Moreover, once the intent to injure is inferred, "it is unimportant that the scope of the injuries inflicted are greater than or different from the injuries which objectively might be expected." Thus, in addition to not being an "accident," Kim's sexual abuse of L.W. was an intentional act for which the insurance policy specifically bars coverage.

Id. at 267-68 (citations omitted).

Because the sexual abuse was both intentional and not accidental, it fell outside of the coverage provided by the auto insurance policy even without considering the "abuse and molestation" exclusion in the policy. The claimant attempted to argue that the presence of the exclusion for abuse of someone "in the care, custody, or control" of the policyholder implied that the policy would otherwise cover sexual abuse claims where the victim was not in the care of the insured. The court rejected this argument. *Id.* at 269 ("We therefore conclude that the exclusion does not grant coverage to injuries resulting from the sexual abuse of a person who is *not* in the care, custody, or control of the insured.") (emphasis added). If, under applicable state law, a taxi passenger would be considered under the care or custody of the cabdriver, this exclusion would also have clearly applied.

The claimant's attempt to invoke the uninsured/underinsured motorist provisions of the auto policy also failed in view of the court's holding that the injuries did not result from an "accident."

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TIME LIMIT FOR BRINGING ACTION UNDER INSURANCE POLICY INCLUDES PERIOD FOR OBTAINING SERVICE OF PROCESS

Wothers v. Farmers Ins. Co. of Washington, 5 P.3d 719 (Wash. App. Div. 1 2000).

Most insurance policies provide that a claim or legal action for recovery must be brought within a specified time period. In many states, this time period, like a statute of limitations, may be extended during a time when the policyholder is unaware of the loss or incapacitated. In other states, the time period begins to run when the loss occurs.

There has been little litigation over the issue of whether litigation rules might extend the time period for bringing suit. The Federal Rules of Civil Procedure, for example, provide that after a plaintiff files a complaint with a federal court, it has 120 days to serve the complaint on the defendant. Many states now have similar provisions. In Washington, the civil rules provide that a plaintiff has 90 days to effect service after filing an action. In *Wothers,* Washington's intermediate appellate court faced the issue of whether a policyholder meets the one-year deadline for bringing a claim under a homeowner's policy by filing a complaint with the court. The *Wothers* court held that the complaint must be served upon the insurer within the one-year period in order to be timely.

Deborah Wothers' home experienced damage from a snow storm on December 29, 1996. Wothers and Farmers Insurance Company disputed whether the storm had also caused damage to the foundation of the home (covered under the policy), or whether the cracks observed in the foundation were the result of pre-snowstorm settling (not covered under the policy). When the parties could not agree, Wothers filed suit on December 29, 1997 alleging breach of contract and violation of the state Consumer Protection Act. However, Farmers was not served with the suit until 99 days later -- April 7, 1998.

According to both the trial court and the appellate court, the bringing of the lawsuit was not complete until service of process against Farmers was made, which did not take place until after the expiration of the one-year period. In essence, the court found that the policy provisions imposing the one-year deadline trumped the civil rules on this point. Wothers did not get the benefit of the additional 90-days for service of process and her action would have been untimely under the policy even if she had effected service

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on Farmers within the 90 days provided under the Washington Rules of civil litigation.

CO-BORROWERS CANNOT COLLECT CREDIT LIFE INSURANCE UNLESS EXPRESSLY NAMED AS BENEFICIARIES IN THE POLICY

Abbott v. CUNA Mut. Ins. Soc'y, 7 P.3d 852 (Wash. App. Div. 2 2000).

The Washington judiciary issued a cautionary tale for co-borrowers. When a person, entity, or group goes into debt, it may elect to purchases credit life insurance. Under a typical credit life insurance arrangement, the policy is issued to a named insured, who pays premiums. The face value of the policy is the value of the debt which generally declines as the balance due on the debt declines (if it does not, the policy would not comply with normal groundrules regarding insurable interest and sound practices for avoiding adverse selection and minimizing moral hazard). If the named insured dies while the debt is still in force, the proceeds of the policy are used to pay of the debt.

