CONNECTICUT INSURANCE LAW JOURNAL

VOLUME 9 | 2002-2003 | NUMBER 2

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THE LAWLESSNESS OF ARBITRATION

Kenneth S. Abraham[*] & *J.W. Montgomery, III*[**]

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INTRODUCTION

Over the past few decades, Alternative Dispute Resolution (ADR) has become a favorite of critics of the American legal system, who decry the system's inefficiency, inaccuracy, and unfairness.[1] ADR is increasingly

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1. *See, e.g.*, Curtis H. Barnette, *The Importance of Alternative Dispute Resolution: Reducing Litigation Costs as a Corporate Objective*, 53 ANTITRUST L.J. 277 (1984); Jeffrey S. Brenner, *Alternatives to Litigation: Toxic Torts and Alternate Dispute Resolution: A Proposed Solution to the Mass Tort Case*, 20 RUTGERS L.J. 779 (1989); Caroline Harris Crowne, *The Alternative Dispute Resolution Act of 1998: Implementing a New Paradigm of Justice*, 76 N.Y.U. L. REV. 1768 (2001); Harry T. Edwards, *Alternative Dispute Resolution: Panacea or Anathema?*, 99 HARV. L. REV. 668 (1986); Eileen Barkas Hoffman, *The Impact of the ADR Act of 1998*, TRIAL, June 1991, at 30; Irving R. Kaufman, *Reform for a System in Crisis: Alternative Dispute Resolution in the Federal Courts*, 59 FORDHAM L. REV. 1 (1990); Robert J. McLucas, *An Insurer's Use of Alternative Dispute Resolution: The Travelers' Experience*, ARB. J., June 1984, Vol. 39, No. 2 at 55; Robert F. Peckham, *A Judicial Response to the Cost of Litigation Case Management, Two-Stage Discovery Planning and Alternative Dispute Resolution*, 37 RUTGERS L. REV. 253 (1985); Lucille M. Ponte, *Putting Mandatory Summary*

available; certain forms of ADR are mandated by some courts as a precondition to the trial of disputes;[2] and a body of law that is highly favorable to and supportive of agreements to engage in ADR has emerged.[3]

One of the principal weapons in the ADR arsenal, mandatory, binding arbitration, is often cited as a desirable alternative to litigation of disputes in courts of law.[4] Whatever the merits of mandatory, binding arbitration in general, however, in certain kinds of disputes this form of ADR involves

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Jury Trial Back on the Docket: Recommendations on the Exercise of Judicial Authority, 63 FORDHAM L. REV. 1069 (1995); Jerome M. Staller, *The Advantages of Alternative Dispute Resolution in Tort Cases*, PRAC. LAW., Mar. 1985, Vol. 31, No. 2 at 57.

2. *See* W.D. OKLA. LCVR. 16.3 SUPP. § 5.2(b) (compulsory non-binding arbitration for most civil cases in which damages would not exceed $100,000); E.D. PA. R. 53.2, R. 53.2.1 (compulsory, non-binding arbitration for cases with potential awards less than $150,000 and compulsory mediation for odd-numbered civil cases); E.D.N.Y. R. 83.10(d) (compulsory arbitration for most civil cases where the amount in dispute does not exceed $150,000). The Judicial Improvements and Access to Justice Act of 1988 authorized compulsory, non-binding arbitration as a precondition to trial for ten federal district courts: Northern District of California, Middle District of Florida, Western District of Michigan, Western District of Missouri, District of New Jersey, Eastern District of New York, Middle District of North Carolina, Western District of Oklahoma, Eastern District of Pennsylvania, and Western District of Texas. 28 U.S.C.A. §§ 651–58 (West 1994).

3. *See, e.g.*, Gilmer v. Interstate/Johnson Lane Corp., 500 U.S. 20, 26 (1991) (questions of arbitrability must be addressed with a healthy regard for the federal policy favoring arbitration). *See also* Rodriguez de Quijas v. Shearson Amer. Express, Inc., 490 U.S. 477 (1989); Shearson Amer. Express Inc. v. McMahon, 482 U.S. 220 (1987); Mitsubishi Motors Corp. v. Soler Chrysler-Plymouth, Inc., 473 U.S. 614 (1985); Moses H. Cone Memorial Hosp. v. Mercury Constr. Corp., 460 U.S. 1, 24 (1983) ("[A]ny doubts concerning the scope of arbitrable issues should be resolved in favor of arbitration . . . ."). *See generally* Phillip C. Essig, *U.S. Supreme Court Tackles Arbitration Issues*, 213 N.Y.L.J. 1 (1995); Preston Douglas Wigner, *The United States Supreme Court's Expansive Approach to the Federal Arbitration Act: A Look at the Past, Present, and Future of Section 2*, 29 U. RICH. L. REV. 1499 (1995).

4. *See, e.g.*, Michael J. Brady & Terry Anastassiou, *Binding Arbitration of Coverage and Bad Faith Disputes: A Way out of the Thicket for the American Insurance Industry*, 51 FED'N INS. & CORP. COUNS. 355 (2001); Charles B. Craver, *The use of Non-Judicial Procedures to Resolve Employment Discrimination Claims*, 11 KAN. J.L. & PUB. POL'Y 141 (2001); James R. Holbrook & Laura M. Gray, *Court-Annexed Alternative Dispute Resolution*, 21 J. CONTEMP. L. 1 (1995); John J. McDonald Jr., *Reinsurance Arbitration 2001: Will the New Ways Cripple "Arbitration Clause"?*, 68 DEF. COUNS. J. 328 (2001); Matthew C. McDonald & Kirkland E. Reid, *Arbitration Opponents Barking up Wrong Branch*, 62 ALA. LAW. 56 (Jan. 2001); Lewis D. Solomon & Janet Stern Solomon, *Using Alternative Dispute Resolution Techniques to Settle Conflicts Among Shareholders of Closely Held Corporations*, 22 WAKE FOREST L. REV. 105 (1987); John M. Flynt, Comment, *A Solution to Force-Placed Insurance Litigation for Lenders: Disclosure and Arbitration*, 26 CUMB. L. REV. 537 (1996).

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serious disadvantages. Although this Article uses insurance disputes as an example, these disadvantages are risked in any dispute in which one of the parties is a repeat player and the dispute involves cutting-edge legal issues.

This Article identifies and analyzes the way such problems may arise when insurance coverage disputes are subject to mandatory, binding arbitration. It argues that arbitration often involves a form of contractual "lawlessness" that is especially undesirable in claims that involve new legal issues. This lawlessness not only adversely affects the parties to each dispute, but the legal system as a whole. As a consequence, in our view insurance policyholders should be reluctant to purchase policies that require binding arbitration of coverage disputes. In addition, since the problems that we identify are likely to arise not only in insurance, where new, cutting-edge issues have regularly emerged for decades,[5] but also in other kinds of disputes posing new legal issues, the legal system should reconsider the highly favorable stance that it takes toward mandatory, binding arbitration in general, so as to take account of the negative effects of arbitration lawlessness. A neutral legal and judicial stance toward binding arbitration would be more appropriate.

I. THE CONTEXT OF INSURANCE ARBITRATION

There can no longer be any doubt that arbitration of commercial and corporate disputes has an important role to play in the resolution of American legal disputes. ADR approaches of various sorts, including binding arbitration, are increasingly relied upon as a complement or alternative to conventional lawsuits.[6] In appropriate cases, such devices as mediation and arbitration have the potential to promote speedier, less expensive, and more amicable resolution of legal controversies than ordinary litigation.

Insurance disputes are no exception. Whether the policyholder is an individual, a partnership, or a corporation, bringing a lawsuit against an

5. *See generally*, Kenneth S. Abraham, *The Maze of Mega-Coverage Litigation*, 97 COLUM. L. REV. 2102 (1997).

6. Between 1998 and 2000, for example, the number of cases filed with the American Arbitration Association doubled. In 2000, 198,491 cases were filed, compared with 140,188 cases in 1999 and 95,143 cases in 1998. *See* AM. ARBITRATION ASS'N, 2000 ANNUAL REPORT 5 (2001); AM. ARBITRATION ASS'N, 1999 ANNUAL REPORT 3 (2000) (on file with the author). *See also*, THE NATIONAL ASSOCIATION OF SECURITIES DEALERS, *Dispute Resolution Statistics*, *at* http://www.nasdadr.com/statistics.asp#arbitration (last visited Mar. 1, 2003) (reporting a twenty-four percent increase in the number of filings with its dispute resolution center from 2000 to 2001).

insurance company often results in a prolonged, expensive, and uncertain legal conflict.[7] When the suit must be brought against dozens of insurance companies—as is often the case when the claim involves toxic tort, products liability, or environmental cleanup—the prospect of entering into litigation is daunting. Sometimes, of course, there is no alternative: the underlying liabilities involve tens or hundreds of millions of dollars, the policyholder's insurers have denied the claim or are offering to settle for only a tiny percentage of the claim, and the decision not to sue would be tantamount to making a multi-million dollar gift from the policyholder's shareholders to its insurers.

Litigation, however, is not always the only alternative available. Arbitration is almost always a possibility. Few standard-form primary commercial liability and property insurance policies issued by American insurers contain arbitration clauses. Certain non-standard insurance policies, in contrast, do contain mandatory arbitration clauses. For example, excess general liability and umbrella policies issued by the Bermuda-based insurers ACE and XL—both of which were formed in order to provide coverage to American policyholders during the extremely tight market of the mid-1980s—incorporate mandatory arbitration clauses.[8] In addition, in our experience liability insurance policies issued by certain segments of the London market contain such clauses; maritime insurance policies frequently contain arbitration requirements; and a variety of other special-purpose policies often require arbitration as well. Finally, insurers whose policies do not contain arbitration clauses are nevertheless likely to be willing to submit disputed claims to binding arbitration rather than litigating them. That is, pre-claim arbitration requirements are common but not the norm, yet post-claim agreement to binding arbitration is always at least a distinct possibility.

Thus, policyholders sometimes have a choice—either at the point of sale or at the point of claim—regarding the method they will employ to resolve disputes with their insurers. At the point of sale, policyholders purchasing coverage in the non-standard market may be presented with a choice between insurers whose policies do and do not contain mandatory arbitration clauses; and after a dispute arises, even standard-form insurers may be willing or even eager to arbitrate. At each of these decision points, policyholders are faced

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7. *See generally* Abraham, *supra* note 5.

8. *See* Mitchell Dolin & Ethan M. Posner, *Understanding the Bermuda Excess Liability Form*, 1 J. INS. COVERAGE 68, 79 (1998); Lorelie S. Masters, *ACE and X.L.: A New "Batch" of Coverage Issues*, 9 COVERAGE 24, 29 (1999).

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with a clear and significant choice between binding arbitration and conventional litigation.

Although the form and nature of insurance arbitrations vary, the general outlines are fairly uniform. Typically there are three arbitrators, one appointed by each of the parties, and a third chosen by the two party-appointed arbitrators. If the party-appointed arbitrators do not agree on the third arbitrator (sometimes called a "referee" or "umpire"), then a designated neutral appoints the third arbitrator. For example, under the English Arbitration Act of 1996, the parties may petition the High Court to appoint a third arbitrator if there is an impasse over his appointment.[9] The rules of the American Arbitration Association also provide a method for appointing the third arbitrator when the parties cannot do so on their own.[10]

Many arbitration clauses contain choice-of-law provisions, designating the law of a specific state to govern disputes under the policy, though sometimes subject to qualifications. For example, the Bermuda-based ACE and X.L. policies designate the law of New York to govern disputes under them, but provide that the policy is to be interpreted in evenhanded fashion, without "arbitrary" rules or construction, without construing ambiguous provisions against either party, and without reference to extrinsic evidence.[11]

Ordinarily, arbitrations are not subject to the strict rules of evidence, but neither is discovery as extensive as in typical civil litigation. Sometimes there is a version of motion practice to narrow issues; and often direct testimony is provided in writing in advance, with in-person cross-examination before the arbitrators. Except under unusual circumstances, actual arbitration hearings tend to last a number of days or a few weeks at most, but not months.

Compared to the rigors of American civil litigation, arbitration as just described may seem to present an attractive alternative. Most importantly, the parties avoid the defining feature of American civil litigation—the lay jury. However, they also lose access to another highly significant feature of litigation—the trial judge and the appellate courts. A choice in favor of binding arbitration instead of litigation therefore risks hidden adverse

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9. Arbitration Act, 1996, c. 1, § 18 (Eng.) (if there is a failure in the appointment procedure, either party may request that the court make any necessary appointments).

10. American Arbitration Association (AAA), Commercial Dispute Resolution Procedures, Rules 13–14 (if the parties are unable to agree upon an arbitrator or cannot do so in a timely manner, the AAA shall have the sole power to make the appointment from among acceptable members of a national panel of arbitrators), *available at* www.adr.org (last visited Mar. 1, 2003).

11. *See* Dolin & Posner, *supra* note 8, at 76–77.

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consequences. Because arbitrations are essentially confidential and set no precedents, they lack an important feature of the rule of law: each arbitration is an island unto itself, not governed by any prior arbitration outcomes and incapable of having an effect on any future arbitration.

This "lawless" feature of arbitration has not only private consequences for the policyholder making the choice to arbitrate, but also public consequences for all future policyholders considering whether to arbitrate or litigate. There are no arbitration precedents because proceedings and results are confidential; no common understanding of the meaning of repeatedly-used provisions emerges unless they are standard-form provisions whose meaning has been publicly litigated; and parties who consider purchasing insurance policies that require arbitration of coverage disputes have no way to anticipate the interpretations that insurers selling these policies may place on such policy provisions when a loss occurs and a claim is filed. Moreover, because any present policyholder will automatically suffer the consequences of earlier policyholders' decision to arbitrate rather than litigate, over time the adverse consequences of successive arbitrations are cumulative. Thus, a seemingly innocent and apparently desirable alternative to litigation turns out to be an enemy of the process of lawfully resolving insurance coverage disputes.

II. THE PRIVATE CONSEQUENCES OF BINDING ARBITRATION

The lawless features of insurance arbitration are troubling in general, but pose especially severe risks in cases that raise issues that have not yet been definitively resolved by established law, or involve the interpretation of non-standard policy provisions whose meaning has not been determined by prior judicial decision. To see how and why, it is useful to consider and then analyze a hypothetical situation involving an insurance claim posing a novel issue. The hypothetical claim can either be litigated or arbitrated, with important consequences flowing from the choice between the two approaches.

A. Litigating Versus Arbitrating a Hypothetical Claim

Suppose that a policyholder makes a claim under its Commercial General Liability (CGL) insurance policy for coverage of certain suits alleging that a product manufactured by the policyholder is defectively designed.[12] The

12. This policy provides the dominant form of general business-liability insurance to virtually all commercial enterprises in the United States. For analysis of the policy, see KENNETH S. ABRAHAM, INSURANCE LAW & REGULATION 393–494 (3d ed. 2000).

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policy excludes coverage of liability for bodily injury or property damage that is "expected or intended" from the standpoint of the insured.

1. Litigating the Claim

The insurer denies the claim and the policyholder brings suit against the insurer for breach of contract. At the close of discovery, the insurer moves for summary judgment on the ground that, because the policyholder had experienced claims alleging liability for this defect in the past, the policyholder "expected or intended" all future damage arising out of this defect, as a matter of law. The issue is whether awareness of a risk that similar claims will be made in the future means that the policyholder "expected or intended" the injuries in question. There is no applicable precedent governing this issue. The trial court grants the insurer's motion and the policyholder appeals.

On appeal the state Supreme Court rules in the policyholder's favor, reversing and remanding the case for trial, on the ground that the standard for determining whether a policyholder "expected or intended" bodily injury or property damage is subjective and particular. Therefore, the court holds, although evidence that there had been past claims and or injuries associated with the alleged product defect is admissible in evidence as tending to prove actual subjective expectation, the mere fact that there have been past claims or injuries does not, by itself, require an inference as a matter of law that the policyholder subjectively expected or intended future injury.

2. Arbitrating the Claim

Suppose now that the same facts exist, except that the policyholder's CGL insurance policy contains a requirement that disputes arising under the policy be arbitrated and that the decision of the arbitrators is binding. The insurer denies the claim. In a motion submitted to the arbitrators (before or at the close of the hearing, depending on the procedure being followed), the insurer argues that as a matter of law the policyholder expected or intended injury, because the policyholder had in the past experienced claims alleging liability for the same product defect at issue in the current claim. As before, there is no precedent governing the issue. The arbitrators accept the insurer's argument and dismiss the policyholder's claim.

B. Analysis

The formal and procedural differences between litigating and arbitrating the hypothetical case are obvious. First, if the parties arbitrated, they kept their dispute out of the public eye. Their dirty linen was not aired in public. Second, they were subject to a set of streamlined rules of procedure and

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evidence. The dispute was therefore less encumbered by legal technicality than it probably would have been had it been litigated. Third, the dispute was probably less costly to process. Counsel fees and other related expenses were lower than in litigation. Finally, arbitrators with at least some familiarity and probably expertise in the subject of the dispute were substituted for the judge and jury who would have decided the case if it were litigated.

The implications of this last feature of arbitration are worth examining, for these implications lead to the potential disadvantages of arbitration. It is not just the jury that is absent from arbitration, but also both the trial judge and recourse to appeal. As a result, neither party has redress when a mistake of law is made in an arbitration. Arbitration decisions are not appealable and may not otherwise be challenged on this (or virtually any other) ground.[13] As a result, there is no way for the parties to obtain an authoritative ruling on issues of first impression raised in the dispute—or in fact on any issue that has not yet been authoritatively resolved by the relevant court or courts. Moreover, even when there is established law on an issue, because of the non-appealability of arbitration results, for practical purposes the dispute is not authoritatively governed by established law. Many arbitration clauses in commercial insurance policies that we have reviewed provide arbitrated disputes are to be resolved under the law of a designated jurisdiction, but not all arbitration clauses contain such choice-of-law provisions. The arbitrators must then determine which state's or nation's law applies. And in any event, when the arbitrators commit error in selecting or applying established law, for practical purposes their error is almost always irreversible.

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13. The Federal Arbitration Act specifies four grounds on which a commercial arbitration award may be vacated:

> (1) where the award was procured by corruption, fraud, or undue means; (2) where there was evident partiality or corruption in the arbitrators; (3) the arbitrators were guilty of misconduct in refusing to postpone the hearing, upon sufficient cause shown, or in refusing to hear evidence pertinent and material to the controversy . . . [and] (4) where the arbitrators exceeded their powers, or so imperfectly executed them that a mutual, final, and definite award upon the subject matter submitted was not made.

9 U.S.C. § 10(a) (2002). In addition to the statutory grounds listed in section 10(a), various federal courts have recognized non-statutory grounds for vacating awards. *See, e.g.*, Tanoma Mining Co. v. Local Union No. 1269, 896 F.2d 745, 749 (3d Cir. 1990) (recognizing that an award may be set aside if it displays "manifest disregard" for the law); United Paperworkers Int'l Union v. Misco, Inc., 484 U.S. 29, 43 (1987) (arbitration award may be vacated if it violates public policy); Montes v. Shearson Lehman Bros., Inc., 128 F.3d 1456, 1458 (11th Cir. 1997) ("arbitration award may be vacated if it is arbitrary and capricious.").

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The absence of any redress for mistakes of law committed in an arbitration is especially troublesome for policyholders in coverage disputes that raise cutting-edge issues—issues of first impression, or those on which conflicts between lower courts have not yet been authoritatively resolved. Arbitrators should ordinarily be able to apply any existing law accurately to frequently-litigated issues.[14] It is virtually certain, however, that arbitrators will sometimes incorrectly resolve issues for which there is no directly-governing precedent or the applicable case law is in conflict. A policyholder litigating such issues has a remedy when a trial court commits a legal error: appeal. But a policyholder whose claim is improperly rejected in arbitration has no redress. The policyholder who arbitrated in our hypothetical was left without a claim.

Further, since many of the insurance policies that contain arbitration clauses today are sold by foreign insurers, it is common for these insurers to appoint foreign lawyers or insurance professionals as arbitrators, and such individuals are sometimes selected as the "neutral" arbitrator as well. The risk that these individuals will commit mistakes of law where American law governs the dispute is high, especially if they are not legally trained. Because even foreign arbitrators who are lawyers are not necessarily experts on the way that American law works, however, it is common practice for the arbitrators to hear competing expert testimony on the state of the law applicable to the claim. But this is hardly a substitute for what Karl Llewellyn once called "situation sense"—the ability of a trained judge or lawyer long-acquainted with a field to discern the presence or absence of the subtle factors that affect both the direction and trajectory of legal development and the application of an established rule of law to a particular set of facts.[15] Wooden reasoning that fails to account for these subtleties may be the result.

Just as importantly, when certain insurers always include arbitration clauses in their policies, then the meaning of policy provisions that are unique or distinctive to these insurers' policies never come to be interpreted in accordance with established law governing their meaning, because there are no judicial decisions interpreting these provisions. Nor can any policyholder considering purchasing such a policy predict how its insurer will interpret

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14. *See* William M. Landes & Richard A. Posner, *Adjudication as a Private Good*, 8 J. LEGAL STUD. 235, 249 (1979) (suggesting that arbitration is usually limited to disputes where the rules are perfectly clear).

15. *See* KARL N. LLEWELLYN, THE COMMON LAW TRADITION: DECIDING APPEALS 121, 203 (1960).

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terms that are unique to its particular policy form. Instead, each arbitration panel faced with a dispute as to the meaning of a particular provision must proceed as if it is writing on a blank slate. Yet the insurer may actually have already been involved in a series of arbitrations in which the meaning of the provision has been determined. Because of the confidential, non-precedent-setting character of those prior arbitrations, however, the policyholder will have no knowledge of the position the insurer took regarding the meaning of the provision, nor any knowledge of the prior arbitration panel's interpretation of the provision.

In any of these settings, the policyholder is subjected to potentially "lawless" treatment in several different ways. First, the insurer may take different positions regarding the meaning of a particular policy provision without concern for the requirements of judicial estoppel that would ordinarily obtain in a judicial proceeding. Therefore, the insurer may with impunity attempt to treat similarly situated policyholders differently, or differently-situated policyholders the same, each time interpreting the relevant policy provision in an inconsistent, but self-serving manner.

Second, an insurer that takes a position about the meaning of a policy provision is entitled to continue to do so even though one arbitration panel after another rejects the insurer's position. In effect, the insurer gets as many bites of the apple as it wishes. In contrast, in ordinary litigation the doctrines of collateral estoppel and stare decisis would give the insurer only one bite of the apple. It is true that, like the insurer, a policyholder who makes a claim which prior arbitration panels have rejected also has the right to assert that claim without being bound by prior precedent. But unlike the insurer, such a policyholder would never have been precluded in litigation by the doctrine of collateral estoppel from asserting the issue itself, because (unlike the insurer) it had not been a party to any of the prior proceedings.[16]

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16. *See, e.g.*, Parklane Hosiery Co. v. Shore, 439 U.S. 322, 327 n.7 (1979): "It is a violation of due process for a judgment to be binding on a litigant who was not a party or a privy and therefore has never had an opportunity to be heard." Defensive collateral estoppel can only be used by a defendant to prevent a plaintiff from asserting a claim that the plaintiff has previously litigated and lost against another defendant; in contrast, offensive use of collateral estoppel is permitted when the plaintiff seeks to foreclose the defendant from litigating an issue the defendant has previously litigated unsuccessfully in an action with another party. *Id.* at 326 n.4. *See also* Blonder-Tongue Laboratories, Inc. v. Univ. of Illinois Foundation, 402 U.S. 313, 328–29 (1971) (defensive use of nonmutual collateral estoppel requires that the plaintiff was a party to the prior action). Many states now follow the same rules. *See generally* Sup. Ct. Bd. of Ethics v. D.J.I., 545 N.W.2d 866 (Iowa 1996); In Re

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These "lawless" features of binding arbitration mean that every policyholder whose claim must be resolved in arbitration risks proceeding as if it is the first policyholder ever to make the kind of claim in question. The insurer is not bound by the results in past arbitrations, yet may employ the experience and knowledge it has gained in those past arbitrations in attempting to succeed in the current arbitration. Because of its involvement in prior arbitrations, the insurer may know how particular potential arbitrators have ruled on recurring issues; yet the policyholder probably will have no access to such information. And if an insurer were to continually take positions in court that prior courts had consistently rejected, it would face the downside possibility of being held liable for extra-contractual damages for the insurer's bad faith.[17] In contrast, in arbitration the insurer can continue to take such positions with impunity. In arbitration there is in this respect no downside for the insurer; there is only upside.

In certain situations this state of affairs is unlikely to be troublesome for policyholders. For example, when the issue or issues at stake in an arbitration have often been litigated and resolved by courts of law, the risk of being subjected to "lawless" treatment is reduced. The law governing the issue will be clear and arbitrators acting in good faith will find it easy to apply. Similarly, when the issue or issues are subject to established custom or trade usage with which the arbitrators and the parties are familiar, then a resolution consistent with these practice is to be expected. Finally, when a dispute turns mainly on issues of fact rather than legal issues of first impression, resolution of these issues in an arbitration may be highly desirable.

The difficulty many policyholders face, however, is that they cannot know in advance the particular character of the dispute or disputes that may arise under a policy containing a mandatory, binding arbitration clause. Those issues may be well-suited to resolution in an arbitration, or they may be issues that are especially susceptible to "lawless" treatment by the insurer and "lawless" resolution in the arbitration itself. Because it is likely to be impossible to know in advance which class of issues will arise in a policyholder's claim or claims, agreeing to mandatory, binding arbitration of

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Cohen, 753 N.E.2d 799 (Mass. 2001); Falgren v. State Bd. of Teaching, 545 N.W.2d 901 (Minn. 1996); Cities Serv. Co. v. Gulf Oil Corp., 980 P.2d 116 (Okla. 1999); Avila v. St. Luke's Lutheran Hosp., 948 S.W.2d 841 (Tex. App. 1997); Nielson v. Spanaway Gen. Med. Clinic, Inc., 956 P.2d 312 (Wash. 1998).

17. On liability for bad faith, see ABRAHAM, *supra* note 12, at 414–31; ROBERT L. JERRY II, UNDERSTANDING INSURANCE LAW § 25G at 151–61 (2d ed. 1996).

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insurance disputes at the point of sale is a risky undertaking for any policyholder. But even after a claim is made the issues that will arise may not be completely predictable. Though agreement on arbitration shortly after the point of claim is less risky, it is not without the same dangers.

III. THE PUBLIC CONSEQUENCES OF THE DECISION TO ARBITRATE

Just as the consequences of arbitrating a dispute risks lawless resolution for the individual parties, for the reasons described below the repeated practice of arbitrating a class of disputes generally risks lawlessness for the legal system as a whole. The fact that arbitration may have adverse consequence for the development of the law is insufficient reason, in itself, for the law to invalidate or even to look unfavorably on this practice. Freedom of contract should not be lightly set aside, especially when arbitration is the result of an agreement between sizable, well-informed commercial enterprises. But the threat of these adverse consequences should be enough to prompt a rethinking of the strong presumption favoring arbitration that prevails in American law.[18] A neutral stance would be far more appropriate.

To see the way in which binding arbitration may adversely affect legal development, consider once again our earlier hypothetical case that can either be arbitrated or litigated. In this case, once the state supreme court's decision on the expected or intended issue was rendered, under the doctrine of collateral estoppel the insurer was precluded from taking the same position in future cases because the issue had been fully litigated and definitively decided against it. Similarly, under the doctrine of *stare decisis*, the decision was binding precedent that would preclude other insurers from relitigating the issue. Because of both doctrines, and regardless of the identity of the insurer, a trial court would be without authority to hold that, on the same essential facts, a policyholder expected or intended bodily injury or property damage as a matter of law.

In contrast, an arbitration decision is not public, is not publicized, and is not published. In fact, in many arbitrations the parties are obligated to keep all proceedings and the outcome of the arbitration confidential. Certainly the decision of one arbitration panel has no binding or precedential effect on any other panel or insurer. And it is probable that in the view of most insurers, the particular insurer against which the first arbitration panel resolved an issue can continue to take the same position when either the same policyholder or any

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18. *See supra* note 4.

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other policyholder makes a claim involving essentially the same relevant facts. For all practical purposes, a decision by an arbitration panel is a public nullity. Consequently, neither the policyholder nor the arbitrators embarking on the arbitration of a dispute that raises issues which have been the subject of past arbitrations has a body of arbitration-generated precedent to guide them.

Thus, both the confidential and the non-precedent-setting features of binding arbitration have significant disadvantages. Established, publicly-known law is a public good. Such law provides guidance that aids and promotes commercial conduct and business planning. Even if a rule is wrong or unwise, if it is publicly known then those who are subject to the rule can govern their conduct accordingly. Established, publicly-available law also binds legal decision-makers, and by so doing makes the outcome of disputes more nearly predictable. Predictability of outcome promotes settlement. And promoting settlement of disputes is a feature of the public policy of virtually every legal jurisdiction, foreign or domestic. Thus, arbitration of disputes prevents the development of a body of established law and governing interpretations of relevant policy provisions, depriving the parties to future arbitrations of this public good.

Of course, the same charge might be made against settlement, which the law strongly favors. Some commentators have in fact argued that private settlement, as distinguished from trial and judgment, is in some ways against the public interest.[19] Settlement, however, is much less likely to have the same precedent-suppressing effect as arbitration. Settlement takes place in the shadow of litigation; the clearer the law governing a dispute, the smaller the divergence of the parties' estimates of the range of probable outcomes is likely to be, and the more likely settlement is to take place.[20] Settlement is therefore

19. *See, e.g.*, Owen M. Fiss, *Against Settlement*, 93 YALE L. J. 1073 (1984).

20. *See* George L. Priest & Benjamin Klein, *The Selection of Disputes for Litigation*, 13 J. LEGAL STUD. 1, 10–11 (1984). Although there has been much subsequent discussion in the literature regarding the Priest-Klein findings, the general point that other things being equal uncertainty of outcome discourages settlement has maintained high credibility. For discussion from various points of view, see Daniel Kessler et al., *Explaining Deviations From the Fifty-Percent Rule: A Multimodal Approach to the Selection of Cases for Litigation*, 25 J. LEGAL STUD. 233 (1996); Steven Shavell, *Any Frequency of Plaintiff Victory at Trial is Possible*, 25 J. LEGAL STUD. 493 (1996); Peter Siegelman & John Donohue, *The Selection of Employment Disputes for Litigation: Using Business Cycle Effects to Test the Priest-Klein Hypothesis*, 24 J. LEGAL STUD. 427 (1995); Peter Siegelman & Joel Waldfogel, *Toward a Taxonomy of Disputes: New Evidence Through the Prism of the Priest/Klein Model*, 28 J. LEGAL STUD. 101 (1999); Robert E. Thomas, *The Trial Selection Hypothesis Without the 50 Percent Rule: Some*

more likely when there is firm, governing precedent. And when such precedent is absent, litigation leading to the establishment of precedent is more likely. Thus, settlement is unlikely to pose the same problems for the development of the law as arbitration. In fact, the practice of arbitration is likely to impede settlement by impeding the development of precedent.

The result is that, even for parties who are not forced to arbitrate insurance coverage disputes, the more prevalent the arbitration of similar disputes has been in the past, the less established law there will be to guide the adjudication and settlement of disputes that are litigated rather than arbitrated. Of equal importance is the fact that the continued, parallel litigation and arbitration of disputes raising the same issues will risk violating perhaps the single most important principle of our jurisprudence: the idea that like cases should be decided alike. This kind of lawlessness—differential treatment of similarly situated parties—reflects the denial of regularity that a system of established legal rules is designed to avoid. At bottom it is analogous to violation of the principle underlying due process requirements.

Ironically, then, the incorporation of arbitration clauses in a series of separate insurance contracts that are ostensibly the product of individual freedom of contract can combine to create a system in which there is little or no law to guide the resolution of disputes arising under the contracts. Designed to benefit the parties to each individual contract, the aggregate consequence of incorporating arbitration clauses in separate insurance contracts for all the parties can be to create disadvantages for these parties that are far greater than the individual benefits they had hoped to achieve through arbitration. Like the "tragedy of the commons," in which each individual has an incentive to consume more of a valuable common resource than is collectively desirable,[21] the practice of arbitrating of insurance disputes—even when it is in fact advantageous to particular parties—can prevent the development of the common resource of established, publicly-available law governing the meaning and application of insurance policies.

CONCLUSION

Without doubt, arbitration of certain commercial disputes, and even of certain commercial insurance disputes, is desirable. When the law governing

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Experimental Evidence, 24 J. LEGAL STUD. 209 (1995); Donald Wittman, *Is the Selection of Cases for Trial Biased?*, 14 J. LEGAL STUD. 185 (1985).

21. *See* Garrett Hardin, *The Tragedy of the Commons*, 162 SCI. 1243, 1244 (1968).

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an issue is well-settled, or where predominantly factual questions are at issue, arbitration offers a confidential, potentially expeditious method of resolving disputes. When legally unresolved issues may arise, however, arbitration of insurance disputes is a trap for the unwary. Because many major disputes under commercial insurance policies tend to raise such issues, commercial policyholders would be well advised to think twice before purchasing insurance policies that provide for mandatory, binding arbitration. They must weigh the advantages of confidentiality, cost-saving, and decision-maker expertise in certain respects, on the one hand, against the disadvantages of potentially lawless resolution of the dispute without recourse to correction by higher authority. And because binding arbitration impedes the production of publicly-known legal rules, the courts themselves should be more neutral toward arbitration than they have tended recently to be. The strong presumption in favor or arbitrating disputes that at least arguably belong in courts of law should be abolished.

CONTAINING THE PROMISE OF INSURANCE: ADVERSE SELECTION AND RISK CLASSIFICATION

*Tom Baker**

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INTRODUCTION

> Insurance, therefore, takes from all a contribution; from those who will not need its aid, as well as from those who will; for it is as certain that some will not, as that some will. But as it is uncertain who will, and who will not, it demands this tribute from all to the uncertainty of fate. And it is precisely the moneys thus given away by some, and these only, which supply the fund out of which the misfortune of those whose bad luck it is that their moneys have not been

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> thrown away, are repaired. The afflicted finds his money spent to some purpose; and only the fortunate part with it for nothing. From this point of view the whole beauty of the system of insurance is seen. It is from this point of view that it presents society a union for mutual aid, of the fortunate and unfortunate, where those only who need it receive aid, and those only who can afford it are put to expense. Thus, while the aggregate of human suffering and calamity remains undiminished . . . thus, while the uncertainty of their visitation remains unremoved, human ingenuity and cooperation equalize the distribution of this fearful aggregate, and alleviate the terrors of uncertainty.
>
> By a system of mutual insurance thus generally established, embracing all callings, a great fund, as it were, for the benefit of society, would be created; a fund to which none could be said to contribute gratuitously, from which none but the needy should be aided; a great reserve fund, held in readiness for the uncertain case of want. We thus have the mechanic, the laborer, and the merchant, joined hand in hand in mutual protection against the risks of their callings; we have the masses, above all, shielded from the most blighting evil of the inequality of human condition, the danger of destitution; we have society united on the basis of mutual insurance.[1]

Written by an American lawyer and insurance entrepreneur, this mid-nineteenth century text offered insurance as a solution to at least some of the contradictions of capitalism. Accepting the inequality that resulted from capitalist modes of production, the author presented insurance as a technology for protecting people from what the sociologist Joseph Schumpeter would later call the "creative destruction" of capitalism. Against Marx (or, more likely, against the mid-nineteenth century French socialists who influenced Marx), Jacques offered a less radical vision. Instead of collective ownership of the means of production, there would be collective protection against misfortune. Not quite "to each according to his need and from each according to his ability," but rather "society united on the basis of mutual insurance."

1. D.R. Jaques, *Society on the Basis of Mutual Life Insurance*, HUNT'S MERCHANT MAG. & COM. REV. 16, 152–53.

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Looking back from our position on the far side of the twentieth century, it is easy to say who held the better crystal ball. The technology and form are not precisely as Jacques predicted, but insurance has become nearly as central a social institution as he imagined. Yet, along with the expansion of insurance, has come a better sense of the limits of insurance as an engine of social solidarity. Notwithstanding the ubiquity of insurance, the "unity" it produces is much less complete than Jacques' utopian image might suggest.

Two reasons commonly given for the limits on the promise of insurance are the problems of moral hazard and adverse selection. "Moral hazard" refers to the change in incentives that can result from insurance protection. "Adverse selection" refers to the theoretical tendency for low risk individuals to avoid or drop out of insurance pools, with the result that, absent countervailing efforts by administrators, insurance pools can be expected to contain a disproportionate percentage of high risk individuals.[2] The problem of moral hazard has received significant attention in the sociology of risk and insurance.[3] Although the rhetoric of moral hazard can be misused to disguise the politics of self-interest, there is little dispute that protection against harm can increase what Jacques called the "aggregate of human suffering and calamity."[4] For this reason, all successful insurance institutions take measures to align individual incentives with the common goal of minimizing the frequency and extent of insured losses.[5]

The problem of moral hazard *contains* (in the sense of *limits*) the promise of insurance by requiring insurance institutions to balance

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2. In this Article I will not challenge the empirical claims made in the name of adverse selection, though, as work in progress by Peter Siegelman reflects, there is considerable evidence that adverse selection plays a much smaller role in many insurance pools than theory would suggest. *See* Peter Siegelman, *Adverse Selection: A Critique* (manuscript on file with the author).

3. Carol Anne Heimer, *Reactive Risk and Rational Action: Managing Moral Hazard*, *in* INSURANCE CONTRACTS (1989); Deborah Stone, *Beyond Moral Hazard: Insurance as a Moral Opportunity*, *in* EMBRACING RISK: THE CHANGING CULTURE OF INSURANCE AND RESPONSIBILITY (Tom Baker & Jonathan Simon eds., 2002); Tom Baker, *Insuring Morality*, 29 ECON. & SOC'Y 559 (2000) [hereinafter Baker, *Insuring Morality*]; Tom Baker, *On the Genealogy of Moral Hazard*, 75 TEX. L. REV. 237 (1996) [hereinafter Baker, *Moral Hazard*]; R. Ericson et al., *The Moral Hazards of Neo-Liberalism: Lessons from the Private Insurance Industry*, 29 ECON. & SOC'Y 532 (2000).

4. Baker, *Moral Hazard*, *supra* note 3.

5. Heimer, *supra* note 3.

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protection and control. The more that a particular risk lays within the control of the insured, the less confidently insurance institutions can insure that risk. To address the problem of moral hazard, insurers require either that the insured relinquish control or retain some risk "coinsurance." Taking control away from insureds—as liability insurers commonly do with respect to the defense and settlement of insured claims—has costs. Where control is particularly expensive, even the most risk averse insured prefers some coinsurance rather than pay the price of full insurance, creating what Carol Heimer has termed a "community of fate" between insurer and insured.[6] Risks that pose a very high degree of moral hazard typically are not insurable at all. For example, intentional harm is almost always excluded from insurance coverage.

This Article begins to extend to the problem of adverse selection the critical attention provided in prior work to the problem of moral hazard. Like moral hazard, adverse selection is an old insurance concept that was adopted, formalized and generalized by economists developing the economics of information. As with moral hazard, insurance economics has addressed the phenomenon of adverse selection largely from the insurers' point of view. Thus, part of my project will be to examine the problem from a different point of view that focuses on how insurers, too, create and shape adverse selection. Towards that end, perhaps the most significant theoretical advance presented here is examining adverse selection in terms that can be applied to both sides of the insurance relationship. At least in the context of insurance risk classification, there is much to be gained in thinking of adverse selection as a "dual" problem (similar to moral hazard), meaning that actions to address adverse selection problem can lead to the de-pooling effect that motivated the actions in the first place.

The Article proceeds in two parts. This first sets forth the case for understanding adverse selection as a dual problem and highlights alternatives to insurance risk classification. The second uses three historical examples to explore moral justifications for insurance risk classification. The three examples are the nineteenth century controversy over age-based pricing in fraternal insurance, the mid-twentieth century controversy over experience rating in unemployment insurance, and the late twentieth-century controversy over efforts to exclude battered women from life, health and disability insurance pools. These examples demonstrate that, rather than being a neutral, technical solution to a

6. *Id.*

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structural dynamic inherent in the insurance relationship, risk classification reflects moral commitments. My goal in this Article is not to discredit the practice of risk classification, but rather to focus attention on the morality that is implicit in arguments for and against risk classification.

PART I

A. Adverse Selection

Sometimes called "anti-selection" in the insurance trade literature, adverse selection refers to the theoretical tendency for low risk individuals to avoid or drop out of voluntary insurance pools, with the result that, absent countervailing efforts by administrators, insurance pools can be expected to contain a disproportionate percentage of high-risk individuals.[7] For example, adverse selection is said to explain the disparity in prices between group and individual health insurance in the United States. With group health insurance, an employer signs up employees as a group, so the insurer gets both the low and the high risks. With individual health insurance, people decide on their own whether to purchase insurance, and those who need it the most are the most likely to purchase it (assuming they have the financial means), with the result that insurers end up with more of the high risks in the pool and less of the low risks.

The phenomenon of adverse selection appears to have been given this name in the life insurance industry in the nineteenth century. In order to decrease the odds of paying a premature death claim, early life insurers, like those today, commonly *selected* among lives according to the health of the applicant. With the development of mortality tables that represented the average rate of death within the population, insurers began using the tables to price their policies on a "scientific" basis.[8] By pricing on the basis of average mortality, building in a margin for expenses and profit, and then selecting to beat the average, insurers were sure to turn a comfortable profit, or at least so insurance theorists reasoned. In practice, insurers were confounded to find that the mortality experience of insured lives matched, and in some cases suffered by comparison to, the mortality experience of

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7. M. Rothschild & J. Stiglitz, *Equilibrium in Competitive Insurance Markets: An Essay on the Economics of Imperfect Information*, 90 Q. J. OF ECON. (1976).

8. J. H. Van Amringe, *Life Assurance*, 15 THE GALAXY 249 (1873) (serialized in the February, March and April 1873 issues).

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the general population.[9] If they were selecting on the basis of health status, the mortality experience of insured lives should be much better than that of the general population!

The answer, actuaries reasoned, was another force at work, *adverse* to their selection efforts. For life insurers, there were two components to this adverse selection. The first operated at the inception of the insurance relationship: "if the medical examiner did not stand at the entrance gate, the weakest and least desirable lives would be surest and soonest to come in."[10] The second was the discovery of ill health by those who already had purchased insurance, with the resulting decline in the average health status of the insured population. The people who decided to discontinue their policies were disproportionately the healthy. Even if "the lives at starting are a very select class, they not only lose this advantage, but degenerate till they are on average worse than the general population."[11] The answer was renewed attention to selection (classification) at the entrance door and the design of insurance contracts that inhibited healthy lives from leaving through the exit.[12]

These two strategies of the nineteenth century life insurers illustrate the two paradigmatic responses to the problem of adverse selection: risk classification and binding risks to the insurance pool. The choice between these responses echoes the choice between the responses to moral hazard: coinsurance and control. Like coinsurance, classification leaves individuals exposed to more risk. Like control, binding risks to the insurance pool constrains at least some aspects of the autonomy of the participants in the pool.

B. Insurance Risk Classification

Insurance risk classification is the process of sorting insurance applicants into categories believed to correspond to differences in expected risk. Common examples include sorting life insurance applicants by age, health insurance applicants by health status, workers compensation insurance applicants by type of industry, and property insurance applicants

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9. G King, *On the Morality Amongst Assured Lives*, 19 J. OF THE INST. OF ACTUARIES 381 (1876).

10. H.C. Lippincott, *The Essentials of Life Insurance Administration*, 26 ANNALS AM. ACAD. POL. & SOC. SCI. 192, 200 (1905).

11. King, *supra* note 9.

12. *Id. See also* Lippincott, *supra* note 10.

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by the nature of the construction of the property to be insured (e.g. wood versus brick).

Risk classification highlights the distributive nature of insurance. Insurance is predicated on the existence of a large percentage of fortunate members of the insurance pool, whose premium dollars go to pay the losses of the unfortunate members. The excerpt from Jacques at the outset presents a "share and share alike" vision of this distribution. All of society is included in the pool: "the mechanic, the laborer, and the merchant, joined hand in hand in mutual protection against the risks of their calling." In this utopian vision, insurance serves only to preserve the status quo, maintaining the economic and social status of members as it stands before misfortune strikes.[13]

The presence of risk classification complicates this picture. Some people have to pay more than others to enter the pool, and others cannot enter at any price. Thus, insurance institutions not only maintain status, they also assign it. For example, the children of a parent refused life or disability insurance maintain a more tenuous grasp on their position as a result of the insurers having classified their parent as a high risk. Should the parent die or become disabled, the children's resulting loss of social position derives not only from the death or disability, but also from the insurance risk classification. Because of that classification, there will be no insurance payment to offset the loss of the parent's income.

In a world of competitive, voluntary insurance organizations, it is easy to see why insurers classify applicants according to risk. Risk classification is one of the most potent competitive tools. Eliminating the most risky from an insurance pool reduces the average cost of insuring the members of the pool, allowing the insurer to offer a lower price and, possibly, obtain a greater profit. An insurer that discovers a new way to identify and exclude high risks improves its competitive position in two ways: it lowers its average risk and, assuming the people it rejects go elsewhere, it increases the average risk of its competitors. This competitive power of risk classification produces a classification "arms race," in which insurers either maintain their classification edge or face the loss of low risks to the competition and the migration of the high risks to their insurance rolls.

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13. *C.f.* Carol Weisbrod, *Insurance and the Utopian Idea*, 6 CONN. INS. L. J. 381 (2000).

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The use of risk classification to exclude applicants from the pool illustrates most starkly the obvious point that classification can reduce the degree to which insurance spreads risk.[14] Charging different prices or offering different contract terms on the basis of expected risk has a similar, if softened effect, as do other, more indirect, risk classification measures such as targeted marketing and designing insurance contracts to segregate applicants on the basis of risk.[15]

C. Risk Classification Can Create Adverse Selection

As the idea of a risk classification "arms race" suggests, risk classification itself can create a kind of adverse selection. Risk classification innovations allow insurers to *select* risks in a manner that is *adverse* to the insurance pool, by reducing the ability of the insurance pool to spread risk. Calling this behavior by insurers "adverse selection" may seem like a play on words. But the dynamics of this insurer-side adverse selection are similar to those of the insured-side adverse selection that risk classification addresses. Both involve self-interested behavior based on the risk status of insureds. Both are collective action problems, in which individually rational actions produce a result that is contrary to the interests

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14. An economist might take exception to this statement because, at least in theory, there are circumstances in which adverse selection by insureds is so strong that a market may not be possible without classification. Rothschild & Stiglitz, *supra* note 7. In such a circumstance, we might think of classification as "containing" the promise of insurance in the sense that a container makes it possible for water to be carried from one place to another.

15. A decision to market insurance to a given target audience classifies that audience as being composed of members with favorable risk characteristics. For example, Medicare HMOs are prohibited from underwriting (i.e. turning away sick applicants), but they are free to design their marketing so that it appeals to healthy, active seniors. Billboards featuring seventy-five year-old men doing gymnastics and free health club memberships are two ways to do this. As compared to risk-based pricing and underwriting, this is not as effective a way of separating a population into risk-based groups; nevertheless, it can perform that function.

Contract drafting can also serve a risk classification function. A decision to offer a given type of coverage as an "extra" rather than as a standards coverage provided by a broad form policy can reflect a judgment that the insurance company cannot identify (classify) individuals who are particularly risky with respect to that type of coverage. Thus, requesting that coverage amounts to self-classification as being risky in that way. Two examples are offering mental health coverage as an extra in health insurance policies and offering sexual harassment coverage as an extra in a liability insurance policy. Alternatively, offering a given type of coverage as an extra may reflect a judgment by the company that it is less expensive to ask people to self classify, e.g. coverage for home business pursuits under a homeowners' policy.

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of the whole. And both inhibit the ability of insurance institutions to spread risk.

The fact that risk classification can lead to a collective action problem means that even those who ordinarily trust or believe in the market cannot easily conclude that any particular risk classification is optimal from an efficiency or utilitarian perspective.[16] Outside formal economic models, there are no purely technocratic, value-free answers to the question of who should pay how much to jump into the insurance pool.

Efforts to address adverse selection share the reactivity of efforts to address moral hazard.[17] Acting to prevent adverse selection on one side of an insurance relationship can promote adverse selection on the other. Thus, as with moral hazard, there is much to be gained in thinking of adverse selection as a "dual" problem that can affect both sides of an insurance relationship.[18]

D. The Alternative: Binding Risks to the Insurance Pool

Just as there is a "control" alternative to the usual "coinsurance" prescription for moral hazard, there is also a "control" alternative to the usual "risk classification" prescription for adverse selection. In the case of adverse selection, the "control" is directed at the ability of insureds to opt out of insurance and the ability of insurers to slice up the insurance pool on the basis of risk.

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16. An additional reason pointed out by Kenneth Abraham is path dependence: insurers have collected risk information based on risk categories chosen in the past. There may be better risk indicators than those insurers have used, yet that cannot be known without the information that is developed only once insurers decide to classify risk on the basis of those indications. KENNETH S. ABRAHAM, DISTRIBUTING RISK (1986). *See also* Norman Daniels, *Insurability and the HIV Epidemic: Ethical Issues in Underwriting*, 68 MILLBANK Q. 497 (1990).