In *Abbott*, an unusual factual situation led to the denial of payments sought. Eleanor Abbott was a licensed practical nurse who ran a licensed adult foster care facility in her home. One of her patients was Fred Epperly, a quadriplegic who needed a ventilator and round-the-clock care, which Abbott provided in exchange for $15,000 per month paid by the State of Washington Department of Labor and Industries. Larry Ketchum was a neighbor and friend of Abbott. In late 1990, Abbott and Epperly opened a joint account at a credit union (the EECU), which contained $149,000 of deposits by Abbott. In early, 1991, the EECU made five loans to Abbott and Epperly totaling $149,000. Abbott was the primary obligor and Epperly the secondary obligor.

They then sought and obtained a joint credit life insurance policy from CUNA Mutual Insurance Society. The Policy provided that "[a]ny death benefits under this Policy will be paid to [EECU in order to] apply the benefits to reduce or pay off the loans for which payment is made. Any excess benefits will be paid . . . by separate check to the beneficiary named in the estate." 7 P.3d at 854. Epperly did not name any beneficiary other

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than his estate. Abbott used the funds for remodeling of her home and to pay outstanding bills.

In mid-1991, Abbott, Epperly, and Ketchum engaged in a similar transaction with another credit union (KFCU), opening an account for $50,000 and obtaining a loan for $50,000 and a similar credit life policy. Abbott, Epperly and others also engaged in a series of similar transactions opening credit union accounts and taking loans that did not involve the credit life insurance at issue in this court case but, interestingly enough, noted by the court. *Id.* at 855. This resulted in the purchase of three Toyotas, a BMW, and other goods.

On August 31, 1991, Epperly died. Abbott and Ketchum asked the credit unions to claim against the credit life policies and to retire the amounts due on the loans. Both credit unions claimed as requested, but EECU also notified CUNA, with perhaps some understatement, that "[t]here are unusual circumstances surrounding this claim." *Id.* CUNA denied the claims, and the credit unions satisfied the debts by using the Abbott-Epperly accounts for payment, leaving Abbott and Ketchum to claim against the insurance policies.

The appeals court did not address the coverage issue but ruled that Abbott and Ketchum could not collect because neither was named as a beneficiary in the policies. The primary beneficiary was the credit union, and it had been paid by the funds on deposit. The secondary named beneficiary, Epperly's estate, was entitled to the money. The court noted that in credit life insurance, it is the life of the debtor that is insured and not the debt itself. *Id.* (citing COUCH ON INSURANCE § 1:43 (3d ed. 1995)). Recall that under the loan arrangements, Abbott was the primary obligor and Epperly the secondary obligor. After Epperly's death, the life insurance policy was to pay proceeds as designated in the policy, which left Abbott and Ketchum out in the cold because of the credit union actions to protect themselves by using the savings accounts when CUNA refused to pay.

The *Abbott* opinion is perhaps even more interesting for the questions it did not address. For example, the court refused to address the question of whether CUNA was estopped from denying coverage or whether there was a proper insurable interest for Abbott and Ketchum to have policies on Epperly's life. The court found these questions immaterial because neither was a beneficiary under the policies and there was no question that CUNA was not estopped from litigating the beneficiary question.

Perhaps, most intriguingly, the majority did not directly comment on what was an obviously suspicious set of circumstances. In less than nine months, Abbott (with some support from Ketchum) essentially became a

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serial borrower and opener of credit union accounts, obtaining loans for the amounts on deposit and purchasing insurance on Epperly's life that was designed to pay off the loans. Epplerly, a quadriplegic on a respirator, died at the end of these nine months. Had things turned out only a bit differently, Abbott would have enjoyed a substantial windfall by correctly estimating that Epperly would not live long. And, of course, as Epperly's care giver, Abbott was in perhaps the best position in the world to know Epperly's health. Certainly, she was far more knowledgeable about Epperly's health than either the insurer or the credit union. This is the type of information asymmetry that can create adverse selection and should have been more troubling to the court than the majority suggests.

In addition to knowing Epperly's health, Abbott was the person most responsible for his health. She took care of him. Even laypersons know that the level of care accorded a quadriplegic can have a dramatic impact on the lifespan of the patient. In an amicus curiae brief, the Washington State Medical Association argued that the court should, as a matter of law, hold that it violates public policy for a health care provider to obtain life insurance on a patient and that such transactions should be void ab initio.

In response to these concerns, many of which were raised in the concurring opinion of Chief Judge Armstrong, the majority reasoned that such issues must "be addressed to the legislature." On the question of the validity of the insurance itself, the majority found that the Revised Code of Washington § 48.18.030 (1) was clearly met regarding insurable interest; both Abbott, Epperly, and Ketchum had actual debt for which they could be held responsible by the credit unions even though they had equivalent funds on deposit. Although this might be a situation too conducive to fraud, "[a]mending the statute is a task for the legislature, not for any of the judges of this court; and exercising a higher level of care in the sale of credit life insurance is a task for CUNA and similar insurers." *Id.* at 858.

The concurrence took issue with this deference to the legislature and argued that the Abbott and Ketchum purchases of credit life insurance should be held void because it violated the twin evils underlying the insurable interest doctrine: wagering and moral hazard. In the view of the concurring judge, Abbott was wagering on Epperly's life (and would have won if she had only induced a shrewder beneficiary designation), and, as a result of the insurance had an incentive to do less for him in her capacity as caregiver. *Id.* at 859-61. The concurrence also saw the case as one where the credit union had no insurable interest because the savings account deposits equaled the debts. *Id.* at 859.

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On the issue of the credit union's security, the concurrence appears to be incorrect. Although Abbott had the funds on deposit, there appears to have been no restraint on her access to these funds. Abbott could, at least in theory, have withdrawn a substantial part of the account while Epperly was on his death bed and spent the money before the credit union knew what had occurred. Under those circumstances, the credit union would then be extremely interested in the proceeds of the credit life insurance. Thus, it seems that the credit life policy was proper in the sense of providing some protection to the credit union.

On the issue of insurable interest and public policy in general, the concurrence raises interesting issues not adequately addressed by the majority. In the instant case, the many transactions appear to have resulted in a wash. Abbott has a remodeled house and cars, etc., but has lost all the savings she placed in the credit union. Because neither Abbott nor Ketchum was a named beneficiary in the Epperly estate, neither Abbott nor Ketchum can be said to have successfully pulled the proverbial "fast one" at the end of this particular day. But they may have come close. If the beneficiary designation had been differently handled, Abbott would have had home remodeling, cars, etc., free and clear and still have credit union accounts amounting to six figures. The bank would be repaid but the insurer would be out a good deal of money on a recently issued life policy for which only a few premiums were paid. In addition, the opinion provides no information about the Epperly estate, although it notes that he had a spouse and children. If Abbott or Ketchum received substantial bequests from the Epperly estate, the particular equities of this situation might again be at issue.

From a policyholder-oriented view, *Abbott* is also potentially troubling. For example, apply the court's decision to a less suspicious transaction. A mother and son open a bank account and take a loan, obtaining credit life insurance on the life of the son, who dies in a car accident. The bank quickly seizes the bank account to satisfy the debt while the insurer is slow in determining its coverage position. After the bank has acted, the insurer now has an ironclad defense: the credit life policy failed to name the mother as a beneficiary. The insurer received the premiums but is off the hook, a most unfair result if there have been several years of premium payments. In addition to losing her son, the mother has no more savings and has been deprived of the planned opportunity to pay off the loan over time while retaining her savings or being protected by the credit life policy.