17. Baker, *Moral Hazard*, *supra* note 3.

18. Carol Heimer has described this insurer side adverse selection as a form of "moral hazard." Carol Heimer, *Insuring More, Ensuring Less: The Costs and Benefits of Private Regulation Through Insurance*, *in* EMBRACING RISK: THE CHANGING CULTURE OF INSURANCE AND RESPONSIBILITY 116 (Tom Baker & Jonathan Simons eds., 2002). Although her use of the term "moral hazard" is consistent with its early "immorality meaning," it is not inconsistent with the use of the term in the economics literature. *See* Baker, *Moral Hazard*, *supra* note 3. There is a value in maintaining a consistent meaning for concepts across the fields of economics and sociology. In the economics of insurance, the term "moral hazard" has been used for changes in incentives that result from an insurance or similar relationship, while the term "adverse selection" has been used for behavior that results from the differences in risk status.

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A simple alternative solution to the problem of adverse selection is mandating universal insurance, to be provided through a single insurer. A universal insurer can charge everyone the same price without any fear of low risks dropping out or defecting to a competitor. Many forms of government-provided insurance work in this way. A leading example is the U.S. Social Security system, which provides nearly universal retirement, disability and life insurance to the employed population.

A second approach is to mandate (directly or indirectly) that everyone purchase insurance and prohibit insurers from charging prices or underwriting on the basis of risk (but to allow multiple insurers into the market). This is the ordinary practice in the United States for employment benefits within large companies,[19] and it was the approach of the Clinton Administration's universal health insurance proposal. Limits on risk classification in auto insurance—which is mandatory in the United States and many other parts of the world—represent partial adoptions of this approach. This approach cannot completely eliminate adverse selection because individual insurers may have some ability to design or market their services in a way that appeals disproportionately to low risks. Nevertheless, this approach can significantly improve the risk spreading function of the affected insurance programs as compared to what is otherwise possible through the market, as demonstrated by comparing the large group and individual health insurance markets in the United States.[20]

A third approach is to prohibit (or limit) risk-based pricing and underwriting, without requiring the purchase of insurance. Some might object that this approach does not address adverse selection at all, but rather deprives insurers of the means to combat it. Yet, this objection focuses

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19. Most health insurance in the United States is received as an employment benefit. Employment-based health plans offer the same benefits to all qualified employees, at the same cost. Although the health benefits are not mandatory, because of United States income tax policy and other reasons, the benefits typically are offered on terms that are so favorable that all employees who do not have insurance from another source (e.g. from the health plan of a spouse), choose to accept the health benefits. When employment groups offer employees a choice of health plans, some adverse selection can occur when low risk employees disproportionately choose certain plans and not others.

20. In the large group market—which is principally employment provided health insurance—insurance is widely available and comparatively inexpensive. In the individual (and small group) market, insurers practice extensive underwriting and risk rating; yet insurance is comparatively expensive even for the "low risk" small groups and individuals. General Accounting Office (GAO) *Private Health Insurance*, GAO/HEHA 97–98, 1996, Washington D.C.

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only on insured-side adverse selection and ignores the role of insurer-side adverse selection in disaggregating insurance pools.

Eliminating insurer-side adverse selection may be enough to keep most risks in at least some insurance pools. Faced with the choice between no insurance and expensive insurance, many or even most low risk applicants would not change their purchasing decision because of the higher price.[21] Purchasing insurance may be the cultural norm, people may be sufficiently risk averse, or there may be institutional arrangements that encourage the purchase of insurance, as in the case of homeowners' insurance in the United States.[22] The degree to which this approach improves on the risk-spreading function of the insurance market is more difficult to determine than in either of the preceding two approaches. The high risks that would not otherwise have been able to purchase insurance are better off than they would be in the absence of regulation of this kind. On the other hand, the low risks that choose not to purchase insurance at the higher price face their risks alone, so they are worse off than they would be otherwise. In contrast to the "free market" situation, however, all the people without insurance would have had the opportunity to buy insurance at a reasonable price. Thus, there are autonomy gains from this apparently anti-autonomy approach.

I am not aware of any complete adoption of this third approach, but there have been many partial adoptions. For example, some forms of health insurance have been required by state law in some states to charge all individual applicants the same price.[23] A more limited approach is to prohibit certain kinds of classifications. Race, religion, and national origin are the most commonly prohibited insurance classifications in the United States, but gender, age and other, more narrowly defined classifications are also prohibited in some contexts. A recent variation on this approach is to prohibit the use of information from genetic testing by insurance companies.

A fourth approach to addressing adverse selection is designing insurance products to change the incentives of low risks that are already in the insurance pool. This addresses the problem identified by the nineteenth century insurers: "even if the lives at starting are a very select class, they

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21. Note that I am discussing personal lines insurance here, not commercial insurance for large corporations, which have many alternatives to traditional insurance.

22. Heimer, *supra* note 18.

23. The State of New York is one such example. *See* Daniels, *supra* note 16.

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not only lose this advantage, but degenerate till they are on average worse than the general population."[24] One example is level premium life or disability insurance products. With a level premium product the insured, in effect, pre-pays part of the premium for later years by paying a higher amount in the early years. Ten years into a twenty-year level premium life or disability insurance policy even the healthiest members of a given cohort will be paying a lower premium than would be available if they started fresh elsewhere.

Level premiums and other methods for keeping low risks in the pool facilitate the spreading of what Robert Works has called in another context "classification risk"—the risk that the risk status of the insured will worsen in the future.[25] Waiting periods before coverage takes effect, pre-existing condition exclusions in health insurance, discounts that apply only after a period of continuous insurance coverage, and penalties for early termination of accumulating value forms of life insurance are all methods for keeping low risks in the pool.

For present purposes, this last approach is less significant for its overall effect on the ability of insurance institutions to spread risk than for its demonstration of two important points. First, even some voluntary insurance institutions ordinarily and regularly define people's choices in a way that constrains their ability to realize the full benefits of their low risk status. Second, people are willing to accept such constraints to further risk spreading objectives. These points are a partial response to autonomy objections to government regulation of insurance risk classification.

PART II

Part I of this Article described adverse selection as a dual problem and highlighted control alternatives to insurance risk classification. As this discussion reflects, insurance risk classification is only one possible approach to the problem of adverse selection, and insurance risk classification can create the very de-pooling that, in theory, it is intended to prevent. Thus, the economics of adverse selection cannot explain in any strong sense a social decision to leave decisions about insurance risk classification in the hands of insurance companies, and the economics of

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24. King, *supra* note 9, at 397.

25. 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. 505 (1999).

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adverse selection are unlikely to adequately explain the decision by insurance companies to classify risks in the way that they do. This second part will describe alternative, moral justifications for the practice of insurance risk classification and explore these justifications in the context of three historical debates.

Justifying Risk Classification

Like political and economic arguments couched in the language of moral hazard, arguments made in the name of adverse selection draw on a reservoir of respect for science. Also like moral hazard arguments, adverse selection arguments are buttressed by moral appeals. Risk classification is justified not only as necessary and inevitable, but also as a good thing. The leading moral justifications for risk classification are the following: 1) without risk classification, low risks are unfairly forced to subsidize high risks; 2) risk classification promotes socially beneficial efforts to prevent loss; and 3) risk classification promotes individual responsibility.

To illustrate these justifications in action I will briefly describe three public policy debates over risk classification. The first is the nineteenth century debate over age-based pricing in British fraternal insurance. The second is the depression era and continuing debate over experience rating in United States unemployment insurance. The third is a recent debate over discrimination by United States life, disability and health insurers against battered women. The age-based pricing debate illustrates the fairness or subsidy justification. The experience rating debate illustrates the loss prevention and responsibility justifications. The insurance for battered women debate illustrates some of the limits of those justifications.

A. Age Rating in Fraternal Life and Sickness Insurance

Well into the twentieth century, many fraternal insurance organizations required their members to make equal contributions to their common fund, regardless of age or health status.[26] In Britain actuaries began challenging this practice by the "friendly societies" in the early nineteenth century.[27] Friendly societies were fraternal organizations that provided life and

26. J.C. Herbert Emery, *Risky Business? Nonactuarial Pricing Practices and the Financial Viability of Fraternal Sickness Insurers*, 33 EXPLORATIONS IN ECON. HIST. 195 (1996).

27. CHARLES ANSELL, A TREATISE ON FRIENDLY SOCIETIES (London, Baldwin & Cradock 1835); CHARLES HARDWICK, THE HISTORY, PRESENT POSITION, AND SOCIAL IMPORTANCE OF FRIENDLY SOCIETIES (London, Routledge 1859).

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sickness insurance benefits to their members. The sickness benefits were what we would call today short term disability benefits. The actuaries complained that the premiums paid to the societies by younger members were used, unfairly, to subsidize the benefits of older members.

Charles Ansell, an actuary for the Atlas Insurance Company, set out this fairness argument in his *Treatise on Friendly Societies*, published under the auspices of the Society for the Diffusion of Useful Knowledge:

> It has been common heretofore to charge members of Friendly Societies who might enter them, at ages often differing by 20 years, the same rates of contribution; but since the following tables, and the data on which they are founded, show very plainly that for every benefit to which they refer the proper contribution varies with every year of age, the injustice of requiring men of different ages to pay a like rate must be manifest; and as little excuses can be hereafter urged for a continuance of so objectionable a practice, it will, in all probability, be at once abandoned, as being utterly at variance with that feeling of equity and benevolence to which all well-regulated Friendly Societies owe their origin and existence.[28]

Notwithstanding the actuaries' complaints, many friendly societies continued to require equal contributions regardless of age, in keeping with their principles of fellowship and mutuality.[29] These friendly societies rejected the underlying assumption of the actuaries' argument: that justice required that members pay for insurance according to their individual chances of loss.

A second argument pushed with increasing vigor in the latter half of the nineteenth century combined Ansell's fairness argument with the logic of adverse selection. The actuaries argued that the friendly societies had not set aside sufficient reserves to protect themselves against the aging of their membership, with the result that the younger workers would not receive the benefits that they were promised in return for their premiums. Thus, the level premium arrangement was a means for the older members to take advantage of the younger.

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28. ANSELL, *supra* note 27, at 107.

29. *Cf.* MARY ANN CLAWSON, CONSTRUCTING BROTHERHOOD: CLASS, GENDER AND FRATERNALISM (1989).

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The actuaries reasoned as follows. Because the societies lacked sufficient reserves to pay future claims without the infusion of new members, the current younger members were dependent on the ability of the friendly societies to continue in the future to attract younger members whose premiums would pay part of their benefits. The current younger members could not count on that in the future because other, more actuarially sound, friendly societies were charging age-based premiums. So, younger people in the future would heed the call of justice and self-interest—as the actuaries defined them—and join these other organizations, abandoning the currently young in friendly societies with aging populations that could not in the long run support the benefits promised.

Quarterly Review summed up one of the conclusions of a series of actuarial reports on friendly societies in 1864 as follows:

> So long as the societies consisted, for the most part, of young, healthy men, and the average amount of sickness remained low, the payments made seemed ample; the funds accumulated, and many flattered themselves that they were in a prosperous state, when in fact they contained the sure elements of decay. For, as the members grew older, their average liability to sickness was regularly increasing. The effects of increased age upon the solvency of benefit clubs soon becoming known, the young men avoided the old societies, and preferred setting up organizations of their own. The consequence was, that the old men began to draw upon their reserves at the same time that the regular contributions fell off; and when, as was frequently the case, a few constantly ailing members kept pressing upon the society, the funds at length became exhausted, and "the box" was declared to be closed.[30]

In this view, friendly societies that continued charging level premiums were "swindling the young members for the sake of the older ones."[31] The proposed solution, which many friendly societies continued to resist, was to adopt age-adjusted premiums of the sort pioneered in the commercial life insurance societies.

Whether the level premiums in fact explain the gradual demise of the friendly societies is a subject of historical dispute. The traditional view

30. *Workmen's Benefit Societies,* 116 Q. REV. 327, 328 (1864).

31. Chambers, *Friendly Societies*, 19 CHAMBERS J. 199, 356 (1853).

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was to this effect, though there have been suggestions that the more significant problem was that the friendly societies began paying "retirement" benefits under the guise of "sickness" benefits.[32] Recent and more sophisticated financial analysis of the Canadian counterparts to the friendly societies demonstrates that, notwithstanding the claims of the nineteenth century actuaries, many level premium fraternal insurance organizations were financially sound well into the 1920's.[33]

For present purposes, the significance of the age rating debate lies, not in the merits, but rather in the relationship between the subsidy and adverse selection arguments invoked in the debate. The subsidy argument makes risk classification "fair," the adverse selection argument makes risk classification "necessary." Where there is resistance to the fairness claim, the necessity claim helps to construct the high risk members of the pool as different from, and hostile to, the low risk members of the pool. At the same time, the fairness claim legitimates behavior by insurers that makes risk classification "necessary"—i.e. the efforts of the risk classifying insurers to poach the low risk members from the resisting insurers (what I would call *insurer-side* adverse selection).

It is of course possible that the mid-nineteenth century predictions of the actuaries proved true, and that the friendly societies did fail because they could not recruit new members. But, that would not demonstrate that age-based premiums were fair and necessary. At most, the age-based premiums were necessary only because of the insurer-side adverse selection, which could have been prevented through government policies that reduced poaching. Moreover, while the ability of some members to collect their benefits was certainly unfair, the failure to attract new members was as likely to be attributable to the actuaries' disparagement of the financial soundness of the level premium societies as it was to the level premiums themselves.[34] Indeed, as explained above, as long as the premiums are adequate, level premiums in fact can help control insured-side adverse selection by keeping low risks in the insurance pool.

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32. Bentley Gilbert, *The Decay of Nineteenth Century British Providence Institutions and the Coming of Old Age Pensions in Great Britain*, 17 ECON. HIST. REV. 551 (1965).

33. Emery, *supra* note 26.

34. For examples of articles disparaging traditional friendly societies and promoting the "scientific" friendly societies see Tuffnell, *Improved Friendly Societies*, 11 PENNY MAG., at 387 (1842) (excerpt from "Mr Tuffnell's Report to the Poor Law Commissioners"). *See also* Chambers, *supra* note 31; Chambers, *Friendly Societies*, 32 CHAMBERS J. (1859).

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Disparaging the financial soundness of a friendly society or other insurer, however, can easily become a self-fulfilling prophecy, much like a run on a bank. Who would want to start a long term relationship with an insurer that might not be able to pay claims in the future? None of this is to claim that concern with fairness or adverse selection played no role in the shift to risk classification, but rather that stronger explanations lie elsewhere—most likely, in my view, in the ascendance of the actuarial vision of insurance in which "the ideal type of insurance involves premiums paid in advance, guaranteed indemnity in the event of a covered loss, and risk-based premiums based on the best available information regarding the expected losses of the individuals insured."[35]

B. Experience Rating in Unemployment Insurance

In contrast to life, health and disability insurance, there has never been a broad unemployment insurance market. Some individual firms and labor unions have provided short term unemployment insurance benefits for their employees or members, and some lenders have provided a modest amount of unemployment insurance in the form of debt forgiveness provisions that are contingent upon unemployment. But, the problems of adverse selection and moral hazard seem to have made a broad market in unemployment insurance impracticable.[36]

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35. EMBRACING RISK: THE CHANGING CULTURE OF INSURANCE AND RESPONSIBILITY 10 (Tom Baker & Jonathan Simons eds., 2002).

36. The moral hazard of unemployment insurance results from the partial but substantial control that employers and workers have over unemployment. The existence of unemployment insurance can change the incentives of employers to retain workers, as well as the incentives of workers to be retained. The adverse selection also results in significant part from this same control. Because low risks can prevent loss in at least ordinary economic conditions by limiting the number of layoffs, they are likely to drop out of an insurance market that does not offer them a low price for their insurance. Yet, an unemployment insurer would find it very difficult to segregate individual employees by their ability or willingness to control unemployment, with the resulting "lemons problem" described so aptly by the economist George Akerlof. *See* George A. Akerlof, *The Market for Lemons: Quality Uncertainty and the Market Mechanism*, 84 Q.J. ECON. 488 (1970). Akerlof analyzed a hypothetical situation in which used car buyers face a market composed of "peaches" and "lemons" and are unable to determine whether any individual car is a peach or lemon. In that situation, the most that a rational buyer will pay is the average price, which is less than a peach is worth. So, owners of peaches will tend to keep them, with the result that the car market becomes disproportionately composed of lemons, so that people will pay even less for cars, driving even more peaches out of the market, and so on. In practice, the used car market does not unravel in this way because people do have ways

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An additional factor inhibiting the development of an unemployment insurance market is the fact that much of the benefit of unemployment insurance accrues to society at large, not simply to the individuals or firms that purchase it. Unemployment insurance allows workers time to look for jobs that match their education and training, and it supports families and communities during hard times, all of which lead to a more productive economy. Termed "positive externalities" by economists, benefits like these cannot be promoted by the market because there is no practical way for individual firms to charge society at large. It's not that positive externalities *prevent* the development of a market, simply that the market will provide less of the thing that produces the positive externalities than society would be willing to pay for.

The positive externalities of, and adverse selection in, unemployment insurance help explain the decision by governments in most developed countries to provide unemployment insurance.[37] Providing the insurance through the state solves the positive externality problems because the state has the means to charge society at large for unemployment insurance benefits. It also solves the adverse selection problem because the state has the authority to bind risks to the pool.

Since states can solve and in most cases have solved the adverse selection problem by mandating universal participation in an unemployment insurance system, why have I included a discussion of unemployment insurance in an essay on risk classification? With mandatory insurance and a single insurance provider there should be no need to classify risks to prevent adverse selection.

Yet, at least in the United States, there *is* risk classification in unemployment insurance, in the form of *experience rating*. Experience rating is the insurance term for charging different prices based on past

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of evaluating whether a car is a peach or lemon. Similarly, it is possible that unemployment insurers could make the same judgment about prospective purchases of unemployment insurance. Yet, unemployment insurance presents a more difficult lemons problem than used cars because of the interaction of adverse selection and moral hazard. In the case of unemployment insurance, the sale is only the beginning of the relationship. The purchasers of the insurance who have behaved like peaches in the past may now start acting like lemons once the insurer picks up the costs of unemployment (moral hazard), making it doubly difficult to know whether a prospective insured is "really" a peach or a lemon.

37. David Moss' research suggests that, at least in the United States, concerns about moral hazard explain the motivation of United States reformers better than concerns about adverse selection. *See* DAVID MOSS, SOCIALIZING SECURITY: PROGRESSIVE-ERA ECONOMISTS AND THE ORIGINS OF AMERICAN SOCIAL POLICY (1996).

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experience. It is a form of risk classification because past experience is used to predict future risk. So, for example, an employer that has laid off significant numbers of workers in the past is treated as a higher risk for layoffs in the future and, accordingly, is charged a higher rate.

The existence of risk classification in unemployment insurance further demonstrates that the appeal of risk classification goes beyond concerns about adverse selection. One basis for that appeal is the fairness justification addressed in discussing the debate over age rating in friendly societies: people should pay according to the risk they bring to the insurance pool. Although that justification is not fundamentally different in the unemployment context, the fairness claim may be stronger since many employers are likely to have more control over their unemployment risks than most people have over the aging component of their risk status.[38]

There is a second, *prevention* justification for experience rating that also relates to this same control: experience rating rewards employers who provide stable employment and punishes those who do not, and thereby encourages employers to stabilize their employment rolls. William Beveridge, one of the architects of the British social welfare system, described the underlying moral hazard concern as follows:

> Those dangers, in a sentence, lie not so much in the risk of demoralizing recipients of relief, so that they do not look for work, as in the risk of demoralizing governments, employers and trade unions, so that they take less thought for the prevention of unemployment . . . . The fear of causing unemployment may vanish from the minds of trade-union negotiators and open the way to excessive rigidity of wages and so to the creation of unemployment. Industries practicing casual engagement or perpetual short time may settle down to batten on the taxation of other industries or of the general public in place of reforming their ways.[39]

As with any other moral hazard situation, the "solutions" will be a mix of control and coinsurance. From a moral hazard perspective, experience

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38. *See* Perry C. Beider, *Sex Discrimination in Insurance*, 4 J. OF APPLIED PHIL. 64 (1987). Beider's article offers an application of the "fair opportunity" principle of distributive justice to insurance risk classification. This principle "requires that the allocation of benefits and burdens reflect some relevant characteristics, which all have had the opportunity to acquire, of the individuals involved." *Id.* at 66.

39. WILLIAM HENRY BEVERIDGE, THE PAST AND PRESENT OF UNEMPLOYMENT INSURANCE 43 (1930).

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rating is a form of coinsurance in which employers face the threat of paying higher premiums in the future as a consequence of layoffs. Control options involve restrictions on layoffs for employers and voluntary quits for employees.[40]

Generalizing from this example we can see many instances in which risk classification is justified on the grounds of loss prevention. Reduced property insurance premiums for buildings with sprinkler systems, fire alarms and night watchmen arguably reduce insurance losses, as do reduced auto insurance premiums for cars with good safety records and anti-theft devices. Whether non-smoking and other lifestyle classifications accomplish the same goal for life and health insurers is more controversial, but these discounts have been justified on that basis as well.

A final justification for experience rating in unemployment insurance is less pragmatic and more openly ideological. Labor economist Joseph Becker described this justification as follows:

> (1) As its main mechanism for the allocation of resources, our society has chosen the free market. (2) The market works more efficiently as market prices more accurately reflect the full costs of production. (3) The costs of production are reflected in market prices the more fully as the unemployment tax is the more completely experience-rated. (4) Thus experience rating accords with society's choice of the market as the main mechanism for the allocation of resources.[41]

Although one could take issue with these four points,[42] they are a useful description of a belief structure that supports experience rating,

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40. It is worth noting that this example illustrates how difficult it can be in practice to separate moral hazard and adverse selection.

41. JOSEPH M. BECKER, EXPERIENCE RATING IN UNEMPLOYMENT INSURANCE: AN EXPERIMENT IN COMPETITIVE SOCIALISM 7 (1972).

42. For me, (3) is the most controversial step in this chain of reasoning, treading on the always difficult question of "what is a cost of what." Why unemployment should be regarded as always and everywhere a cost of production is a mystery, particularly given the "creative destruction" of capitalism. For example, it seems odd to assign to one form of production the costs of unemployment that results from the emergence of a competing form of production. Yet, assigning those costs to the emerging form of production would inhibit the development of a superior technology that is one of the main benefits of capitalism.

What makes (1) debatable includes the use of the term "*free* market," since markets are shaped. What makes (2) debatable includes both the enormous complexities that are hidden by the deceptively simply idea of the "costs of production" as well as the limits on the

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specifically, and risk classification more generally. The underlying idea here is that actors should be made responsible for the risks that they bring with them to the market. Accordingly, prices for insurance should be tailored to the expected risk of each insured. In the context of unemployment insurance that means that unemployment premiums should be based on the experience and risk of the individual firm or, perhaps even on the experience and risk of the individual employee, though that has not yet to my knowledge been advocated.

What makes this different from the prevention (moral hazard) justification for risk classification is the explicit connection to the governmental rationality—"governmentality"—of liberalism and responsibility. Risk classification is not simply fair, and it does not depend on the empirical grounds of moral hazard. It is constitutive of an entire approach to governing the self and others.[43] This connection between risk classification and individual responsibility helps explain why risk classification seems like a "natural" and "essential" aspect of insurance to people brought up within the liberal tradition, and it also helps explain the passionate commitment of many in the insurance industry and actuarial professions to risk classification.

Nevertheless, it is important to be clear that, even within a liberal framework, responsibility only justifies risk classification in general, not every risk classification. Whether a particular risk classification is justified depends on the nature of the classification and the meaning and purpose of responsibility—which is a complex concept, with multiple and not always consistent meanings.[44] People can be made responsible ("accountable") so that they will become responsible "trustworthy, loyal . . . ." Or people can

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market highlighted by, *inter alia*, the economics of information and institutions. Finally, as (4) depends on (1), (2) and (3), it obviously is debatable as well.

43. Pat O'Malley, *Imagining Insurance: Risk, Thrift, and Life Insurance in Britain*, *in* EMBRACING RISK: THE CHANGING CULTURE OF INSURANCE AND RESPONSIBILITY Tom Baker & Jonathan Simons eds., 2002) *and* NIKOLAS S. ROSE, POWERS OF FREEDOM: REFRAMING POLITICAL THOUGHT (1999). I do not wish to enter here into the debate whether there is any significant difference between "liberalism" and "advanced liberalism." Since the nineteenth century, one of the core characteristics of liberalism has been this emphasis on individual responsibility. Francois Ewald, *The Return of Descartes' Malicious Demon: An Outline of a Philosophy of Caution*, *in* EMBRACING RISK: THE CHANGING CULTURE OF INSURANCE AND RESPONSIBILITY (Tom Baker & Jonathan Simons eds., 2002).

44. Tom Baker, *Risk, Insurance and the Social Construction of Responsibility*, *in* EMBRACING RISK: THE CHANGING CULTURE OF INSURANCE AND RESPONSIBILITY (Tom Baker & Jonathan Simons eds., 2002).

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be held responsible ("accountable") only when they are in fact responsible (have a causal or controlling role with regard to the risk in question). Like any other governmental rationality, "responsibility" does not provide a single answer to a social question, but simply a conceptual and institutional approach.

C. Prohibiting Discrimination Against Battered Women

My final example comes from the controversy surrounding the revelation in the late 1980's that some large United States insurers were refusing to sell life, health and disability insurance to battered women on the grounds that they posed an unacceptably high risk.[45] In response to this news, states began enacting legislation prohibiting insurers from discriminating against victims of domestic violence, and bills to do the same on a national level were introduced into Congress. In the effort to defeat this legislation, the insurers' defense was that excluding battered women from the insurance pool was "actuarially fair." According to the insurers, the history of abuse meant that these women were much more likely to make life, health or disability insurance claims in the future than other, otherwise similarly situated women who were not domestic abuse victims. This higher risk meant that it was "actuarially fair" to exclude them from the insurance pool, just as insurers excluded other unacceptably high risks. This actuarial fairness justification is a somewhat more elaborate version of what I earlier described as the simple fairness, or subsidy, justification in the discussion of age rating in fraternal life insurance.

The legal philosopher Deborah Hellman used this controversy as an occasion to examine the ethical basis for insurance risk classification. As she described, the actuarial fairness justification for excluding high risks rests on a view that "fairness requires that low risk insureds be permitted to join together in insurance pools and thereby benefit from their good health" or other low risk status.[46] This view rests, in turn, on the existence of a liberty interest—freedom of association—that is qualitatively distinct from the moral hazard and adverse selection justifications for risk classification.

Whether this liberty interest justifies any particular risk classification depends, in Hellman's view, on whether the resulting low risk status is

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45. Deborah S. Hellman, *Is Actuarily Fair Insurance Pricing Actually Fair?: A Case Study in Insuring Battered Women*, 21 HARV. C.R.–C.L. L. REV. 355 (1997).

46. *Id.* at 398.

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"deserved" and, if it is not deserved, whether one accepts the link between desert and entitlement made most famously by Rawls.[47] If the low risk status is deserved, the moral claim to benefiting from that status is a strong one. If the low risk status is not deserved, the moral claim to benefiting from that status is a weaker one that rests on drawing a clear distinction between desert and entitlement—a distinction often associated with the work of Nozick[48]—so that people may be morally entitled to the fruits of attributes that they have done nothing to deserve.

Hellman concludes that good health is "morally arbitrary:" the victims of domestic violence do not deserve their "high" risk status, just as most other people usually do not deserve their life or health risk status. She describes the dispute over the significance of her conclusion as follows:

> Does the moral arbitrariness of that fact mean that low-risk insureds are not entitled to the benefits that follow from good health? Or instead, is it interference with the low-risk insured's ability to benefit from good health that requires justification? Those struck by the moral arbitrariness of good health are likely to believe that risk rating is unjustified in most cases. Since the healthy do not deserve the benefits health makes possible, they have no legitimate claim of entitlement to them. This rationale supports community rating and single payer schemes.[49] Those who are struck by the idea that my talents, fortunes, and experiences are my own and thus that the community needs a powerful justification to interfere with my ability to use and enjoy these traits, are likely to believe that any restraint on my ability to join with whomever I wish in insurance schemes constitutes an infringement of liberty requiring a defense. This rationale supports the utilization of risk rating by private insurers.[50]

47. JOHN RAWLS, A THEORY OF JUSTICE 101, 104, 311–12 (1971).

48. ROBERT NOZICK, ANARCHY STATE AND UTOPIA 225–26 (1974).

49. "Community rating" is the practice of charging all the participants in a health plan the same rate (a "community" rate), and "single payer" refers to the practice of allowing only a single, monopoly insurer. As discussed above, this is a common approach to the adverse selection problem. Most western countries go one step further and mandate participation in the national health plan.

50. Hellman, *supra* note 45, at 402.

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Thus, debates over the legitimacy of particular forms of risk classification invoke classic debates over the nature of distributive justice.

As the insurers' position in the battered women controversy demonstrates, actuarial fairness adopts a version of the libertarian position. Actuarial fairness saddles people with all the consequences of their high risk status, whether deserved or not. Conversely, it entitles other people to all the benefits of their low risk status, also whether deserved or not.

Yet, on close examination we can see that actuarial fairness is not in fact grounded on the liberty interests of individuals. As Hellman[51] and others have noted, proponents of actuarial fairness defend the freedom of insurance institutions to classify, but they do not put individual liberty above the interests of those institutions.[52] Defending individual liberty above the interests of insurance institutions would mean vesting individuals with a right to *accurate* risk classifications, and the level of accuracy required would not be within the sole purview of the insurance institutions themselves. Put another way, a truly libertarian approach would obligate insurers to do more than classify applicants accurately within the context of their ordinary business arrangements. Instead it would obligate them to conduct research to determine accurate forms of classification. How much research, and at what cost, would have to be determined, but there is no reason to believe that it would match the amount of research insurers presently determine is appropriate.

In practice, the fairness argument has been mobilized in public policy debates, not to protect the rights of low risk individuals, but rather to promote the freedom of insurance organizations to classify insureds through any means they wish. While some "low risk" individuals may believe that they are benefited by risk classification, any particular individual may be only one technological innovation away from losing his or her privileged status—the reality that lies behind the widespread concern with genetic testing by insurance companies.[53] If there is a fundamental

51. *Id.*

52. *See also* Daniels, *supra* note 16, at 497.

53. The fairness argument in favor of age rating for sickness insurance would also justify genetic-based risk classification. Indeed, the subsidy claim is stronger in the case of genetic classification than it is for age classification, since everyone gets old, while genetic makeup is fixed at conception. Since risk classification on the basis of genetic testing is widely regarded as repugnant (a state of affairs that is demonstrated by the many statutes prohibiting that practice), that demonstrates the existence of an at least implicit counter vision of "fairness." For an argument that insurance risk classification on the basis of

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moral principle at work here, it is not liberty, but utility. Once we are in the realm of utility, liberty is only one value among many, and there is no reason to make insurance institutions the arbiter of that utility, especially because of the collective action problem created by risk classification. This is not to say that risk classification is always and everywhere a bad, but rather that the fairness justification for classification does not carry all the moral force that its proponents assert.

Like Hellman, I do not pretend to be able to resolve the debate over the morality of risk classification. My purpose in invoking the debate it is to demonstrate that risk classification involves substantial moral commitments. Classifying insureds according to risk both reflects and creates a moral vision. Risk classification reflects a commitment to individual responsibility, recognizing that what that means is up for debate. Risk classification also creates that commitment by helping to persuade people that the purpose of insurance is individual protection and, accordingly, that the insurance group is a collection of individuals without any responsibility to one another.[54] Seen in this light, it is hardly surprising that many friendly societies and other fraternal insurance organizations long resisted risk classification, and that strong forces are arrayed against health insurance risk classification today.[55]

CONCLUSION

These are hardly the last words on either adverse selection or the challenge that it poses to the promise of insurance. My intent, so far only imperfectly realized, is to expose the concept of adverse selection, and the technologies that relate to it, to the kind of genealogical analysis previously given to the related concept of moral hazard. As with work on moral hazard, the objective is to demonstrate how the rhetoric of adverse selection disguises ideological or moral commitments. The goal is not to discredit the concept itself, but rather to clear away some of the underbrush that inhibits addressing very real problems in the design of socially responsible insurance institutions.

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genetic tests will eventually become socially acceptable, see Carlos Novas and Nikolas Rose, *Genetic Risk and the Birth of the Somatic Individual*, 29 ECON. & SOC'Y 485 (2000).

54. *Cf.* Baker, *supra* note 44.

55. Stone, *supra* note 3. *See also* Deborah Stone, *The Struggle for the Soul of Health Insurance*, 18 J. HEALTH POL. POL'Y & L. 287 (1993).

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In particular, much of the literature on insurance treats risk classification as an inevitable, essential response to the problem of adverse selection and ignores the role of risk classification in promoting adverse selection. The literature often takes for granted the following familiar belief structure. "Private" insurance is better than "public" insurance. "Voluntary" insurance is better than "mandatory" insurance. The following statement by the then president elect of the American Academy of Actuaries to the United States Commission on Civil Rights is typical:

> The basic principle is quite simple to state: The risk classification process is essential to the viability of private, voluntary insurance mechanisms. Where substantive differences in risk of loss exist, they must be recognized in a private, voluntary insurance mechanism to avoid anti-selection by those subject to high risks against those subject to low risks. . . . It is at best questionable, and more likely, impossible, that broad social cost-spreading objectives can be accomplished through voluntary, private market mechanisms.[56]

These are arguments in favor of particular interests, within the context of a particular moral vision. The particular interests are those of insurance institutions seeking maximum autonomy from societal control. The particular moral vision is that of "actuarial fairness"—a watered down form of liberalism that privileges individual interests over the common good and that privileges, above all, the interests of insurance institutions organized on its terms.

56. UNITED STATES COMMISSION ON CIVIL RIGHTS, DISCRIMINATION AGAINST MINORITIES AND WOMEN IN PENSIONS AND HEALTH, LIFE & DISABILITY INSURANCE 141 (1979).

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THE ANTITRUST IMPLICATIONS OF COLLABORATIVE STANDARD SETTING BY INSURERS REGARDING THE USE OF GENETIC INFORMATION IN LIFE INSURANCE UNDERWRITING

Robert H. Jerry, II[*]

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Whenever two or more market participants collaborate to restrain trade, the potential applicability of federal and state antitrust laws must be considered. When the collaborating parties are insurance companies, a further layer of analysis may be necessary to determine whether the activity is exempt from federal antitrust regulation. Even if the activity enjoys an exemption, state antitrust law may have different things to say about the activity. Embedded in each of these levels of analysis are many difficult and complex subsidiary questions. In short, the law of insurance antitrust is not a subject for the faint of heart.

Antitrust law often has implications in situations where its relevance is least expected, as many who have credentials as antitrust offenders know well. For example, with respect to whether insurers should surrender their option to use genetic information in life insurance underwriting,[1] a seemingly reasonable, innocuous suggestion might be made:

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1. As of 2002, forty-five states have some kind of statutory regulation with respect to genetic testing in health insurance, including limitations on insurer requirements that testing occur, insurer requests for information about past tests, or insurer use of the information in making eligibility or renewal decisions, setting rates, or underwriting. *See* 2 NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS, COMPENDIUM OF STATES LAWS ON INSURANCE TOPICS, HE-43-1 *et seq.* (2002) (compendium of laws on genetic testing for insurance coverage). Only a few of these statutes are relevant to life insurance. Arizona declares it an unfair trade practice in life insurance to consider a genetic condition in determining rates, terms or conditions of a policy, or to reject an application based on a genetic condition, unless the applicant's medical history and condition and claims experience or actuarial projections establish that substantial differences in claims are likely to result from the genetic condition. ARIZ. REV. STAT. ANN. § 20-448 (West 2002). *See also* CAL. INS. CODE § 10146–10149.1 (West Supp. 2002) (establishing standards for underwriting life and disability insurance on the basis of genetic characteristics); ME. REV. STAT. ANN. tit. 24-A, § 2159-C (West 2000) (stating that life insurers may not unfairly discriminate based on the results of a genetic test); MASS. GEN. LAWS. ANN. ch. 175, § 120E (West. Supp. 2002) (stating that a life insurer may not unfairly discriminate in any of the terms of the policy based on genetic information). Montana has a statute that applies to all lines of insurance, including life insurance. The law makes it an unfair trade practice to consider genetic information and imposes restrictions on use of genetic

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> Life insurers should voluntarily agree to place a moratorium on the use of genetic information in underwriting. Presently, no insurer makes use of such information, so now is the time to forge such an agreement, before some insurers begin to use the information and then become unwilling to forego the practice.[2]

But such a moratorium is essentially an agreement among competing insurers to fix one determinant of the product's price, and this restraint of trade calls into question the possible applicability of federal and state antitrust law (as well as the relevance of possible exemptions under federal or state law, or both).[3] This Article discusses the antitrust issues that would accompany the

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information to reject an application. MONT. CODE ANN. § 33-18-206 (2001). N.J. STAT. ANN. § 17B:30-12(f) (West Supp. 2002) (stating that life insurers may not unfairly discriminate in the application of the results of a genetic test or genetic information in the issuance, withholding, extension, or renewal of a policy); VT. STAT. ANN. tit. 8, § 4724(7)(D) (Supp. 2001) (stating that it is unfair discrimination to condition rates or renewal practices on the results of genetic testing absent a relationship between the medical information and the insurance risk). A few other states have statutes relating to informed consent in testing and refusal to issue a policy based on the sickle cell trait, a specific kind of genetic information. *See, e.g.*, N.C. GEN. STAT. § 58-58-25 (1999) (sickle cell trait); N.Y. INS. LAW § 2612 (McKinney 2000) (titled "Genetic testing written informed consent").

2. Whether life insurance companies should commit to forbear from using (or be compelled to make such a commitment, or be flatly prohibited from using) genetic information in underwriting is a difficult, controversial question. This Article takes no position on that threshold question and instead simply assumes that the question has been answered in favor of restricting insurers' use of genetic information (defined here as the results of DNA testing) in life insurance underwriting.

What constitutes "genetic information" is, of course, another extremely important question. Family history is a form of genetic information and medical files (with information from routine physical exams, blood tests, urine tests, etc.) contain genetic information, but this Article takes it as a foregone conclusion that insurers will not surrender, except under legal compulsion, the right to use family history and medical information, even if it is genetic in nature, that the industry has used in underwriting for many years. Thus, unless stated otherwise, this Article treats "genetic information" as referring to the results of DNA and RNA tests.

3. Another way to impose the restriction is via direct statutory regulation of insurer practices, as some states have done. *See supra* note 1. As discussed below, this approach presents no antitrust perils to life insurers. Likewise, if life insurers act unilaterally to forswear the use of genetic information in underwriting (a scenario which, at least for the present, is very unlikely to unfold), no antitrust problems are created. *See, e.g.*, Theatre Enters., Inc. v. Paramount Film Distrib. Corp., 346 U.S. 537, 540 (1954) ("crucial question is whether respondents' conduct toward petitioner stemmed from independent decision [which does not violate antitrust law] or from an agreement, tacit or express"); In re Baby Food Antitrust Litig.,

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articulation and implementation of such restrictions.[4]

The discussion in this Article is divided into four parts. Part I summarizes the landscape, past and present, with respect to insurer collaboration in underwriting. Part II considers whether, absent an antitrust exemption, multi-insurer agreements and collaborative insurer standard-setting with respect to underwriting violate federal antitrust law. This Part also evaluates whether insurers, to the extent potential federal liability exists, enjoy any kind of statutory or judicial exemption from federal law for such activities. Part III considers the same questions addressed in Part II but in the context of state antitrust laws. Because antitrust law, including the law of antitrust exemptions, is so vast and intricate, the discussion in this Article must necessarily be cursory in many respects. But the discussion will be detailed enough to provide a sense of the complexities involved in assessing the validity of a multi-insurer compact on the use of underwriting criteria. Finally, Part IV discusses the implications of the sometimes tentative conclusions in Parts II and III for collaborative insurer activity in this area.

I. AN OVERVIEW OF INSURER COLLABORATION IN UNDERWRITING

There are many situations in which insurers collaborate. Insurers have long cooperated in drafting standardized policy forms, sharing data regarding the identification and quantification of risks, and collecting and disseminating loss and expense data.[5] There is also a long tradition of cooperation in the setting of rates in the fire and casualty lines.[6] For the most part, as discussed

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166 F.3d 112 (3d Cir. 1999) (escalation of prices in oligopolistic but competitive market is not enough to show violation of section 1of the Sherman Act); Hise v. Philip Morris, Inc., 46 F. Supp. 2d 1201 (N.D. Okla. 1999) (violation of section 1 was not established where a lack of evidence excluded the possibility that companies acted independently of each other for legitimate and reasonable business interest of passing costs of tobacco settlement on to consumers). If, however, life insurers should agree among themselves not to use genetic information in underwriting, a complex set of questions, which are the focus of this Article, is presented.

4. Necessarily, some of the discussion is this Article is more broadly relevant to insurer agreements in any line of insurance with respect to any kind of underwriting factor.

5. *See generally* THE INSURANCE ANTITRUST HANDBOOK: A PROJECT OF THE INSURANCE INDUSTRY COMMITTEE, SECTION OF ANTITRUST LAW 41–86, 113–24 (Mark F. Horning & Roger W. Langsdorf, eds., 1995) (hereafter INSURANCE ANTITRUST HANDBOOK).

6. For more discussion refer to *Memorandum from Tim Wagner on Insurance Rating Bureaus* (July 2, 2002), *available at* http://www.naic.org/1committee/Improve_State_Based_wg/jirfinal110300.pdf (last visited March 1, 2003).

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in more detail below, these collaborative activities have been exempted from federal antitrust scrutiny by the McCarran-Ferguson Act.[7] Similar exemptions at the state level to the application of state antitrust laws have also protected these practices.[8]

There are, however, very few industry precedents for collaborative insurer agreement or standard-setting with respect to the use or non-use of particular underwriting criteria in setting the terms of insurance coverage or the price charged for it (or both). The absence of such examples is not surprising. If a particular underwriting factor is actuarially unsound, no compact is needed to discourage insurers from using it. If a particular underwriting factor is actuarially sound, insurers will be loathe to surrender their ability to use it in underwriting, and there is no advantage to be accrued from arranging a compact among insurers pursuant to which all agree to use the underwriting factor.

Even in the relatively rare circumstances where such a compact might be perceived to have advantages, evidence of multi-insurer collaboration is difficult to find. Until the mid-1960s, insurers used race-distinct actuarial tables in life insurance underwriting; it is probably not coincidental that race-neutral tables became the norm around the time of the enactment of the Civil Rights Act of 1964.[9] Information about this transformation is sparse,[10] but the industry probably understood that this underwriting practice would be prohibited if it were not voluntarily abandoned.[11] Moreover, a federal prohibition would constitute a toehold for more expansive federal regulation at a time when the industry generally preferred the existing system of state regulation. In the circumstances of the mid-1960s, it would not be surprising if life insurers agreed through some kind of industry standard or articulated "guiding principles" to abandon the use of race in underwriting, but there is no evidence of life insurers acting in concert to bring about this result.

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7. *See* discussion *infra* Part C.1.

8. *See* discussion *infra* Part C.2.

9. 42 U.S.C. §§ 1971, 1975a–1975d, 2000a–2000h (1994).

10. *See* Robert H. Jerry, II & Kyle B. Mansfield, *Justifying Unisex Insurance: Another Perspective*, 34 AM. U. L. REV. 329, 352 n.139 (1985) (discussing the transformation with citation to some contemporary commentaries on insurer practices).

11. From time to time, evidence of race-based pricing turns up in the market, which is surprising given the opprobrium with which it is held. *See* Jim Connolly, *NAIC Acts on Race-Based Premium Rates*, NAT'L UNDERWRITER (LIFE-HEALTH), June 19, 2000, at 3; *Minority Policyholders Win Settlement From Unitrin on Race-Based Premium*, 12 ANDREWS INS. COV. LITIG. REP. 13 (May 17, 2002).

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Likewise, when some insurer trade organizations went on record opposing the use of sexual orientation in underwriting in the mid-1980s, one might have anticipated that some insurers would collaborate to implement the public positions of the organizations to which they belonged. There is, however, no evidence that this occurred. When the AIDS epidemic emerged in the mid-1980s, the largest single group of AIDS victims were gay men with same-gender sexual experiences. Many insurers responded by attempting to identify the sexual orientation of applicants for the purpose of excluding all gay men from their risk pools, even though the overwhelming majority of gay men would never become AIDS victims.[12] In 1985, the National Association of Insurance Commissioners[13] appointed an Advisory Committee on AIDS; this committee undertook to draft guidelines relating to appropriate underwriting practices. The Committee worked on draft "Medical/Lifestyle Questions and Underwriting Guidelines" throughout 1986, and the NAIC approved the Guidelines at its December 9, 1986 meeting. The Guidelines forbade life and health insurers from inquiring into an applicant's sexual orientation or using sexual orientation in the underwriting process and also condemned the use of factors such as gender, marital status, living arrangements, occupation, beneficiary designations, medical history, and zip code or other territorial identifiers as substitutes for questions about an individual's sexual orientation.[14] The Health Insurance Association of America (HIAA) and the American Council on Life Insurance (ACLI), two associations of insurance companies that were represented on the Committee, supported the Guidelines.[15] There is no evidence, however, of any agreement among

12. *See* Benjamin Schatz, *The AIDS Insurance Crisis: Underwriting or Overreaching?*, 100 HARV. L. REV. 1782, 1783–88 (1987).

13. The National Association of Insurance Commissioners (NAIC) is an association of the chief regulatory official of the fifty states, the District of Columbia, and the United States territories. It was organized in 1871. Through its staff and various committees, it proposes model laws and regulations for possible adoption by the states, studies problems of insurance regulation, gathers and distributes information on regulatory problems, and maintains financial data for the purpose of detecting insurer insolvency at an early stage. *See* ROBERT H. JERRY, II, UNDERSTANDING INSURANCE LAW § 23[b], 127–28 (3d ed. 2002).

14. *See* NAIC MODEL LAWS, REGULATIONS & GUIDELINES, Medical/Lifestyle Questions and Underwriting Guidelines, §60-1 et seq. (1988, 2002).

15. In December 1986, the two associations submitted a joint report explaining the associations' opposition to prohibitions on HIV testing of applicants by insurance companies. This report also endorsed the model guidelines. *See* Health Insurance Association of America & American Council of Life Insurance, Statement to the Health Insurance Committee of the National Association of Insurance Commissioners on Acquired Immunodeficiency Syndrome

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insurance companies to refrain from particular underwriting practices with respect to HIV testing or from the use of sexual orientation in underwriting.[16]

Thus, although insurers collaborate in many aspects of the insurance business, there is little precedent for insurer collaboration with respect to underwriting criteria. How the antitrust laws would apply to this kind of concerted conduct, if it were to occur, is discussed in the next section.

II. THE FEDERAL ANTITRUST LAWS AND ANTICOMPETITIVE INSURER CONDUCT

A. Overview: The Federal Antitrust Framework

The federal antitrust statute with the most relevance to the insurance industry is the Sherman Act, the substance of which rests in two brief but sweeping provisions enacted by Congress in 1890. Section 1 is the "restraint of trade" provision; it is relevant to many kinds of collaborative conduct, including horizontal restraints among competitors. Section 1 states: "Every contract, combination . . . or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is . . . illegal."[17] Section 2, the "monopoly abuse" provision, states: "Every person who shall monopolize, or attempt to monopolize, or combine or conspire with any other person or persons, to monopolize any part of the trade or commerce among the several States, or with foreign nations, shall be deemed guilty of a felony . . . ."[18] The presence of monopoly power (classically defined as "the power to control prices or exclude competition")[19] is not enough to make out a violation of section 2; rather, the offender must possess monopoly power plus engage in

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(AIDS) and the Recommendations of the NAIC Advisory Committee on AIDS, Dec. 9, 1986 (unpublished report) (on file with the author).

16. The Advisory Committee's December 9, 1986 report records broad support by all members of the Committee, including the industry representatives, for the proposition that inquiries into sexual orientation or use of sexual orientation as an underwriting factor were inappropriate "and should not be allowed." The Report also clearly records that industry representatives were opposed to any restrictions on prior test history or to prohibitions on testing for underwriting purposes. The Advisory Committee was never able to reach a consensus on the testing issue. *See* 1 PROCEEDINGS OF THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS 609, 657–59 (1987).

17. 15 U.S.C. § 1 (2000).

18. *Id.* § 2.

19. United States v. E.I. du Pont de Nemours & Co., 351 U.S. 377, 391 (1956).

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anticompetitive conduct to obtain, use, or preserve it.[20] Because most insurance markets do not have a single insurer with dominant market power, section 2 has less practical importance to the insurance industry than section 1.[21] Regardless, section 1 is the provision relevant to concerted insurer conduct to eliminate use of one or more underwriting factors when determining coverage or premium levels.

The statutory language of the Sherman Act depends on judicial interpretation and construction for its content.[22] As the Court stated in *Apex Hosiery Co. v. Leader*,[23] "[t]he prohibitions of the Sherman Act were not stated in terms of precision or of crystal clarity and the Act itself did not define them. In consequence of the vagueness of its language . . . the courts have been left to give content to the statute."[24] But in doing so, courts must adhere to the Act's purpose: "The Sherman Act was designed to be a comprehensive charter of economic liberty aimed at preserving free and unfettered competition as the rule of trade. . . . [T]he policy unequivocally laid down by the Act is competition."[25]

Other federal antitrust laws have potential relevance to the insurance industry. Congress passed The Clayton Act in 1914 to compensate for the Sherman Act's perceived failure to remedy anticompetitive conduct before it occurred.[26] The two most important provisions of the Clayton Act for the insurance industry are section seven,[27] which prohibits mergers and acquisitions that may substantially lessen competition or tend to create a

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20. *See* United States v. Grinnell Corp., 384 U.S. 563, 570–71 (1966) (noting that a section 2 violation requires monopoly power and "the willful acquisition or maintenance of [monopoly] power as distinguished from growth or development as a consequence of a superior product, business acumen, or historic accident.").