Under the *Abbott* opinion, this sequence of events is a real possibility. If it occurs, does the mother have a bad faith claim against the bank or the

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insurer? Only if they collude? In fact, under *Abbott*, it appears that this sequence of events could occur even if the mother has been clearly named as policy beneficiary. Eventually, she would be paid the outstanding balance of the note if the bank had already satisfied the debt by raiding her savings, but this could entail months of delay and financial disruption to the mother. By deciding on narrow grounds, the *Abbott* court leaves these questions unanswered. Apparently, it is caveat emptor for the depositor/debtor/insured as well as for the bank and the insurer -- but is that good public policy? The court could have, for example, refined the groundrules for interpreting insurance policies in situations where the underlying insurable interest was suspect or where the transaction has negative public policy implications. Perhaps, for example, in cases like *Abbott*, the normal ground rules for construction in favor of the policyholder or beneficiary should be neutralized or even reversed.

On the other hand, the majority has strong arguments for not delving further into this issue. In addition to deference to the legislature, the majority essentially suggests that banks and insurers are sufficiently sophisticated and that they should bear the consequences of loose underwriting of loans and policies. Although the Abbott-Epperly-Ketchum transactions look suspicious, the credit unions wrote loans of their own free will, and CUNA issued credit life policies of its own volition. A few cases like this might have the salutatory effect of inducing greater care in underwriting.

However, the "let the chips fall" approach has historically not been the view of the law in this area. If so, there would be no insurable interest doctrine as such and society would depend entirely on the self-interest and prudence of insurers to prevent the evils animating the doctrine. Instead, the law has provided to insurers a defense to coverage that is available (absent estoppel) even though the insurer's own sloppiness led to issuance of the policy. Certainly, society would not want to permit recovery to a psychotic killer (or his innocent beneficiaries) who obtained thousands of policies on the lives of comparative strangers. In this area, courts have been willing to act even where the legislature has not spoken with clarity. A case like *Abbott* presents the tough question of whether the court should have done more than simply decide the case before on the most narrow terms available. Although the court's mere recitation of the facts sounds like a made-for-television movie, the court never focused on the issue of why Epperly had anything legitimate to do with these transactions. He made no deposits, appeared to reap no benefits from the loans, and was not bringing income into the household that benefited from the loans.

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The position of the Washington Medical Association, which argued for a per se rule against health care givers having insurance on patients, raises significant questions. Generally, the benefits of a life insurance policy may be freely assigned because life insurance today is both a financial planning tool and a means of protection against the contingency of untimely death. The assignee may even be someone in a position to effect the health of the insured. There is even a United States Supreme Court decision, written by Oliver Wendell Holmes, that permitted a prospective surgery patient to assign policy benefits to the physician who would perform the surgery. *Grigsby v. Russell*, 222 U.S. 149 (1911). However, the Court's view is not binding on states because insurance is largely under the control of state substantive law rather than federal law. Despite the venerable of *Grigsby* decision, states may want to consider the rule proposed by the Washington Medical Association or to distinguish between ordinary life insurance and credit life insurance as to the propriety of purchase, beneficiary designation, or assignment and the status of the parties.

Even for "ordinary" life insurance, there may be public policy issues worth considering. Despite *Grigsby*, one may recoil a little at the view that a surgeon is more likely to get paid if the patient does not survive the operation. But the doctor is subject to professional regulation, and the operating room is full of witnesses should things go wrong. By contrast, care of the disabled often occurs in individual homes or rooms and, thus, out of sight. At the same time, one can readily understand that a seriously ill patient may wish to provide for a valued caregiver by naming him or her as a life insurance beneficiary. But does this mean the state should permit the caregiver to go on a buying spree of insurance policies on the life of the patient?

Abbott makes interesting reading and clarifies some important aspects of credit life insurance, but can be viewed as a missed opportunity to articulate groundrules of insurability.

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