21. *See* INSURANCE ANTITRUST HANDBOOK, *supra* note 5, at 18.

22. In this regard, the Sherman Act has been compared to the Bill of Rights, which also depends on judicial interpretation for determining the content of its short but sweeping provisions. United States v. Topco Assocs., 405 U.S. 596, 610 (1972) ("Antitrust laws . . . are the Magna Carta of free enterprise. They are as important to the preservation of economic freedom and our free enterprise system as the Bill of Rights is to the protection of our fundamental personal freedoms.").

23. 310 U.S. 469 (1940).

24. *Id.* at 489.

25. N. Pac. Ry. Co. v. United States, 356 U.S. 1, 4 (1958).

26. JOHN H. SHENEFIELD & IRWIN M. STELZER, THE ANTITRUST LAWS: A PRIMER 15, 21 (1993) (the substance of the Clayton Act tends to "look to the future and require a prediction of probable anticompetitive effect.").

27. 15 U.S.C. § 18 (2000).

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monopoly, and section 8,[28] which prohibits with some exceptions the officers and directors of one corporation from serving in the same capacity at a competing corporation. The Clayton Act is not relevant to horizontal restraints among competitors in underwriting, but potentially relevant is the Federal Trade Commission Act, passed by Congress in 1914. Section 5(a)(1) of the FTC Act, as subsequently amended, gives the Commission the authority to regulate "[u]nfair methods of competition in or affecting commerce," a standard that includes conduct that violates either the letter or spirit of other antitrust laws.[29]

Whether challenged insurer activity violates any of these antitrust laws is a question that, at least in theory, is preliminary to whether the insurer activity enjoys an exemption from federal antitrust law. Although the analysis needed to determine the applicability of an exemption can be very complicated, sometimes deciding the exemption question is easier than determining whether the challenged conduct is an antitrust violation.[30] Thus, it can be expedient to proceed initially to the exemption analysis rather than grapple with the question of antitrust liability. The following discussion, however, visits the antitrust liability issue first and then proceeds to the exemptions.

B. Horizontal Restraints and Section 1 of the Sherman Act

1. Elements of Section 1

The text of section 1 begins with the phrase "contract, combination . . . or conspiracy."[31] Each term in the phrase requires cooperative conduct by at least two actors—either two (or more) sellers, two (or more) buyers, or a seller and buyer (or more) in combination.[32] In some circumstances, this concerted

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28. *Id.* § 19.

29. Fed. Trade Comm'n v. Brown Shoe Co., 384 U.S. 316, 320–21 (1966) (FTC "has broad powers to declare trade practices unfair," particularly with respect to "trade practices which conflict with the basic policies of the Sherman and Clayton Acts even though such practices may not actually violate these laws"); Atl. Ref. Co. v. Fed. Trade Comm'n, 381 U.S. 357, 369 (1965) (FTC Act declares unlawful practices that exhibit the same "central competitive characteristic[s]" as those which constitute Sherman Act violations); Fed. Trade Comm'n v. Cement Inst., 333 U.S. 683, 694 (1948) (violations of the Sherman Act also constitute violations of the FTC Act).

30. Note, however, that even if the exemption issue is decided first, concluding that the insurer's conduct enjoys an antitrust exemption does not establish that the conduct is unlawful in the absence of an exemption.

31. 15 U.S.C. § 1 (2000).

32. SHENEFIELD & STELZER, *supra* note 26, at 15.

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action requirement can be met by the activity of a trade association or similar group.[33] The reference to "several States, or with foreign nations" means that the trade restrained by the concerted action must be either in or at least have an effect upon interstate or foreign commerce; incidental commerce that is entirely intrastate in character and impact is not the concern of section 1.[34] Because every contract restrains trade by obligating the contracting parties to deal only with each other with respect to the contract's subject matter, a literal reading of section 1 would invalidate all contracts, an obviously untenable result.[35] In 1911, the United States Supreme Court, drawing upon the common law of unfair competition, interpreted section 1 as only prohibiting *unreasonable* restraints of trade,[36] and this reading of section 1 has been reiterated on numerous subsequent occasions.[37]

The meaning of "unreasonable restraint" has evolved along two lines. First, "there are certain agreements or practices which because of their pernicious effect on competition and lack of any redeeming virtue are conclusively presumed to be unreasonable."[38] These kinds of restraints—such as direct price-fixing, bid-rigging, division of markets among competitors, some kinds of boycotts (*i.e.*, concerted refusals by competitors with market power to deal with third parties), and resale price maintenance—are deemed to be "unreasonable *per se*."[39] The logic of this categorization is that courts have determined from past experience that some kinds of restraints are so fundamentally anti-competitive and so lacking in justification that no analysis beyond the determination of the fact of the existence of the restraint is necessary to determining invalidity.

The second line of analysis is known as the "rule of reason." With respect to any activity that is not *per se* unreasonable, the relevant circumstances must

33. *See, e.g.*, Allied Tube & Conduit Corp. v. Indian Head, Inc., 486 U.S. 492 (1988); Nat'l Collegiate Athletic Ass'n v. Bd. of Regents, 468 U.S. 85 (1984); Broad. Music, Inc. v. Columbia Broad. Sys., Inc., 441 U.S. 1 (1979); E. States Retail Lumber Dealers' Ass'n v. United States, 234 U.S. 600 (1914).

34. SHENEFIELD & STELZER, *supra* note 26, at 15.

35. *See* Chi. Bd. of Trade v. United States, 246 U.S. 231, 238 (1918) ("the legality of an agreement or regulation cannot be determined by so simple a test, as whether it restrains competition. Every agreement concerning trade, every regulation of trade, restrains.").

36. Standard Oil Co. of N.J. v. United States, 221 U.S. 1 (1911).

37. *See, e.g.*, Nat'l Collegiate Athletic Ass'n v. Bd. of Regents, 468 U.S. 85, 98 (1984); Nat'l Soc'y of Prof'l Eng'rs v. United States, 435 U.S. 679, 690(1978).

38. N. Pac. Ry. Co. v. United States, 356 U.S. 1, 5 (1958).

39. *Id.* at 9.

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be evaluated to determine whether the conduct is, on balance, pro-competitive or anti-competitive.[40] The rule of reason is "the prevailing standard" under section 1 of the Sherman Act and is the "standard traditionally applied for the majority of anticompetitive practices" challenged under that provision.[41] For example, a bona fide joint venture (to be distinguished from a "sham" joint venture, which is a subterfuge for an agreement to fix prices and is therefore unreasonable *per se*) may be a legitimate effort to achieve efficiencies that promote, rather than stifle, competition.[42] Most "vertical" agreements (*i.e.*, agreements between companies at different levels of product distribution, such as a manufacturer and wholesaler)—as distinct from "horizontal" agreements (*i.e.*, agreements among competitors)—are tested under the rule of reason.[43] Although an agreement to fix one or more components of price may be a *per se* violation, "courts have applied the rule of reason rather than the *per se* rule where . . . the relationship between the restraint and price is sufficiently attenuated."[44] Social considerations are generally excluded from rule of reason analysis: "[b]ecause the rule of reason focuses on the restraint's competitive effect, factors unrelated to competition—with possible rare exceptions for health and safety considerations and for deviations from the traditional profit-maximizing business model such as the professions, municipalities, and universities—are generally irrelevant."[45]

2. Underwriting Collaboration as Price Fixing

Because "[p]rotection of price competition from conspiratorial restraint is an object of special solicitude under the antitrust laws,"[46] courts have generally "declared unlawful *per se* agreements among competitors to raise, lower, stabilize, or otherwise set or determine prices."[47] To constitute

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40. *See Nat'l Soc'y of Prof'l Eng'rs*, 435 U.S. at 691 (an inquiry under the rule of reason is limited to whether the restraint "is one that promotes competition or one that suppresses competition.").

41. *See* Bus. Elecs. Corp. v. Sharp Elecs. Corp., 485 U.S. 717, 723 (1988).

42. INSURANCE ANTITRUST HANDBOOK, *supra* note 5, at 13–14.

43. ABA SECTION OF ANTITRUST LAW, ANTITRUST LAW DEVELOPMENTS 79 (5th ed. 2002) [hereinafter ANTITRUST LAW DEVELOPMENTS].

44. *Id.* at 82.

45. *Id.* at 54.

46. United States v. Gen. Motors Corp., 384 U.S. 127, 148 (1966).

47. ANTITRUST LAW DEVELOPMENTS, *supra* note 43, at 82. The three verbs—"raise," "lower" and "stabilize"—come from the Supreme Court's decision in *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150, 221 (1940). *See, e.g.*, Ariz. v. Maricopa County Med. Soc'y, 457 U.S. 332 (1982); Catalano, Inc. v. Target Sales, Inc., 446 U.S. 643 (1980).

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horizontal price fixing, the agreement need not involve an agreement among competitors about the ultimate price; on the contrary, "[a]ny combination which tampers with price structures is engaged in an unlawful activity."[48] Thus, any factor relevant to the ultimate cost to the consumer—such as credit terms, trade-in allowances, cash down payment requirements, discounts, free service, or any other element of price—which is the subject of competitor agreement can constitute a *per se* unlawful restraint.[49] Other less direct connections between the activity and price—such as agreements to use specific accounting methods, to require a percentage contribution from each contract to an industry-wide collective bargaining fund, to use only particular subcontractors, etc.—have also been deemed *per se* violations of section 1.[50] Agreements to "fix some element of price or the process by which price is determined . . . do not fix the price as such, [but] they do require participants to compute the price in a certain way . . . . Once such an agreement is appropriately classified as naked, *per se* condemnation follows as a matter of course."[51]

Allegations of concerted action are not always based on alleged formal agreements among competitors. Frequently, such allegations are based on patterns of uniform business conduct, which is commonly referred to as "conscious parallelism."[52] As one treatise explains, "lower courts have consistently held that conscious parallelism, by itself, will not support a

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48. United States v. Socony-Vacuum Oil Co., 310 U.S. 150, 221 (1940).

49. The leading case for this proposition is Catalano, Inc. v. Target Sales, Inc., 446 U.S. 643 (1980). For more discussion, see ANTITRUST LAW DEVELOPMENTS, *supra* note 43, at 84.

50. *See* ANTITRUST LAW DEVELOPMENTS, *supra* note 43, at 85–86.

51. 12 HERBERT HOVENKAMP, ANTITRUST LAW & 2020, at 121–22 (1999). *See* UNR Indus., Inc. v. Cont'l Ins. Co., 607 F. Supp. 855, 859–60 (N.D. Ill. 1984):

> [*P*]*er se* status . . . has been conferred on price-fixing not merely because it harms consumers (which it does) but because it harms consumers in a particular way—by (almost always) restraining competition . . . . The price-fixing label can by analogy attach to conduct more subtle than a simple conspiracy to directly fix prices . . . but the analogy is successful only if the challenged conduct is, like traditional price-fixing, virtually certain to reduce competition.

Id.

52. *See, e.g.*, Am. Tobacco Co. v. United States, 328 U.S. 781 (1946) (noting that a pattern of unexplained parallel conduct by three tobacco companies supported finding of conspiracy); Interstate Cir., Inc. v. United States, 306 U.S. 208 (1939) (pattern of uniform conduct among motion picture distributors that had imposed nearly identical restraints was sufficient to permit the inference of the existence of an agreement). *See generally* ANTITRUST LAW DEVELOPMENTS, *supra* note 43, at 9–16.

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finding of concerted action . . . . [O]ther facts and circumstances, often referred to as 'plus factors,' typically must be combined with evidence of conscious parallelism to support an inference of concerted action."[53] The presence of legitimate business reasons that would lead firms to independently follow the same course of action or the absence of motive for a conspiracy exemplify the kinds of considerations that will rebut the allegation of conscious parallelism.[54] Insurers tend to compete rather than cooperate with respect to risk classification determinations.[55] Therefore, it is improbable that a "conscious parallelism" argument would succeed with respect to such determinations. Thus, if antitrust claims are to have viability, it will be with respect to demonstrated, formal collaborations among insurers.

Applying the foregoing general principles to collaborations among insurers presents no special difficulties. In insurance, the product is the insurance policy, and the price of the product is the premium. Thus, if insurers agree among themselves to fix the level of insurance premiums, they are engaged in price-fixing in violation of the Sherman Act; unless the anticompetitive conduct earns an antitrust exemption, the insurer combination constitutes a *per se* violation of section 1. Likewise, when two or more insurers agree that a particular underwriting factor shall not be used in determining the level of premiums, the insurers are taking a factor relevant to the ultimate cost to the consumer and agreeing to eliminate this factor as a basis for competition.[56] In other words, when insurers surrender the right to make price distinctions based upon a particular underwriting factor, insurers

53. ANTITRUST LAW DEVELOPMENTS, *supra* note 43, at 10–11.

54. *Id.* at 12–13.

55. *See* KENNETH S. ABRAHAM, DISTRIBUTING RISK: INSURANCE, LEGAL THEORY, AND PUBLIC POLICY 67–68 (1986) (explaining "proliferation of risk classifications in insurance markets." "Different insurers sometimes may classify in different ways in the hope of capturing a different slice of the universe of good risks."); COMPTROLLER GENERAL, U.S. GENERAL ACCOUNTING OFFICE, ISSUES AND NEEDED IMPROVEMENTS IN STATE REGULATION OF THE INSURANCE BUSINESS 102–04 (1979) (describing fierce competition through classification in automobile insurance). *See also* Cynthia J. Crosson & Michael L. Albanese, *Gap Widens Between Haves and Have-Nots*, 97 BEST'S REV. 63 (1997) (describing conditions of "intense competition" in life insurance industry); Scott E. Harrington, *Insurance Rate Regulation in the 20th Century*, 19 J. INS. REG. 204, 211–12 (2000) ("Economists generally agree that market structure and ease of entry are highly conducive to competition in auto, homeowners, workers' compensation, and most other property-liability insurance lines.").

56. *See* Dep't of Justice Response Letter (B.R.L. 92-1) (Jan. 14, 1992) ("an agreement among competitors regarding the price or terms under which they will underwrite insurance would raise antitrust concerns.").

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forfeit the ability to segregate a risk class and offer the members of the subdivided classes a differentiated product based on coverage or price (or both), all of which has the effect of stabilizing price in the relevant market by eliminating competition based on a component of product price. This, too, falls within the category of restraints that courts have traditionally deemed *per se* violations of section 1.

Insurers agreeing upon the manner in which insurance premiums will be calculated is analogous to the arrangement declared a *per se* violation of section 1 in *In re Wheat Rail Freight Rate Antitrust Litigation*,[57] where defendant railroads set the manner in which freight would be priced—flat rate or proportional—depending on whether the freight was transit or nontransit.[58] As the court explained, "the agreement in question did not actually fix prices, but rather the manner in which those rates/prices are calculated. Nevertheless, the concept of price fixing which defines *per se* illegal conduct includes defendants' conduct."[59] This reasoning would seem to support a conclusion that insurer collaboration with respect to underwriting factors is *per se* unlawful, but one possible basis for distinguishing the restraint in *Wheat Rail Freight* from horizontal insurer agreements on underwriting criteria is the proximity of the restraint to the effect on price. In *Wheat Rail Freight*, the court observed that "[t]he agreement among defendants to eliminate the transit privilege on proportional rate freight has a direct effect on the price of freight. . . . [A]n agreement on how rates are to be calculated effectively fixes prices."[60] As explained above, if the relationship between the restraint on a component of price and the ultimate price is sufficiently attenuated, courts have applied the rule of reason rather than the *per se* rule in assessing the restraint. In circumstances where insurers agree not to use a particular underwriting factor in determining premiums, one might argue that the impact on price is more attenuated because competition can still occur with respect to other underwriting factors, thereby diluting the impact on price of the

57. 579 F. Supp. 517 (N.D. Ill. 1984), *aff'd*, 759 F.2d 1305 (7th Cir. 1985), *cert. denied sub nom.*, Little Crow Milling Co. v. Baltimore & Ohio R.R., 476 U.S. 1158 (1986). Most price-fixing cases involve direct restraints on price or output (or both). It is less common for competitors to agree to fix a *component* of price, although examples of such conduct do exist. Still less common are agreements among competitors to agree upon a *methodology* for determining product price, but *Wheat Rail Freight* provides an example of this kind of collaboration. *See, e.g.*, *Wheat Rail*, 579 F. Supp. at 523.

58. *Wheat Rail*, 579 F. Supp. at 538.

59. *Id.*

60. *Id.*

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agreement not to use one particular factor. This analysis does not validate the restraint, but it does provide a basis for testing it—and possibly upholding it—under the rule of reason.

If the rule of reason is the appropriate standard, the question becomes whether the restraint "is one that promotes competition or one that suppresses competition."[61] Exactly how this analysis would play out in the case of insurer agreements with respect to use of underwriting criteria is difficult to predict. On the one hand, competition would be enhanced based on the fact that consumers whose genetic profiles indicate higher risk would have access to insurance that would otherwise not be available at all or would be available only at higher rates. But consumers whose genetic profiles do not show propensity for higher risk or which affirmatively demonstrate a propensity for lower risk would not be able to receive the advantages of their relatively advantageous genetic profiles. When these consumers are grouped with consumers whose risks are higher, competition is impaired. In the same vein, consumers whose family history puts them in a higher-risk group would not be able to use genetic information to negate the assumptions normally drawn from adverse family history; for these consumers, competition is reduced. It is by no means obvious that the pro-competitive virtues of a restraint on the use of genetic information in underwriting outweigh the anticompetitive aspects of the restraint (or vice versa); thus, it cannot be assumed that the restraint would pass muster under the rule of reason.

Because a restraint on the use of genetic information arguably furthers egalitarian values and public policies which encourage the equal treatment of individuals based on factors beyond their control, the question arises as to whether these justifications count in the restraint's favor under a rule of reason analysis. As noted earlier, social considerations are generally excluded from rule of reason analysis. For example, in *National Society of Professional Engineers v. United States*,[62] the United States Supreme Court rejected the professional organization's argument that a provision in its canon of ethics prohibiting competitive bidding by member engineers was necessary to prevent inferior engineering work and to protect the public's health, welfare, and safety.[63] The Court reasoned that its role was "not to decide whether a policy favoring competition is in the public interest, or in the interest of the

61. Nat'l Soc'y of Pro. Eng'rs v. United States, 435 U.S. 679, 691 (1978).
62. 435 U.S. 679 (1978).
63. *Id.* at 681.

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members of an industry,"[64] because the Sherman Act reflects Congress's judgment that competition "will produce not only lower prices, but also better goods and services,"[65] and that under the rule of reason, inquiry into "the question of whether competition is good or bad" is not permitted.[66] Similarly, in *Federal Trade Commission v. Indiana Federation of Dentists*,[67] the Court rejected the professional organization's quality of care justifications for a refusal to provide x-rays to insurance companies. The Court explained:

> The argument is, in essence, that an unrestrained market in which consumers are given access to the information they believe to be relevant to their choices will lead them to make unwise and even dangerous choices. Such an argument amounts to "nothing less than a frontal assault on the basic policy of the Sherman Act."[68]

The restraint in *Professional Engineers* is arguably distinguishable from a insurer-imposed restraint on use of an underwriting factor in that the professional association's restraint on competitive bidding is directly beneficial to the economic self-interest of the association's members, whereas the insurance restraint does not eliminate competitive bidding but merely alters the terms on which the insurers' competition for business occurs. The restraint in *Indiana Federation* is similarly distinguishable; it, too, bore a direct relationship to the economic betterment of the dentists imposing the restraint. If a constraint on the use of genetic information in underwriting has any economic benefit for insurers, it is highly indirect and much less significant to the insurers than the restraints in *Professional Engineers* and *Indiana Federation* were to the parties imposing them.

The economic self-interest factor was important to the Third Circuit's analysis in *United States v. Brown University*,[69] where an agreement among universities on the financial aid to be offered students to eliminate a bidding war among the universities for top applicants was at issue. The universities argued that the agreements were designed to help make more money available for needy students, and the district court rejected this justification as an

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64. *Id.* at 692.
65. *Id.* at 695.
66. *Id.*
67. 476 U.S. 447 (1986).
68. *Id.* at 463 (quoting *Prof'l Eng'rs*, 435 U.S. at 695).
69. 5 F.3d 658 (3d Cir. 1993).

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inappropriate social, non-economic justification.[70] The Third Circuit disagreed, reasoning that the aims of the financial aid agreement would increase the quality of the educational product by increasing socio-economic diversity on campuses and would increase consumer choice by making high-quality education available to different students, unlike the restraint in *Professional Engineers* which reduced consumer choice.[71] The Third Circuit remanded the case to the district court for full rule of reason analysis.[72]

How the choice-enhancing factor that aided the restraint in *Brown University* plays out in the insurance context is difficult to assess. On the one hand, it might be argued that a restraint on use of genetic information in underwriting increases consumer choice by making insurance available to more persons. Those who would have been denied insurance or only offered insurance on limited terms due to negative genetic information are benefited if insurers cannot take such information into consideration. On the other hand, applicants who do not present negative genetic information would presumably be rated as lower-risk insureds and would have access to lower-cost insurance if insurers did not foreclose their ability to make underwriting distinctions based on genetic information. How these two factors would be balanced by a court—and whether, ultimately, the restraint would be determined to achieve a net pro-competitive effect—is difficult to predict.

Perhaps a more likely outcome is that courts would observe that prohibiting life insurer use of genetic information in underwriting is something that the legislatures could do; after all, many state legislatures have taken precisely that position with respect to health insurance underwriting and a few have done so with respect to life insurance underwriting.[73] The failure of some legislatures to include life insurance in the statutes prohibiting the use of genetic information in health insurance underwriting stands, arguably, as an indirect, but deliberate statement of legislative policy that such a prohibition is not desired, at least at this time. In some states, the relevant statute has an explicit carve-out for life insurance.[74] In circumstances where legislatures have declined to elevate egalitarian values with respect to the use of genetic information in life insurance underwriting, a court may decline to take it upon itself to elevate such values in the face of legislative unwillingness to do so.

70. *Id.* at 664.
71. *Id.* at 677–78.
72. *Id.* at 678.
73. *See supra*, note 1.
74. *See* MO. REV. STAT. § 375.1303(3) (2000).

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3. Underwriting Collaboration as a Concerted Refusal to Deal

Courts have also interpreted section 1 as placing limitations on competitors' ability to agree not to deal with, or to deal only on particular terms with, other entities.[75] These arrangements are typically described as "group boycotts" or "concerted refusals to deal."[76] For purposes of the applicability of the Sherman Act, it is not necessary to distinguish between boycotts and concerted refusals to deal; "as far as the Sherman Act (outside the exempted insurance field) is concerned, concerted agreements on contract terms are as unlawful as boycotts."[77] Early cases treated these combinations as *per se* violations of section 1, but more recent cases tend to analyze such restraints under the rule of reason.[78] Exactly how one draws the line between a refusal to deal that is *per se* unlawful and one that receives rule of reason treatment is difficult to articulate. Even the United States Supreme Court has acknowledged this problem with respect to boycotts: "'there is more confusion about the scope and operation of the *per se* rule against group boycotts than in reference to any other aspect of the *per se* doctrine.'"[79]

In the insurance context, the argument might be made that an agreement among insurers to deal with individual applicants only on terms that make no distinction based on genetic information constitutes a boycott or concerted refusal to deal. Authority for this position comes from cases like *Sandy River Nursing Care v. Aetna Casualty*,[80] where the First Circuit held that concerted

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75. ANTITRUST LAW DEVELOPMENTS, *supra* note 43, at 104.

76. *Id.*

77. Hartford Fire Ins. Co. v. Cal., 509 U.S. 764, 803 (1993). The Court cited *Paramount Famous Lasky Corp. v. United States*, 282 U.S. 30 (1930) and *United States v. First Nat'l Pictures, Inc.*, 282 U.S. 44 (1930) for the proposition that an agreement among competing motion picture distributors refusing to license films to exhibitors except on standardized terms was unlawful, and *Anderson v. Shipowners Ass'n of Pac. Coast*, 272 U.S. 359 (1926), which involved the effort of an association of employers to establish industry-wide employment terms, as examples of unlawful concerted refusals to deal.

The distinction between concerted refusals and boycotts is, however, highly relevant to the scope of the McCarran-Ferguson Act's antitrust exemption because no protection is given boycotts. This issue is discussed below.

78. *See, e.g.*, Fed. Trade Comm'n. v. Ind. Fed'n of Dentists, 476 U.S. 447 (1986); N.W. Wholesale Stationers, Inc. v. Pac. Stationery and Printing Co., 472 U.S. 284 (1985); ANTITRUST LAW DEVELOPMENTS, *supra* note 43, at 105.

79. N.W. Wholesale Stationers, Inc. v. Pac. Stationery & Printing Co., 472 U.S. 284, 294 (1985) (quoting LAWRENCE A. SULLIVAN, HANDBOOK OF THE LAW OF ANTITRUST § 83, at 229–30 (1977)).

80. 985 F.2d 1138 (1st Cir. 1993), *cert. denied*, 510 U.S. 818 (1993).

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efforts by insurers to refuse to offer certain types of insurance coverage in an attempt to induce the Maine legislature to authorize rate increases was "an economic boycott that beyond doubt 'constituted a classic restraint of trade within the meaning of Section one of the Sherman Act'"[81] and was *per se* unlawful (although the boycott was ultimately exempted from the antitrust laws by virtue of the state action doctrine, which is discussed below).

In *Sandy River*, the concerted action was designed to secure objectives collateral to the transactions in which the restraint was imposed, which under the United States Supreme Court's reasoning in *Hartford Fire*, constitutes a boycott for purposes of section 3(b) of the McCarran-Ferguson Act.[82] An effort to impose standard terms is, in contrast, a concerted refusal to deal, as it is difficult to imagine a scenario in which an agreement among life insurers to abandon the use of genetic information in underwriting would have any purpose in a collateral transaction. Although this concerted conduct is unlawful under the Sherman Act, the antitrust exemption provided by the McCarran-Ferguson Act immunizes it, as discussed more fully below.

4. Underwriting Collaboration as a Uniform Product Standard

Industry self-regulation efforts can also give rise to allegations of concerted refusal to deal.[83] One of the most common scenarios involves industry enforcement of trade association membership criteria; if, for example, an association member deviates from association guidelines, other association members might take steps to sanction the offending member, perhaps through actions that exclude the offender from markets.[84] Association membership criteria can also be directed at third parties, as, for example, occurs when a professional organization explicitly seeks to deny third parties (fox example, an association of physicians creating standards that exclude non-physicians) privileges that come with association membership. In evaluating whether such restrictions constitute unlawful concerted action, "courts typically have examined whether the collective action is intended to accomplish a goal

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81. *Id.* at 1143 (quoting FTC v. Super. Ct. Trial Lawyers Ass'n, 493 U.S. 411, 422 (1990)).

82. For more discussion of this aspect of *Hartford Fire*, see text accompanying notes 120–25, *infra*.

83. ANTITRUST LAW DEVELOPMENTS, *supra* note 43 at 114.

84. *See, e.g.*, N.W. Wholesale Stationers, Inc. v. Pac. Stationery & Printing Co., 472 U.S. 284 (1985).

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justifying self-regulation and, if so, whether the action is reasonably related to the goal."[85]

Industry associations sometimes also set standards for product quality or safety, occasionally offering certifications for products that meet the standards. When a particular firm's product is excluded from or disadvantaged in the market on account of its failure to meet such standards, the firm might claim that the association's standards constituted an unlawful restraint on trade. For example, in *Allied Tube & Conduit Corp. v. Indian Head, Inc.*,[86] the petitioner, a manufacturer of steel conduit, lobbied a trade association to disapprove the use of polyvinyl conduit as an approved type of electrical conduit.[87] The respondent, a manufacturer of polyvinyl conduit who was disadvantaged by the association's action, brought an antitrust action against the respondent and the association under the logic that the action constituted a concerted refusal to deal, and the United States Supreme Court upheld the section 1 claim.[88] When challenged, such standards are usually evaluated under the rule of reason:

> Key factors determining whether . . . standard-setting or certification programs restrain trade are the extent of the economic detriment they cause to an excluded or non-qualifying firm, the breadth of restrictions in relation to their need, and how the standards are used. In considering the manner in which standards are used, courts have considered whether the application of nominally acceptable rules is designed to suppress competition.[89]

Product standard-setting is common in the insurance industry; most notable is the practice in many lines of insurance of the creation of standardized forms. When challenged, courts have noted the pro-competitive aspects of industry standardization of forms, in that standardization makes

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85. *Id.*

86. 486 U.S. 492 (1988).

87. *Id.* at 496–97.

88. *Id.* at 511. *See also* Am. Soc'y of Mech. Eng'rs, Inc. v. Hydrolevel Corp., 456 U.S. 556 (1982) (association held liable for acts of agents where agents used association's safety standards against plaintiff at urging of one of its competitors); United States v. Am. Bar Ass'n Proposed Final Judgment & Competitive Impact Statement, 60 Fed. Reg. 39,421 (Aug. 2, 1995) (Department of Justice accepted consent decree that bars ABA from imposing accreditation requirements or conditions on various aspects of law school faculty compensation, library standards, etc.).

89. ANTITRUST LAW DEVELOPMENTS, *supra* note 43, at 115–16.

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consumer comparison of the price of alternative products easier.[90] If insurers were to agree that policy pricing would not be based on certain criteria, it could be argued that this combination constituted the equivalent of a trade association standard or perhaps the standardization of the product itself. Those who could claim disadvantage from the practice would be consumers who would have benefited if the underwriting criterion had been used (in this context, consumers lacking genetic characteristics that would have been disadvantageous in the underwriting process) and, perhaps, firms that wish to market policies based on genetic distinctions if efforts to exclude these firms from the market accompanied the promulgation of the standard. The evaluation of the standard would proceed under the rule of reason, and, it is difficult to predict what conclusions courts would draw when applying the rule.

5. Summary

If life insurers were to act collaboratively to set standards for use of genetic information in insurance underwriting, the practice could be characterized as unlawful price-fixing in that competition with respect to a component of product price is being eliminated, as a concerted refusal to deal with consumers on terms other than the sale of products which are not based on such underwriting, or as a concerted refusal to deal under the guise of association standard-setting. There is authority for viewing the fixing of a component of product price as a *per se* violation of section 1 of the Sherman Act, although the attenuated connection between the restraint and ultimate price may mean that the restraint is tested under the rule of reason. The other contentions are likely to be evaluated under the rule of reason. In the absence of clear precedent on insurer combinations involving underwriting factors, particularly combinations involving restraints motivated by pro-egalitarian values, it is difficult to predict how a court would balance the pro-competitive

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90. *See, e.g.*, Maple Flooring Ass'n v. United States, 268 U.S. 563, 566 (1925) (standardization is beneficial to both industry and consumers); Tag Mfrs. Inst. v. FTC, 174 F.2d 452, 462 (1st Cir. 1949) (concerted efforts to standardize products are beneficial to "all concerned, including the consumer who, among other benefits, is thereby better enabled to know what he is buying and to make intelligent price comparisons"); James S. Greenan & John P. Markin, *The Impact of California's Proposition 103 on Insurance and Related Industries: Exchange of Information, Standardization of Forms and Products, and Effect of Joint Activities Outside California*, 659 PLI/CORP 639, 648 (1989) (in the absence of concerted action to mandate use of the standardized form, "the existence of a product standard that may be used by competitors based upon unilateral choice should not be judged an antitrust violation.").

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and anti-competitive aspects of the restraint. The possibility that the restraint would be declared unlawful cannot be casually dismissed. At that point, the analysis would proceed to a further question, the answer to which could moot all of the Sherman Act analysis: whether the insurer conduct enjoys an exemption from federal antitrust law. The three possible exemptions—the McCarran-Ferguson exemption; the state action exemption; and the Noerr-Pennington exemption—are discussed in the next three subsections.

C. The McCarran-Ferguson Federal Antitrust Exemption

1. Origin of the Exemption and Substantive Overview

Although the McCarran-Ferguson Act is often described as a statute preempting federal antitrust law, the Act does much more than that. The statute's most important purpose is to give primacy to state regulation of the insurance business to the extent that the states choose to regulate the industry, at least to the extent that Congress opts not to reassert its primacy, as it can at any time or in any specific context.[91] Yet because the Act's emergence can be traced to the concern of stock fire and casualty companies about the application of antitrust laws to their business, the Act's antitrust implications are very significant.

Even before the Sherman Act was passed in 1890, it was assumed that the federal government lacked authority to regulate the insurance industry. Under the authority of the Supreme Court's 1869 decision in *Paul v. Virginia*,[92] a policy of insurance was deemed not to be "a transaction of commerce," which was tantamount to putting the business of insurance outside the constitutional authority of Congress.[93] Under this precedent to which the Court adhered for seventy-five years,[94] individual states retained the authority to regulate insurance companies.

In 1944, the Supreme Court overruled *Paul* in *United States v. South-Eastern Underwriters Ass'n*[95] and held that insurance transactions were

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91. *See* Spencer L. Kimball, *The Meaning of the McCarran-Ferguson Act Today*, 10 J. INS. REG. 5, 6 (1991) ("[Act] was intended primarily to allocate power in our federal system to deal with and make law for insurance.").

92. 75 U.S. (8 Wall.) 168 (1868).

93. *Id.* at 183.

94. *See, e.g.*, N.Y. Life Ins. Co. v. Deer Lodge County, 231 U.S. 495, 508 (1913); Hooper v. Cal., 155 U.S. 648, 655 (1895).

95. 322 U.S. 533 (1944).

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subject to federal regulation under the Commerce Clause.[96] This also meant that the insurance industry was subject to federal antitrust statutes. In response to the *SEUA* decision, the industry and the National Association of Insurance Commissioners rallied behind legislation to limit the impact of the decision, and Congress enacted the McCarran-Ferguson Act[97] in 1945.

The *SEUA* decision arose out of the effort of the Missouri Attorney General to indict an association of 198 stock fire insurance companies in six states, its officers, and its member companies for unlawful agreements to fix insurance rates and boycott nonmembers. It is undoubtedly no coincidence that Congress began to consider an antitrust exemption for the insurance industry while the *SEUA* litigation was pending.[98] In October, 1943, Congress began hearings on a number of bills that would have provided a total antitrust exemption for the insurance industry, but this approach, sponsored by stock fire insurance companies but opposed by the life and mutual companies, did not garner sufficient support for enactment. Congress then turned to an alternative proposal backed by the NAIC, and it was this proposal which became the basis for what was ultimately adopted as the McCarran-Ferguson Act. The predominant purpose of the NAIC was not to create an antitrust exemption (which, of course, had been the purpose of the stock fire insurance companies who were concerned about the *SEUA* indictments) but was to preserve the system of state regulation.[99] Thus, it is correct to observe that the McCarran-Ferguson Act was most importantly a federalism statute, not an antitrust preemption statute.[100]

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96. *Id.* at 579.

97. 15 U.S.C. §§ 1011–1015 (2000).

98. This history is summarized in *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 218–25 (1979). For a detailed discussion, see Alan M. Anderson, *Insurance and Antitrust Law: The McCarran-Ferguson Act and Beyond*, 25 WM. & MARY L. REV. 81, 83–89 (1983); Charles D. Weller, *The McCarran-Ferguson Act's Antitrust Exemption for Insurance: Language, History and Policy*, 1978 DUKE L.J. 587, 592–97 (year); EARL W. KINTNER, ET. AL., FEDERAL ANTITRUST LAW: A TREATISE ON THE ANTITRUST LAWS OF THE UNITED STATES, § 70.3, at 184–88 (1994).

99. The Interim Report of the NAIC's Subcommittee on Federal Legislation in 1945 described the NAIC's task as "preserving state regulation and at the same time not emasculating the federal anti-trust laws." Weller, *supra* note 98, at 593 (quoting 1945 NAIC PROC. 156, 159-60). Further, a 1944 report of the Subcommittee specifically recommended "a limited exemption of insurance from the Sherman and Clayton Acts for cooperative procedures related to statistics, rates, coverage and similar matters." *Id.* at 594 (citing 1945 NAIC PROC. 23, 28–29, *reprinted in* 90 CONG. REC. A4403-05 (1944)).

100. *See Royal Drug*, 440 U.S. at 219, n.18:

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The substantive core of the McCarran-Ferguson Act is contained in section 2:

> (a) The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.
>
> (b) No Act of Congress shall be construed to invalidate, impair, or supersede 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: *Provided*, That after June 30, 1948, [the Sherman Act, the Clayton Act, and the Federal Trade Commission Act] shall be applicable to the business of insurance to the extent that such business is not regulated by State law.

Section 2(a) states that the "business of insurance"—a phrase that is not defined in the Act—is appropriately within the domain of state regulation. The portion of section 2(b) before the proviso functions as a "reverse preemption" statute; Congress uses its commerce power to state that no act of Congress shall preempt state law unless Congress is explicit that it intends such preemption to occur. Because antitrust laws are general statutes that do not "specifically relate" to insurance, the antitrust laws would be applied to the insurance business if the text of section 2(b) ended before the proviso. The section 2(b) proviso addresses the antitrust question and creates a limited antitrust exemption: after June 30, 1948, the federal antitrust laws shall apply to the business of insurance to the extent the states opt not to regulate such business. The proviso does not explain what kind or intensity of regulation is necessary to trigger the antitrust exemption; like the "business of insurance" definition, this matter is left to the courts for development and interpretation.

Section 3(b) of the Act created an exception to the section 2(b) antitrust exemption. It states that the Sherman Act applies to some insurer activities regardless of whatever regulation the states might enact: "Nothing contained in this chapter shall render the said Sherman Act inapplicable to any

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> There is no question that the *primary* purpose of the McCarran-Ferguson Act was to preserve state regulation of the activities of insurance companies, as it existed before the *South-Eastern Underwriters* case. . . . The question in the present case, however, is one under the quite different *secondary* purpose of the McCarran-Ferguson Act—to give insurance companies only a limited exemption from the antitrust laws.

For further discussion, see Weller, *supra* note 98, at 598; JERRY, *supra* note 13, § 21[c], at 77.

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agreement to boycott, coerce, or intimidate, or act of boycott, coercion, or intimidation." None of the three practices listed in section 3(b) is defined in the statute. The term "boycott" has been a difficult one in antitrust law, and coercion and intimidation are concepts that are potentially much broader than whatever meaning is given to the term "boycott."

When the meaning of the McCarran-Ferguson Act for antitrust enforcement is digested from the Act's provisions, the following formula emerges: if a federal antitrust law is sought to be applied to an insurer activity, the activity—(1) if it constitutes the "business of insurance"—is exempt from such regulation (2) to the extent that such business "is regulated by" state law and (3) the challenged insurer activity does not constitute "a boycott, coercion or intimidation" within the meaning of the section 3(b) exception.[101] The three elements of this formula are discussed in the ensuing subsections.

2. The "Business of Insurance"

For many years after the McCarran-Ferguson Act was enacted, it was widely assumed that federal antitrust law—and state antitrust law as well—had limited relevance to the activities of insurance companies.[102] However, two United States Supreme Court decisions—*Group Life & Health Insurance Co. v. Royal Drug Co.*[103] in 1979, and *Union Labor Life Insurance Co. v. Pireno*[104] in 1982—construed the McCarran-Ferguson Act narrowly, thereby exposing insurance companies to increased antitrust scrutiny. This narrowing of the McCarran-Ferguson immunity has continued during the last twenty years, perhaps reflecting a view that the immunity was initially construed too broadly, or perhaps that the immunity has become unnecessary in light of the availability of the state action immunity, which is discussed below.[105]

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101. *See, e.g.*, Uniforce Temp. Personnel, Inc. v. Nat'l Council on Comp. Ins., 87 F.3d 1296, 1299 (11th Cir. 1996) (stating that McCarran-Ferguson Act exempts the business of insurance if it is regulated by state law and does not constitute a boycott); UNR Indus., Inc. v. Cont'l Ins. Co., 607 F. Supp. 855, 862 (N.D. Ill. 1984) ("The McCarran-Ferguson Act exempts from the antitrust laws conduct which is the business of insurance, is regulated by state law, and does not amount to boycott, coercion or intimidation."). For more discussion, see JERRY, *supra* note 13, § 21[d], at 78–96.

102. INSURANCE ANTITRUST HANDBOOK, *supra* note 5, at 1.

103. 440 U.S. 205 (1979).

104. 458 U.S. 119 (1982).

105. *See* 1 PHILLIP E. AREEDA & HERBERT HOVENKAMP, ANTITRUST LAW ¶ 219a, at 325–26 (Rev. 2d ed. 2000); KINTNER ET AL., *supra* note 98, § 70.6, at 203–05.

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As explained above, the McCarran-Ferguson Act exempts the "business of insurance" from federal antitrust laws if the challenged activity is regulated by state law and does not constitute a boycott, coercion, or intimidation within the meaning of section 3(b) of the Act. Thus, the threshold question is whether the challenged insurer activity involves the "business of insurance." If this question is answered in the negative, the insurer conduct enjoys no protection from antitrust analysis. Under the *Royal Drug–Pireno* test, three questions must be asked and answered in the affirmative when determining whether an insurer's activity constitutes the "business of insurance:" (1) Does the activity involve the underwriting or spreading of risk? (2) Does the activity involve an integral part of the insurer-insured relationship? (3) Is the activity limited to entities within the insurance industry?[106] None of the three factors is necessarily determinative in and of itself.[107]

To satisfy the first element, which requires that the activity involve the underwriting or spreading of risk, the insurer's activity must have "the effect of transferring or spreading a policyholder's risk."[108] Transactions in which the insurer does not assume risk and distribute it across a pool of similarly situated insureds in similar transactions will not meet this test. If, for example, the insurance product is primarily an investment instrument, such as a variable life insurance or variable annuity product, the product may not involve the spreading of risk and thus may not be the business of insurance. Thus, in *Securities and Exchange Commission v. Variable Annuity Life Insurance Co. of America*,[109] the Court concluded that the variable annuity policies offered by insurance companies were not part of the business of insurance protected by the McCarran-Ferguson Act:

> [T]he concept of "insurance" involves some investment risk-taking on the part of the company. The risk of mortality, assumed here, gives these variable annuities an aspect of insurance. Yet it is apparent, not real; superficial, not substantial. In hard reality the issuer of a variable annuity that has no element of a fixed return assumes no true risk in the insurance sense. It is no answer to say that the risk of declining returns in times of depression is the reciprocal of the

106. For detailed discussion of *Royal Drug* and *Pireno*, see AREEDA & HOVENKAMP, ANTITRUST LAW ¶ 219b, at 326–41 (2d ed. 2000).

107. *Pireno*, 458 U.S. at 129.

108. *Id.*

109. 359 U.S. 65 (1959).

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> fixed-dollar annuitant's risk of loss of purchasing power when prices are high and gain of purchasing power when they are low. We deal with a more conventional concept of risk-bearing when we speak of "insurance." For in common understanding "insurance" involves a guarantee that at least some fraction of the benefits will be payable in fixed amounts.[110]

The underlying public policy advanced by the Court's decision is causing variable annuities sold by insurance companies to be subject to the regulatory scheme of the securities laws.[111] The logic of this policy is as follows: If the insurance company's instrument is the functional equivalent of the financial instruments sold by non-insurers, it is not unique to the insurance business and insurance company activities with regard to it should not enjoy special status as "business of insurance" under the McCarran-Ferguson Act. By this analysis, inter-insurer agreements with respect to these kinds of insurance products should have no immunity from federal antitrust laws.

The second part of the *Royal Drug-Pireno* test—whether the activity involves an integral part of the insurer-insured relationship—was derived from *Securities and Exchange Commission v. National Securities, Inc.*,[112] where the Court stated that section 2(b) was designed to protect from impairment, invalidation, or preemption by congressional action state laws concerned with the relationship between the insurance company and its policyholders:

> Congress was concerned with the type of state regulation that centers around the contract of insurance . . . . The relationship between insurer and insured, the type of policy which could be issued, its reliability, interpretation, and enforcement—these were the core of the "business of insurance." Undoubtedly, other activities of insurance companies relate so closely to their status as reliable insurers that they too must be placed in the same class. But whatever the exact scope of the statutory term, it is clear where the focus was—it was on the relationship between the insurance company and the policyholder. Statutes

110. *Id.* at 71.

111. *See* JONATHAN R. MACEY & GEOFFREY P. MILLER, COSTLY POLICIES: STATE REGULATION AND ANTITRUST EXEMPTION IN INSURANCE MARKETS 17–18 (1993).

112. 393 U.S. 453 (1969).

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> aimed at protecting or regulating this relationship, directly or indirectly, are laws regulating the "business of insurance."[113]

Royal Drug refined the foregoing analysis somewhat, as it can be argued that "every business decision made by an insurance company has some impact on its reliability, its ratemaking, and its status as a reliable insurer."[114] Thus, if the insurer's activity has only an "indirect" effect on the reliability of the insurer or on the insurer-insured relationship, that minimal effect is not enough to qualify the activity as the "business of insurance."[115]

To satisfy the third part of the test, it is necessary to show that the challenged insurer activity is limited to entities within the insurance industry. The Court in *Royal Drug* looked to the legislative history of the McCarran-Ferguson Act and observed that, "the primary concern of both representatives of the insurance industry and the Congress was that cooperative ratemaking efforts be exempt from the antitrust laws."[116] Given that purpose, the Court reasoned that the exemption did not extend to activities involving parties outside the insurance industry.[117]

Under the tripartite test, it is well settled that rate-making activity constitutes the business of insurance for purposes of the McCarran-Ferguson Act.[118] Scope of coverage, including the content of policy provisions, is very closely connected to rate-making; thus, joint activities with respect to scope of coverage also fit within the business of insurance. As one court explained, "[m]atters of rate, extent of coverage, and policy provisions go to the very heart of the relationship between the insurance company and the policyholder and therefore clearly fall within the *National Securities* definition of the business of insurance."[119]

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113. *Id.* at 460.

114. Grp. Life & Health Ins. Co. v. Royal Drug Co., 440 U.S. 205, 216–17 (1979).

115. *Id.*

116. *Id.* at 221.

117. *Id.* at 231.

118. *Id.* at 224–25 n.32 ("the fixing of rates is the 'business of insurance'"). *See also* Uniforce Temp. Pers., Inc., *supra* note 101, at 1300 ("appellees' rate-making activity clearly constitutes the business of insurance for purposes of the McCarran-Ferguson Act"); KINTNER ET AL., *supra* note 98, § 70.7, at 213 ("It is clear that agreements among insurance companies as to their rates are within the 'business of insurance.'").

119. McIlhenny v. Am. Title Ins. Co., 418 F. Supp. 364, 369 (E.D. Pa. 1976). As another court explained, "[i]t is obvious that an agreement to change the type of policy offered is the business of insurance. The type of coverage offered directly affects the spreading of risk, is at the very heart of the policy relationship, and the agreement is limited to insurance companies." UNR Indus. v. Cont'l Ins. Co., 607 F. Supp. 855, 862 (N.D. Ill. 1984). *See also* Ocean State

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This is consistent with the Supreme Court's analysis in *Hartford Fire Insurance Co. v. California*,[120] where the Court reaffirmed the tripartite test articulated in *Royal Drug* and *Pireno* when evaluating United States insurers' joint actions to standardize policy forms.[121] The Ninth Circuit did not hold, as the Supreme Court observed, that the domestic insurers' conduct with respect to standardization of forms fell outside the business of insurance, and the Supreme Court said nothing to call this conclusion into doubt.[122] It is unlikely that the Court would have let the Ninth Circuit's analysis pass without comment if the Court thought it erroneous. The holding in *Hartford Fire* concerned whether domestic insurers lost their antitrust exemption when they acted in concert with foreign reinsurers (the Supreme Court concluded that they did not),[123] but under the reasoning of *Hartford Fire*, joint insurer standard setting with respect to the terms of coverage and prices is squarely within the "business of insurance."[124] Although joint insurer conduct with respect to underwriting criteria has not been directly challenged or the subject

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Physicians Health Plan, Inc. v. Blue Cross & Blue Shield of R.I., 883 F.2d 1101, 1108 (1st Cir. 1989), *cert. denied*, 494 U.S. 1027 (1990) (the marketing and pricing of insurance policies is the business of insurance).

120. 509 U.S. 764 (1993).

121. *Id.* at 780–81.

122. *Id.* at 782. The Court referenced the joint insurer conduct in footnote ten, where it observed that while it "might be tempting to think that unlawful acts are implicitly excluded from the 'business of insurance,'" such analysis would not conform to the text of § 2(b) of the McCarran-Ferguson Act, which contemplates that illegal acts, *i.e.*, acts that violate the Sherman Act, may still enjoy antitrust immunity. *Id.* at n.10.

123. The Ninth Circuit held that the McCarran-Ferguson exemption was lost because foreign reinsurers, which the circuit court found not subject to state regulation and therefore not exempt under the McCarran Act, had participated in the activities. In re Ins. Antitrust Litig., 938 F.2d 919, 928 (9th Cir. 1991), *aff'd in part and rev'd in part on other grounds sub nom*, Hartford Fire Ins. Co. v. Cal., 509 U.S. 764 (1993). The Supreme Court disagreed, holding that even if the foreign reinsurers were non-exempt (an issue the Court did not decide), their participation with the domestic insurers was still part of the "business of insurance" and did not eliminate the domestic insurers' antitrust immunity. *Hartford Fire*, 509 U.S. at 784.

124. A more recent decision dealing with claims practices also upheld the McCarran-Ferguson immunity. In *United States Dep't of Treasury v. Fabe*, 508 U.S. 491 (1993), the Court held that an Ohio statute granting policyholders' claims priority over claims of the federal government in proceedings to liquidate an insurance company escaped preemption because it regulated the business of insurance. *Id.* at 505. The pattern of the Supreme Court cases is that activities within the traditionally understood business of insurance—ratemaking; standardization of forms; claims processing; etc.—enjoy the protection of the McCarran-Ferguson Act.

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of a judicial decision,[125] the logic of the foregoing cases would surely consider such agreements to fall within the ambit of the "business of insurance." If this is correct, it follows that an agreement by life insurers not to use genetic information as an underwriting factor would rest at the core of the "business of insurance." If, however, the insurance product in question did not involve the transfer of risk (as in the case, for example, of an investment instrument), the agreement on underwriting criteria would fall outside the "business of insurance."

3. "Regulated by State Law"

When the statute sought to be applied to an insurer's activity is a federal antitrust law, the analysis becomes more complicated because of the section 2(b) proviso, which requires that the insurer activity be "regulated by State Law" to prevent the application of federal law. The difficulty with this language is its ambiguity with respect to *what kind* of regulation is needed and the extent to which the regulation must be *effective* to avoid the regulation of federal antitrust law. In applying this language, courts have been disposed to treat statutes of general applicability, such as corporation codes,[126] general

125. In *Owens v. Aetna Life & Cas. Co.*, 654 F.2d 218 (3d Cir. 1981), *cert. denied*, 454 U.S. 1092 (1981), an insurance broker brought an action in which he alleged that multiple insurers and some individuals conspired to give a particular insurer a monopoly in the medical malpractice field, engaged in an unlawful boycott, and conspired to drive the plaintiff out of business. *Id.* at 220–21. In the course of explaining the "business of insurance" exemption, the court stated that "it is clear that at least the following activities are the business of insurance, either because they pertain to risk-spreading or to the contract between the insurer and insured," and one of the four activities listed was "deciding upon rating classification differences between individual policies and group marketing plans, either individually or jointly through a rating bureau . . . ." *Id.* at 225–26. Joint determination of the factors to be used for pricing individual policies differently from group policies is functionally the equivalent of joint determination of underwriting criteria. The quoted passage from *Owens* is dicta because that practice was not at issue in the case, but the analysis is consistent with the results in other cases. As one prominent treatise states with citation to supporting authority, "[a] number of other essentially horizontal arrangements among insurance companies, which affect the scope or amount of coverage afforded to an insured, or which indirectly affect the premium paid by the insured, have also been held within the 'business of insurance.'" KINTNER ET AL., *supra* note 98, § 70.7, at 213.

126. Manasen v. Cal. Dental Serv., 424 F. Supp. 657 (N.D. Cal. 1976), *rev'd on other grounds*, 638 F.2d 1152 (9th Cir. 1979) (in suit by dentists against corporation providing prepaid dental plans, state antitrust law, corporation code and business and professions code are sufficient to constitute state regulation of business of insurance).

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business and professional codes,[127] and state antitrust laws,[128] as the kinds of laws that regulate the business of insurance. It is assumed that state legislatures made a judgment when the general statutes were enacted about the extent to which insurers should be regulated. When general statutes are deemed sufficient to meet the state regulation requirement, challenged insurer activity becomes immune from federal regulation without the state taking definite steps targeted at the insurer-insured relationship. As for the effectiveness of state regulation, for the most part, courts have not been particularly concerned about how much regulation occurs when seeking to justify recognition of the antitrust exemption. As one treatise states, "[t]he courts have generally been satisfied with the existence of a state regulatory scheme and rather superficial indicators of supervision, without much regard for the actual intensity of state regulation."[129] This result strikes some observers as being rather odd, as "it is likely that Congress intended the antitrust exemption to be available only when effective state regulation, rather than a mere pretense of regulation, exists."[130] The generally lax approach of the courts with respect to the McCarran-Ferguson exemption is more lenient

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127. *See, e.g.*, Ocean State Physicians Health Plan, Inc., *supra* note 119, at 1108–09 (marketing and pricing of health insurance was regulated by state law where state department of business regulation approved the activities); Manasen, *supra* note 126, at 657 (in suit by dentists against corporation providing prepaid dental plans, state antitrust law, corporation code, and business and professions code are sufficient to constitute state regulation of business of insurance).

128. *See, e.g.*, Klamath-Lake Pharm. Ass'n v. Klamath Med. Serv. Bureau, 701 F.2d 1276, 1287 (9th Cir.) (state antitrust laws meet state regulation requirement), *cert. denied*, 464 U.S. 822 (1983); State v. Blue Cross & Blue Shield Ass'n, 620 F.Supp. 907, 920–21 (D. Md. 1985) (Maryland's antitrust laws are sufficient to met the state regulation requirement).

129. 1 PHILLIP E. AREEDA & HERBERT HOVENKAMP, ANTITRUST LAW ¶ 219c, at 342 (Rev. 2d ed. 2000). *See generally* ANTITRUST LAW DEVELOPMENTS, *supra* note 43, at 1373. *See also* 1 PHILLIP E. AREEDA & HERBERT HOVENKAMP, ANTITRUST LAW ¶ 219c, at 341–42 (Rev. 2d ed. 2000) ("Except in a few non-antitrust decisions, the courts have not scrutinized the nature and intensity of state regulation very closely."). *See, e.g.*, Uniforce Temp. Pers., Inc. v. Nat'l Council on Comp. Ins., 892 F. Supp. 1503 (S.D. Fla. 1995) (state regulation prong of test for business of insurance met if state regulatory agency has jurisdiction generally over the challenged practices and maintains authority to approve or prohibit them), *aff'd*, 87 F.3d 1296 (11th Cir. 1996). *But see* McIlhenny, *supra* note 119, at 370–71 ("The McCarran-Ferguson Act does not require an examination into the regulatory status of every detail of the business of insurance; it is sufficient that the state regulatory scheme is comprehensive and meaningfully administered.").

130. JERRY, *supra* note 13, § 21[d][4], at 91–93.

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than the "active supervision" requirement needed for an exemption under the *Parker* doctrine, discussed below.[131]

The leading Supreme Court decision on this issue is *Federal Trade Commission v. National Casualty Co.*,[132] a 1958 decision in which the Court rejected the FTC's argument that the states' uniform unfair insurance practices statutes were insufficient to support application of the McCarran-Ferguson Act exemption.[133] The FTC argued that the state statutes had not been effectively elaborated or applied, but the Court essentially took the position that once a statute purporting to regulate insurance practices has been enacted, the effectiveness of state regulation is irrelevant.[134] The Court did note that the FTC had not argued that the state unfair practices acts "were mere pretense,"[135] thereby leaving open the possibility that a sham regulatory scheme would not be sufficient to create antitrust immunity. Exactly where this leaves the issue is uncertain.

National Casualty also left open the question of whether state regulation could be ineffective because of constitutional constraints on the extraterritorial effect of state regulation. This issue was addressed in *Federal Trade Commission v. Travelers Health Ass'n*,[136] which involved the FTC's effort to prohibit an insurer's nationwide distribution of allegedly deceptive circulars.[137] The Eighth Circuit upheld the insurer's state action exemption claim on the basis of a Nebraska statute regulating deceptive insurance practices.[138] The Supreme Court held that "the state regulation which Congress provided should operate to displace [federal antitrust law] means regulation by the State in which the [insurer activity] is practiced and has its impact."[139] This means that regulation by a particular state "cannot provide an exemption for insurer activity occurring beyond its borders."[140]

Is concerted insurer activity with respect to the use of underwriting criteria, and with respect to criteria on the use of genetic information in

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131. *See infra* text accompanying note 159.
132. 357 U.S. 560 (1958) (per curiam).
133. *Id.* at 560-65.
134. *Id.* at 564–65.
135. *Id.* at 564.
136. 362 U.S. 293 (1960).
137. *Id.* at 298-99.
138. *See* Travelers Health Ass'n v. Fed. Trade Comm'n, 262 F.2d 241, 244 (8th Cir. 1959), *vacated and remanded*, 362 U.S. 293 (1960).
139. Fed. Trade Comm'n v. Travelers Health Ass'n, 362 U.S. 293, 298–99 (1960).
140. Anderson, *supra* note 98, at 103.

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particular, "regulated by state law"? No state statute gives explicit approval to such restrictions. At least forty-five states regulate some aspect of genetic testing in health insurance, and many of these statutes restrict insurers' underwriting practices. A few states extend these prohibitions to life insurance underwriting.[141] The fact that legislatures in many states opted not to regulate underwriting in life insurance at the same time they enacted such regulations in health insurance suggests that the states made a judgment about the extent to which regulation of underwriting with respect to genetic information should occur.

In addition, the unfair trade practices statutes of most states contain unfair discrimination prohibitions that specifically reference sex, marital status, race, religion, and national origin.[142] The omission of genetic characteristics (other than sex and race) from this list could be viewed as a deliberate legislative assumption that insurers should not be subject to regulation with respect to their use of information relevant to such characteristics. The unfair trade practices statutes have generally not been held to prohibit underwriting criteria that are "actuarially fair,"[143] and sex and marital status often figure

141. *See* NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS, *supra* note 1.

142. *See Model Unfair Trade Practices Act, in* 5 NAT'L ASSOC. OF INS. COMM'RS, MODEL LAWS, REGULATIONS, AND GUIDELINES, § 4(G)(5), at 880–84 (2001) (prohibiting "[r]efusing to insure, refusing to continue to insure, or limiting the amount of coverage available to an individual because of the sex, marital status, race, religion or national origin of the individual"). Note that by its literal terms, the model act does not reach the level of premium charged for particular classifications. Generally speaking, distinctions based on sex (and presumably other listed factors) are not deemed "unfair" if they are based on "actuarially sound" classifications. *See, e.g.*, State Dept. of Ins. v. Ins. Serv. Office, 434 So.2d 908, 912–13 (Fla.App. 1983) (Unfair Trade Practices law only prohibits unfair discrimination, not actuarially sound discrimination); Ins. Serv. Office v. Comm'r of Ins., 381 So.2d 515, 517 (La.App. 1979) (statute requires that classifications be reasonable and not unfairly discriminatory). *See also* Nat'l Org. for Women v. Metro. Life Ins. Co., 516 N.Y.S.2d 934, 936 (1987) (Human Rights Law does not prohibit gender classifications with regard to the terms and conditions of life and disability insurance policies in insurance).

143. *See* Roberta B. Meyer, *Justification for Permitting Life Insurers to Continue to Underwrite on the Basis of Genetic Information and Genetic Test Results*, 27 SUFFOLK U. L. REV. 1271, 1286 (1993) ("courts have interpreted their own state unfair discrimination statutes as permitting insurers to distinguish among applicants in underwriting on the basis of any characteristic that places the insured at a greater hazard for illness or a lower life expectancy, provided insurers do so fairly"); Joseph M. Miller, Comment, *Genetic Testing and Insurance Classification: National Action Can Prevent Discrimination Based on the "Luck of the Genetic Draw,"* 93 DICK. L. REV. 729, 749 (1989) (courts have interpreted state unfair discrimination statutes as permitting insurance companies to "use any trait to differentiate among insureds as long as there is a reasonable basis for concluding that the trait places the insured at a greater

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prominently in underwriting in some lines of insurance in many states. Although one might argue that this demonstrates that the use of genetic information in underwriting is *not* regulated by state law, courts' disposition to treat statutes of general applicability as the kinds of laws that regulate the business of insurance strongly suggests that the unfair trade practices statutes are specific enough to satisfy the "regulated by State law" requirement, thereby supporting the proposition that insurer underwriting practices with respect to genetic information do enjoy an antitrust exemption.

The territoriality question could serve in some situations to limit the scope of the exemption. Assuming an insurer activity which operates and has its impact nationally, under the authority of *Travelers Health*, discussed above, effective regulation of the activity in state A does not provide an exemption for the activity's operation and impact in state B; only if state B also regulates the activity does it enjoy the benefit of an exemption in state B.[144] All states have unfair trade practice regulation, but not all states have genetic information underwriting regulation. To the extent the exemption's existence depends on genetic information regulation, it is possible that a national business practice could enjoy the exemption in some states but not in others.

In short, what constitutes being "regulated by state law" for purposes of the McCarran-Ferguson Act exemption from federal antitrust law is indefinite. Because general state statutes have been deemed sufficient to create an antitrust exemption in other contexts, the best prediction is that courts would hold that the subject of underwriting with respect to genetic information is subject to state regulation and therefore enjoys an exemption from antitrust scrutiny. As one court stated, "[i]t is not necessary to point to a state statute which gives express approval to a particular practice; rather, it is sufficient that a state regulatory scheme possess jurisdiction over the challenged practice."[145] If, however, a court opted to require more specific evidence of state regulation, it is possible that the exemption would be nonexistent in some jurisdictions.

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hazard for illness or a lower life expectancy"); Leah Wortham, *The Economics of Insurance Classification: The Sound of One Invisible Hand Clapping*, 47 OHIO ST. L. J. 835, 851 (1986) ("Such unfair discrimination statutes have been construed only to require that there be a statistical difference in the average loss between groups for any classification used.").

144. *See* KINTNER ET AL., *supra* note 98, at § 70.12, at 235–37.

145. Feinstein v. Nettleship Co. of L.A., 714 F.2d 928, 933 (9th Cir. 1983).

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4. The "Boycott" Exception to the Exemption

If one seeks to subject an insurer's activity to Sherman Act scrutiny, the Sherman Act will apply—even if the insurer's activity constitutes the "business of insurance" and even if state law regulates it—if the activity involves a boycott, coercion, or intimidation. The McCarran-Ferguson Act provides that nothing in the Act "shall render the . . . Sherman Act inapplicable to any agreement to boycott, coerce, or intimidate, or any act of boycott, coercion, or intimidation."[146]

The Supreme Court has spoken to the content of section 3(b) on two occasions. In 1978, the Court decided *St. Paul Fire & Marine Insurance Co. v. Barry*,[147] which addressed a conflict in the circuits as to whether section 3(b) was limited to boycotts or concerted activity directed against competing insurers or agents, or whether the boycott or concerted activity could apply to conduct directed against policyholders as well. In *Barry*, physicians sued four malpractice insurers, three of which allegedly agreed not to offer insurance on any terms to customers or former customers of the fourth insurer.[148] The Court rejected defendants' argument that the exemption only extends to activities intended to coerce competitors rather than policyholders and held that the boycott exception extends to insurer activities affecting parties outside the industry.[149] That holding broadened the exception to the exemption, which had the effect of narrowing the antitrust exemption. The case also did not resolve the meaning of "boycott," but the Court did reject the suggestion that price fixing standing alone constitutes either a "boycott" or "coercion" within the meaning of section 3(b).[150]

In 1993, the Court again examined the meaning of "boycott" in section 3(b) in *Hartford Fire Insurance Co. v. California*,[151] a case in which nineteen states and numerous private parties brought antitrust suits against domestic insurers, domestic and foreign reinsurers, and insurance brokers on account of

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146. 15 U.S.C. § 1013(b) (2000).

147. 438 U.S. 531 (1978).

148. *Id.* at 531.

149. *Id.* at 550, 552. The decision in *Barry* did not consider the meaning of "coercion" and "intimidation," the two other key terms in section 3(b). *Id.* at 541 n.10.

150. *Id.* at 544. *See also* Slagle v. ITT Hartford, 102 F.3d 494 (11th Cir. 1996) (alleged concerted refusal of insurers to issue windstorm insurance on the open market in certain Florida coastal areas and to refer such business to a joint underwriting association whose premiums the insurers set constituted the business of insurance to which the McCarran-Ferguson antitrust immunity extended).

151. 509 U.S. 764 (1993).

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their alleged agreement to boycott general liability insurers that used non-conforming policy forms.[152] The insurers urged the McCarran-Ferguson Act exemption, and the question was whether the agreements among primary insurers and reinsurers on standardized policy forms and terms of coverage constituted agreements to boycott.[153] The Ninth Circuit applied a broad definition of boycott, defining it as any "use of economic power of a third party to force the boycott victim to agree to the boycott beneficiary's terms."[154] A majority of the Court rejected this standard, concluding instead that a boycott exists only when the refusal to deal goes beyond the targeted transaction.[155] For example, a labor strike where the union refuses to work unless the employer agrees to employment terms is not a boycott, but would become a boycott if the union members agreed not to purchase the employer's product until agreement is reached on employment terms.[156] Thus, a collective refusal by the defendant insurers to reinsure risks on the disfavored policy forms until desired changes were made was not a boycott.[157] Stated more generally, it is not a boycott for insurers to refuse to engage in a particular transaction until the coverage or other terms of that transaction are agreeable.[158]

In light of the Supreme Court's narrow construction of the term "boycott" in *Hartford Fire*, it is clear that if insurers agree to use particular underwriting criteria and do not use this agreement to try to extract favorable terms from third parties on collateral transactions, a section 3(b) boycott is not involved and the exception to the antitrust exemption is not triggered. Under this logic,

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152. *Id.* at 770–71.

153. *Id.* at 779 n. 8.

154. In re Ins. Antitrust Litig., 938 F.2d 919, 930 (9th Cir. 1991), *aff'd in part and rev'd in part on other grounds sub nom*, Hartford Fire Ins. Co. v. Cal., 509 U.S. 764 (1993).

155. *Hartford Ins. Co.*, 509 U.S. at 802–03. The Court unanimously agreed that "only those refusals to deal involving the coordinated action of multiple actors constitute section 3(b) boycotts," *Id.* at 785, and that a section 3(b) boycott need not involve an "absolute refusal to deal," but could instead be conditional. *Id.* at 785–86.

156. *Id.* at 805.

157. *Id.* at 806.

158. *See id.* at 806 ("it is obviously not a 'boycott' for the reinsurers to 'refus[e] to reinsure coverages written on the ISO CGL forms until the desired changes were made,' . . . because the terms of the primary coverages are central elements of the reinsurance contract—they are *what* is reinsured."(emphasis in original)). *See also* Uniforce Temp. Pers., Inc., *supra* note 101, at 1300 (conduct does not constitute a boycott unless there is a "refusal to deal" in order to coerce a desired transaction); N.J. Auto. Ins. Plan v. Sciarra, 103 F. Supp. 2d 388, 407 (D.N.J. 1998) ("refusal to deal except on certain terms" does not constitute a boycott).

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if the insurers are entering into this agreement without any effort to extract concessions on other collateral matters, it is difficult to imagine how such conduct would fall within the ambit of "coercion" or "intimidation," two other terms in section 3(b) which to date have received no definitive interpretation in judicial decisions. Thus, it seems likely that a multi-insurer agreement not to use particular information in underwriting would not involve a Section 3(b) boycott, thereby triggering the exception to the antitrust exemption.

5. Summary

If life insurers were to agree to place a moratorium on the use of genetic information in underwriting, such an agreement would almost certainly be considered the "business of insurance" unless the policies in question did not involve risk spreading (*i.e.*, were investment vehicles), in which case the agreement would be outside the "business of insurance." It is probable that the activity would be considered a part of business "regulated by State law" and it is very probable that the activity would not fall within the boycott exception to the exemption. Thus, a multi-insurer agreement not to use such information in underwriting would probably enjoy an exemption from federal antitrust laws under the McCarran-Ferguson Act, except with respect to insurance products that fall within the category of investment vehicles and thus fall outside the "business of insurance."

D. The State Action Exemption (the "Parker Doctrine")

Under the state action doctrine, restraints of trade that are the product of state regulatory policy are exempt from the antitrust laws. Sometimes called the "*Parker* doctrine" after the United States Supreme Court decision that is its cornerstone,[159] antitrust immunity is given to private parties as long as their conduct is authorized and regulated by the state. It is not enough for the state

159. In *Parker v. Brown*, 317 U.S. 341 (1943), the Court upheld a California program regulating production and marketing of raisins by the state's growers. The program was created by statute and was implemented by an advisory commission on which the state director of agriculture participated. The statute authorized programs that restricted competition among growers and maintained prices in the distribution of agricultural commodities to packers. The Court explained that this program was an "act of government which the Sherman Act did not undertake to prohibit." *Id.* at 352. *Parker's* roots lie in older cases sustaining state ownership and operation of business, state control of entry requirements through licensing, and state regulation of markets against Sherman Act attack. Milton Handler, *The Current Attack on the* Parker v. Brown *State Action Doctrine*, in 1 ANTITRUST IN TRANSITION 201, 208–09 (M. Handler, ed. 1991). For further discussion of *Parker*, see 1 PHILLIP E. AREEDA & HERBERT HOVENKAMP, ANTITRUST LAW ¶ 221b, at 359–62 (Rev. 2d ed. 2000).

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to immunize private conduct that would otherwise be unlawful, as would be the case if the state simply authorized private actors to fix prices; rather, the state must be involved so that the competitive restraints constitute "state action or official action directed by a state."[160]

The test for determining the availability of the exemption has two elements: "First, the challenged restraint must be 'one clearly articulated and affirmatively expressed as state policy'; second, the policy must be 'actively supervised' by the State itself."[161] The "clear articulation" prong is met if the state clearly intends through the enactment of a regulatory scheme to displace competition in a particular market.[162] "Specific detailed legislative authorization" of the restraint of trade is not required,[163] and it is only necessary that the statute permit, as opposed to require, the anticompetitive conduct.[164] The "active supervision" prong is met if state regulators have the statutory authority to review the challenged anticompetitive conduct and actually exercise that authority.[165] Exactly how vigorous state review must be to create the state action immunity is uncertain. In *Federal Trade Commission v. Ticor Title Co.*,[166] the Supreme Court found the active supervision test was not met where statutory review authority over rate filings existed, and the insurance department was "staffed and funded" and showed "some basic level of activity" in enforcing the rating law.[167] This fell short of demonstrating that "the State has exercised sufficient independent judgment and control so that the details of the [conduct] have been established as a product of deliberate state intervention."[168] Thus, more aggressive state regulation is needed to create *Parker* immunity than is needed for McCarran-Ferguson Act immunity, but existing case law does not quantify this difference.[169] The difference

160. *Parker*, 317 U.S. at 351. For more discussion, see 1 PHILLIP E. AREEDA & HERBERT HOVENKAMP, ANTITRUST LAW ¶ 222a, at 387–88 (Rev. 2d ed. 2000).

161. Cal. Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc., 445 U.S. 97, 105 (1980) (citations omitted).

162. S. Motor Carriers Rate Conference v. United States, 471 U.S. 48, 60–61, 64 (1985).

163. Lafayette v. La. Power & Light Co., 435 U.S. 389, 415 (1978).

164. *See* Columbia v. Omni Outdoor Adver., Inc., 499 U.S. 365, 372–73 (1991).

165. Fed. Trade Comm'n v. Ticor Title Ins. Co., 504 U.S. 621, 634 (1992); Patrick v. Burget, 486 U.S. 94, 101 (1988).

166. 504 U.S. 621 (1992).

167. *Id.* at 637–39.

168. *Id.* at 634 (alteration in original).

169. For more discussion, see Phil Goodin, Note, *Keeping the Foxes From Guarding the Henhouse: The Effect of* Humana v. Forsyth *on McCarran-Ferguson's Antitrust Exemption for the Business of Insurance*, 86 IOWA L. REV. 979, 984–85 (2001).

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between the two regimes is largely academic, as it is difficult to imagine a situation where the *Parker* doctrine would confer immunity in circumstances where the insurer activity is insufficiently regulated by state law to obtain the McCarran-Ferguson immunity.[170]

Nevertheless, in those few states that presently limit life insurers' use of genetic information in underwriting,[171] an agreement among insurers not to use such information would be immune from antitrust liability under the *Parker* doctrine. Whatever anticompetitive impact would arise from such a restraint would be absolutely irrelevant under antitrust law by virtue of the state action doctrine. Likewise, if similar statutes were to be adopted in other states, insurers in those states would be absolutely immune from antitrust liability. As noted above, many more states have statutes that prohibit the use of genetic information in the underwriting of health insurance policies.[172] These statutes should not be viewed as constituting state action that immunizes collaborative conduct by life insurers with respect to genetic information. The enactment of a health insurance regulation does not carry a clearly stated legislative purpose to authorize the anticompetitive conduct in life insurance and does not put in place state mechanisms that supervise private conduct in this area.

To summarize, the state action doctrine does not immunize life insurers from antitrust liability for joint agreements to forego using genetic information in underwriting, except in those states where the use of such information is prohibited by state statute. The fact remains, however, that by exercising their prerogative to regulate and supervise insurers' use of genetic information in life insurance, the states could create federal antitrust immunity under the state action doctrine. If a few states enacted such legislation and life insurers, acting independently, conformed their underwriting practices to the requirements of these states, this conduct should not be deemed an unlawful combination triggering antitrust scrutiny.[173]

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170. KINTNER ET AL., *supra* note 98, § 70.13, at 249.

171. *See supra* note 1.

172. With respect to health insurance policies provided by employers as fringe benefits, the requirements of the state statutes are preempted by ERISA. *See generally* 29 U.S.C. §§ 1001-01a (1994). This gap is substantially filled with respect to genetic information, however, by the Health Insurance Portability and Accessibility Act of 1996, which prohibits group health insurers from making underwriting distinctions based on "genetic status." Pub. L. No. 104-191, §702(a)(1)(F), 110 Stat. 1936, 1945 (1996) (codified in scattered sections of 29 and 42 U.S.C.).

173. On the one hand, there is the general principle that a state cannot regulate activity outside its borders. *See* text accompanying AREEDA, *supra* note 160, at 146, from which it

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E. The Noerr-Pennington Doctrine

The *Noerr-Pennington* doctrine, which is named for two United States Supreme Court decisions that articulate the doctrine's substantive core,[174] gives antitrust immunity to restraints that derive from legislative, executive, regulatory, or judicial decisions resulting from the joint lobbying or litigation efforts of competitors. The protected conduct is the petitioning of the government to restrict competition in the marketplace.[175] Standard-setting by a private association is not protected by this doctrine; rather, the restraint must flow from government action.[176] Thus, life insurers would be free to collaborate to petition state legislatures to adopt statutes that would eliminate underwriting based on genetic factors. *Noerr-Pennington* would not protect an agreement among life insurers to stop using genetic information in underwriting.

Under existing authority, it is doubtful that joint insurer lobbying of the National Association of Insurance Commissioners (NAIC) would be protected by the *Noerr-Pennington* exemption, even though the NAIC is a voluntary body of government regulators, the efforts of which are often translated

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arguably follows that regulation in one state cannot create immunity in another state that lacks such regulation. But, although few cases have discussed the extraterritorial reach of *Parker* immunity, the logic of the doctrine seems to dictate that the exemption "must be coextensive with the scope of the Sherman Act, and thus [apply] to the interstate effects of a particular form of state action." Caribe Trailer Sys. v. P.R. Mar. Shipping Auth., 475 F. Supp. 711, 723 (D.C. Dist. Ct. 1979). In *Caribe Trailer*, the actions of a Puerto Rican government agency in acquiring and operating steamships were protected by the state action exemption, even though this extended the exemption to state control of shipping lines operating outside the territory of Puerto Rico. The court noted that *Parker v. Brown* itself involved action by the State of California "to raise and stabilize the price of raisins, ninety-five percent of which were sold outside the state." *Id.* (citing *Parker*, 317 U.S. at 345).

174. United Mine Workers of Am. v. Pennington, 381 U.S. 657 (1965); E.R.R. Presidents Conf. v. Noerr Motor Freight, 365 U.S. 127 (1961).

175. *See* 1 PHILLIP E. AREEDA & HERBERT HOVENKAMP, ANTITRUST LAW ¶¶ 201–202d, at 148-64 (Rev. 2d ed. 2000).

176. *See* Premier Elec. Constr. Co. v. Nat'l Elec. Contractors Ass'n, 814 F.2d 358, 376 (7th Cir. 1987):

> If the injury is caused by persuading the government, then the antitrust laws do not apply to the squelching (*Parker v. Brown*) or the persuasion (*Noerr-Pennington*). If the injury flows directly from the "petitioning"—if the injury occurs no matter how the government responds to the request for aid—then we have an antitrust case. When private parties help themselves to a reduction in competition, the antitrust laws apply.

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directly into official state policy throughout the nation.[177] In *Preferred Physicians Mutual Risk Retention Group v. Cuomo*,[178] the court rejected insurers' claim of immunity, reasoning that *Noerr-Pennington* does not apply because the NAIC is not a governmental body: "[the NAIC] is a private trade association composed of government regulators from different states, and *Noerr-Pennington* immunity does not apply to such private associations."[179] Because the *Noerr-Pennington* immunity is grounded in a First Amendment right to petition the government, the fact that the NAIC is not a government entity—even though its membership consists of government officials—means that non-recognition of the immunity for efforts to petition the NAIC is sound doctrinally. As a matter of antitrust policy, however, it is not obvious that the *Noerr-Pennington* issue was decided correctly in *Preferred Physicians*. The leading Supreme Court authority on the question, upon which the court in *Preferred Physicians* relied, involved a very different trade organization and overtly anticompetitive conduct,[180] which would not be the situation with respect to collaborative insurer conduct with respect to underwriting factors. Even so, in the absence of clear case law endorsing multi-insurer collaboration to lobby the NAIC, one should not expect insurers to voluntarily test the limits of the immunity by engaging in such conduct. But *Noerr-Pennington* would apply if insurers collaborated to petition state legislators or insurance commissioners for a statute or rule authorizing industry-wide disregard of particular underwriting factors.

III. THE STATE ANTITRUST LAWS AND ANTICOMPETITIVE INSURER CONDUCT

Generally speaking, state antitrust laws use language that tracks closely the federal statutes, and state courts give federal cases varying degrees of precedential value, but there are notable deviations from both propositions.[181]

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177. *See* NAT'L ASSOC. OF INS. COMM'RS 2001 ANNUAL REPORT, *available at* http://www.naic.org/pressroom/2001_Annual_Report_X.pdf (last visited March 1, 2003), at 3.

178. 865 F. Supp. 1057 (S.D.N.Y. 1994), *vacated on other grounds*, Preferred Physicians Mut. Risk Retention Group v. Pataki, 85 F.3d 913 (2d Cir. 1996).

179. *Id.* at 1072.

180. In *Allied Tube & Conduit Corp. v. Indian Head*, 486 U.S. 492 (1988), petitioner unsuccessfully urged that its efforts to affect a trade association's product standard-setting process were immune from antitrust liability. In that case, however, the petitioner recruited and orchestrated a vote at an annual meeting to approve a trade standard (one widely adopted verbatim in city codes) that would disadvantage the product of its competitors.

181. 14 HERBERT HOVENKAMP, ANTITRUST LAW ¶ 2410, at 302–03 (1999).

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According to one recent compilation, forty-eight of the fifty states have general antitrust statutes, and many states have "little FTC" acts that generally operate in the same way as the federal statute.[182] Twelve states have statutory provisions specifically exempting some insurance-related activities.[183] Several states have statutes that incorporate federal exemptions, most notably the McCarran-Ferguson exemption and the state action doctrine, into state law.[184] But many states have no such exemption and some generally refuse to find any immunity for insurance companies from state antitrust law.[185] Twenty-one states have a generic exemption for regulated industries, including insurers; these exemptions are usually functional equivalents of the state action doctrine.[186] In a number of states without statutory exemptions, courts have applied doctrines of exclusive and primary jurisdiction or the federal "filed rate" doctrine to provide insurers with defenses in state antitrust actions involving insurance rates.[187] It is difficult to generalize about state exemptions, except to say that in many states the exemption is a limited one.[188]

About a decade ago, state antitrust law became more significant for the insurance industry.[189] State enforcement became more aggressive and more coordinated,[190] and some states repealed part or all of the provisions giving state antitrust immunities to the insurance industry.[191] In 1988, California voters approved Proposition 103, which, *inter alia*, repealed the insurance antitrust exemption and substituted two safe harbors limited to the exchange of certain historical data and participation in state approved residual market mechanisms.[192] Thereafter, the legislature restored an exemption for joint

182. INSURANCE ANTITRUST HANDBOOK, *supra* note 5, at 34.

183. *Id.* at 35.

184. *Id.* at 36.

185. Hovenkamp, *supra* note 181, ¶ 2411d, at 309–10.

186. INSURANCE ANTITRUST HANDBOOK, *supra* note 5, at 36.

187. *Id.* at 37–38. In Keogh v. Chic. & Nw. Ry. Co., 260 U.S. 156 (1922), the Court held that a private shipper could not recover treble damages against railways that had set uniform rates filed with, and approved by, the Interstate Commerce Commission.

188. INSURANCE ANTITRUST HANDBOOK, *supra* note 5, at 37–38.

189. *Id.* at 33.

190. *See id.* (citing the multi-state investigation and federal court actions which resulted in the Court's decision in *Hartford Fire Ins. v. Cal.*, 509 U.S. 764 (1993)).

191. *See id.* (citing California, Texas, and New Jersey as prominent examples). *See also* Macey & Miller, *supra* note 111, at 5–6.

192. *See* CAL. INS. CODE § 1861.03(a), (b) (West 1993).

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development of standardized policies.[193] In 1990, New Jersey eliminated its exemption for joint ratemaking in the private passenger automobile insurance market except for the "collection, compilation and dissemination of historical data."[194] In 1991, Texas eliminated its exemption based on the McCarran-Ferguson exemption and substituted an exemption for "actions required or affirmatively approved by any statute of this state . . . or by a regulatory agency of this state."[195] Since this flurry of activity a little over a decade ago, state legislatures appear to have given relatively little attention to insurance antitrust issues.

It is impossible to summarize here the antitrust law of all fifty states, but as a general proposition, insurers cannot be assured without careful study of the law of individual states that they will enjoy the same breadth of immunity from antitrust enforcement in the states as they do at the federal level. As a result, insurers will be reticent to engage in collaborative conduct, particularly if the perceived benefits from the conduct are relatively limited.

IV. THE IMPACT OF UNCERTAINTY

Although insurers are in the business of assuming and distributing risk, they are risk averse, just like the individuals and firms who pay premiums to transfer risk to them. Risk averse actors assign probabilities to the outcomes of conduct, and if the expected benefits of an activity do not exceed the expected losses, the activity will not occur.

As a matter of antitrust law, there is no impediment to individual life insurers unilaterally rejecting of the use of genetic information in underwriting. The Sherman Act and its state counterparts subject collaborative behavior between two or more market participants to antitrust scrutiny, not unilateral conduct. But individual insurers are not likely to renounce the right to use genetic information. As long as genetic information is thought to have the potential to help insurers make more precise risk classifications and more accurately price coverage, no insurer is likely to unilaterally subject itself to the comparative disadvantage that goes with renouncing the use of a viable, or potentially viable, rating tool. If information has predictive power for risk classification, the insurer that ceases to make distinctions based on genetic information will attract higher-risk

193. CAL. INS. CODE § 1855.3–.4 (West 1993). Whether this legislation comports with Proposition 103 is arguable.

194. N.J. STAT.ANN. § 17:33B-31 (West 1994).

195. TEX. BUS. & COM. CODE ANN. § 15.05(g) (Vernon 2002).

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insureds to its pools, and the insurer that uses the information to make distinctions will be able to offer lower-risk insureds a more favorably priced product, which in turn will cause lower-risk insureds to depart the pool of the insurer that declines to make such distinctions. Ultimately, the insurer ceasing to make distinctions will be forced to raise premiums to cover its higher-risk pool, which in turn will drive more insureds out of the pool. Left uncorrected, this adverse selection spiral will result in the collapse of the pool. The only circumstances in which an insurer should seriously contemplate unilaterally surrendering an underwriting tool is if the insurer is convinced that other insurers will follow suit. But in a competitive market, the insurer should anticipate that some other insurers will decline to do so in order to gain the comparative advantages that accompany the use of an underwriting tool with predictive power.

If unilateral surrender is not viable, the question becomes whether concerted action by multiple insurers could achieve the same result. For the same reasons discussed above, it is unlikely that insurers would be able to forge an industry-wide moratorium on the use of genetic information because of the industry's inability to effectively police the moratorium against nonconforming insurers. The possibility of competitive advantage from violating the moratorium means that the moratorium would not be accepted on an industry-wide basis. In these circumstances, some insurers might endorse the moratorium in principle but would be unwilling to subscribe to it knowing that industry-wide adherence is impossible.

Moreover, even if such an agreement could be reached, the collaborative conduct would raise the antitrust issues discussed earlier in this Article. The discussion in the prior two sections of this Article suggests that collaborative insurer standard-setting with respect to use of genetic information in underwriting would probably pass muster under the federal antitrust laws (provided the policies involved are insurance products, as opposed to financial investment devices that do not involve the spreading and distribution of risk). Greater uncertainty exists under state laws, particularly for insurers whose business is multi-state. For insurers, because the costs of being wrong about the lawfulness of such conduct are so significant, the conclusion that joint conduct is *probably* lawful is insufficient to cause insurers to proceed with the activity. A prominent insurance treatise explains the problem in this way:

> The pervasive uncertainty about how antitrust principles will be applied in different insurance contexts chills not only the ardor of the more aggressive competitors but also the willingness of many insurers to participate in collective mechanisms to serve various public policy objectives. The

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> threat of litigation is real. Antitrust law permits, even encourages, such actions by providing for treble damages . . . . The possibility of treble damages, the creativity of plaintiff antitrust lawyers, the potential of large and hugely expensive class action litigation, the civil and criminal penalties available to the government, and the uncertain results when applying antitrust law to insurance all tend to stifle even activity that might ultimately pass antitrust muster.[196]

Only if collaborative conduct promises benefits more substantial than the risks associated with possible antitrust liability would the rational insurer be interested in joining the agreement. The cost-benefit calculus does not favor concerted action to surrender the use of a viable underwriting tool.

The creation of an explicit statutory immunity for collaborative insurer activity with respect to underwriting factors—or with respect to the use of genetic information in particular—would remove the antitrust uncertainty, but it would not alter the competitive forces that make a multi-insurer agreement unlikely in the first place. As is often the case in insurance underwriting, industry movement to a particular underwriting standard occurs only if the movement is universally adopted, which will not occur absent compulsion by some external authority (such as government regulation). Thus, the most effective way to achieve a moratorium on insurers' use of genetic information in life insurance underwriting is to prohibit the practice outright, as many states have done with health insurance and some have done with life insurance. This, however, turns the discussion full circle to the fundamental question that is the root of this discussion: whether it is feasible and desirable to prohibit life insurers from using genetic information in underwriting and, if so, whether such prohibitions are politically achievable in the legislative arena. It is because this question is so difficult to answer in the affirmative that it becomes attractive to ask whether insurers could achieve the proscription by simply agreeing to it among themselves. Unfortunately for those hoping for the simple solution, the complexities and uncertainties of insurance antitrust stand in the way, relegating those who wish a change in the *status quo* to take their case to the political arena.

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196. Jon S. Hanson, *The Regulation of Life Insurance–Part 2*, *in* MCGILL'S LIFE INSURANCE at 673–74 (Edward E. Graves ed., 3d ed. 2000).

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CATASTROPHES, LIABILITY AND INSURANCE

Christian Lahnstein[*]

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INTRODUCTION

An international reinsurer must be credited with a certain degree of experience with catastrophes. But the question is, given the individual character of each loss and the diversity of the scenarios, how far can he meaningfully "process" such experience? This is hardly possible using actuarial methods alone. It calls for methods that are probably more akin to those of an historian than those of an actuary, scientist, economist or legal expert. For this reason, the interdisciplinary approach that seems to be cultivated at United States universities is perhaps the best method of analyzing such risks. The first part of this Article provides an overview of the wide range of catastrophe or large loss scenarios that involve questions of liability. In Part II, one individual catastrophe scenario will be singled out—asbestos-related bodily injuries—in order to show how the same problem is handled differently in each European legal system. Part III concludes with a few thoughts by an outsider on the compensation of asbestos-related diseases in the United States.

I. CATEGORIZING DISASTER SCENARIOS

A. Concept of Large Loss

In the insurance industry, the term "large loss" seems to clearly encompass all major accidents including the most spectacular and exceptional events which occur at a moment's notice, such as exceptional situations like industrial accidents, earthquakes or terrorist attacks. But when it comes to detail, the criteria are open to dispute. An earthquake in the Gobi Desert will not cause any damage, however strong it is: an event, not a loss event. On the other hand, the 1985 eruption of the Nevado del Ruiz volcano in Colombia, though relatively harmless on the basis of the Volcanic Explosivity Index,[1] nearly buried an entire town, killing 23,000.[2] Nevertheless, the private insurance industry was affected much less by this than by the smashed roofs and dented cars caused by the July 1984

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1. Volcano World, *How BIG are Volcanic Eruptions?*, *at* http://volcano.und.nodak.edu/vwdocs/eruption_scale.html (last visited Mar. 1, 2003).

2. Volcano World, *Nevado del Ruiz*, *at* http://volcano.und.nodak.edu/vwdocs/volc_images/img_ruiz.html (last visited Mar. 1, 2003).

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hailstorm in Munich.[3] The United Nations Department of Humanitarian Affairs defines a large loss (i.e. "national disaster") as an event for which the capacity to respond is beyond the ability of the national or regional authorities alone.[4] What if that nation's or region's ability to respond to national disasters is already overburdened by everyday grievances? It must also be assumed that an exceptional situation will generate political pressure.[5]

1. Large Loss and Liability

In large loss scenarios, questions of liability already play a part where natural hazards or political risks are to the fore. Flooding can also be caused as a result of zoning plans being faulty or not properly monitored. The causes of an earthquake cannot be attributed to anyone, but foreseeable or avoidable consequences of construction defects or poor disaster management can. The World Trade Center in New York, extolled as collapse-proof, was found to have construction weaknesses—the light, unprotected suspended construction and the unsafe connections between the floors and the vertical supporting members.[6] "Failings" of this kind had also been discussed following the sinking of "unsinkable" ships—the *Titanic* in 1912[7] and the *Andrea Doria* in 1956.[8]

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3. The losses attributed to the 1984 Munich hailstorm are around $950 million, about half of which was borne by the insurance industry. *See* MUNICH RE GRP., TOPICS 2000: NATURAL CATASTROPHES—THE CURRENT POSITION 27–28, (1999), *available at* www.munichre.com/pdf/topics_sh_2000_e.pdf (last updated Nov. 20, 2000).

4. *See* United Nations, *Humanitarian Action*, *at* http://www.un.org/ha/moreha.htm (last visited Mar. 1, 2003).

5. Christian Lahnstein, *Großschaden und Haftungsrecht: Unternehmenshaftungsrecht im internationalen Überblick am Beispiel Asbest, in* 1 Grossschäden: Rechtliche und alternative Regulierungsstrategien im In- und Ausland = Complex Damages Rostocker Arbeiten zum Internationalen Recht 117 (Harald Koch & Armin Willingmann eds., 1st ed. 1998) (on file with the author); Christian Lahnstein, *Liability and Liability Insurance in Large Loss Scenarios, in* EUROPEAN TORT LAW 2001, TORT & INSURANCE LAW YEARBOOK (Helmut Koziol & Barbara C. Steininger eds., 2002).

6. Oral Buyukozturk & Franz-Josef Ulm, *How Safe are our Skyscrapers?: The World Trade Center Collapse*, *MIT NEWS*, *at* http://web.mit.edu/newsoffice/nr/2001/skyscrapers.html (Sept. 21, 2001) (discussing the structure of the Towers themselves and why they collapsed; and stating that there is indirect evidence that the vertical resistance would have slowed down the process).

7. *Causes and Effects of the Rapid Sinking of the Titanic*, *at* http://tc.engr.wisc.edu/steuber/papers/titanic (last visited Mar. 1, 2003).

8. *See* Max Frankel, *Andrea Doria and Stockholm Collide; 1,134 Passengers Abandon Italian Ship in Fog at Sea; All Saved, Many Injured*, N.Y. TIMES, July 25, 1956, at

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2. Latent Loss and Liability

In what are initially less obvious large loss situations, public pressure builds up in a process we may call "name, blame and claim." Such apportionment of blame may relate not only to exceptional but also to everyday situations, to familiar and long-accepted risks associated with production, consumption and transport. This is often what first creates acute public awareness of a large loss, transforming one of the various latent or accepted grievances into a scandal. In the United States it became strikingly clear how industry, labor unions, health authorities and workers' compensation insurers had tried to ignore the problem of asbestos for decades until it was picked up in the 1970s as a result of more strictly defined product liability and solved by the bankruptcy of the manufacturers.[9] Today, even though most asbestos processing has been stopped in the last thirty years, the wave of bankruptcies is still continuing to catch new groups of former manufacturers and their legal successors, though the attribution criteria are becoming increasingly questionable.[10]

3. Large Loss and "Event" Definitions in Insurance and Reinsurance

In insurance and reinsurance, terms like "event" or "loss event," "accumulation loss" and "serial loss" form the subject of abstract, ambiguous contract clauses used to limit, in both contractual relationships, deductibles and retentions on the one hand and sums insured or reinsured on the other. Far-reaching consequences are attached to "soft" preconditions that can be interpreted in different ways.

4. Large Loss as a Construct

The term "large loss" is therefore a construct—not only an object of observation but also a concept of observation, or glasses that are put on to identify a specific need for action. The same facts may be assessed for different purposes on the basis of different criteria by ecologists or medics,

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A1, *available at* http://www.nytimes.com/learning/general/onthisday/big/0725.html (last visited Mar. 1, 2003).

9. *See* PAUL BRODEUR, OUTRAGEOUS MISCONDUCT; THE ASBESTOS INDUSTRY ON TRIAL 288–91 (1985); David Rosenberg, *The Dusting of America: A Story of Asbestos-Carnage, Cover–up, and Litigation,* 99 HARV. L. REV. 1693, 1695–96 (1986).

10. *Cf.* Scott Moser, *Mealey's Seminar Friday 16th November 2001*, MEALEY'S LITIG. REP., Dec. 11, 2001, at 27–34.

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regional or central administrations, experts on social law and liability law, property and liability insurers, primary insurers and reinsurers, and also between liability insurers.

5. Large Loss and Mass Media

The role of the mass media and public perception also often contribute to what is perceived as a large loss. This includes the interest in scandal, in attributing fault to persons, companies and institutions in an often moralizing way, even if a most difficult evaluation of the consequences is involved; fitting things into a certain pattern or putting them under a certain heading so that, when the facts are complex, one particular aspect is emphasized and one of several possible interpretations made; the snowball effect of risk perception when the media reflect each other, when commentaries are themselves commented on, and when statements of opinion are themselves scandalized.[11] In this way, pressure to take political action is exerted before there has been any opportunity to clarify the issue in factual terms. Then again, through this political action it may be possible to isolate the problem and to demonstrate initiative and efficiency in a state of emergency, instead of struggling with fundamental, commonplace, structural problems.

B. Large Loss Scenarios

1. Overview

A structured overview of large loss scenarios should differentiate between accidental causes of loss arising in the short term and those acting over a long period of time, and examine separately the liability scenarios associated with technological, natural and political risks. This results in six observation fields:

a. Accidental Risks

(1) Technological risks, infrastructure (fire, explosion, escape of substances, business interruption), traffic (road, rail, bridges, tunnels, ships, aircraft, space), "crowd management" (hotels, shopping centers, stadiums, events);

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11. *Cf.* NIKLAS LUHMANN, DIE REALITÄT DER MASSENMEDIEN 53–81 (Auflage 1996) (on file with the author). *See also* Sharon Dunwoody & Hans Peter Peters, *The Mass Media and Risk Perception, in* RISK IS A CONSTRUCT: PERCEPTIONS OF RISK PERCEPTION 293–317 (Bayerische Ruck ed., 1993).

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(2) Liabilities in connection with natural hazards (earthquake, flood/landslide, windstorm, fire/lightning) and accidental environmental damage; and
(3) Liabilities in connection with political risks (terrorism, riots, sabotage).

b. Long-term Risks

(4) Technological and consumer risks: waste, emissions, noise; product risks (food, animal feed, chemicals, pharmaceuticals, tobacco), hazardous substances and technologies (asbestos, chlorine and chlorides, genetic engineering); service risks (planning, consulting, healthcare);
(5) Ecological risks: technological risks in connection with natural-climatic, geological, hydrological-conditions; and
(6) Political risks: restitution in relation to historical guilt (colonialism, discrimination).

The transitions are fluid: even accidents, events arising in the short term, can result in long-term damage, almost unlimited in the case of nuclear accidents, for example. A large number of individual accidents—such as leaks in industrial plants—can be seen as the result of one continued risky operation. The causes of an industrial fire may be specific to that industry, but they may also be sabotage or terrorism.

Nevertheless such a differentiation still appears to make sense. On the one hand, ecological and political aspects should each be looked at separately: the technological, ecological and social standards of corporate liability. On the other hand, common elements should be identified in large loss scenarios—although each has a unique individual profile—and adequate claims management methods developed. However, where questions of liability law and insurance cover become too complex for detailed application, it has not yet really been possible—in the reality of extrajudicial ad hoc payments or fund arrangements—to develop satisfactory alternative solutions.[12] Finally, it is in long-term scenarios

12. According to Harald Koch:

> The diversity of complex damages incidents may resist a precise systematic categorization or even normative definition. But it seems fairly obvious that the traditional tort and liability rules are very much based in the individual bi-partisan constellation between tortfeasor and victim and are not very well equipped for multiple and more complex participation on either side—which is characteristic for our case scenarios. Hence the conclusion is near at hand that specific rules of liability are necessary in

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"abundantly clear that neither the judicial system nor the legislature will ever solve the problem of mass tort litigation until we find a way to resolve the futures problem,"[13] the problem of anticipating future claims when responsible parties insist on "global peace."[14]

2. Accidents

a. Industry, Infrastructure, Transport

A typical example of explosion damage in production and storage facilities was the explosion of ammonium nitrate on September 21, 2001 at a plant in Toulouse belonging to the TotalFinaElf Group: over 80,000 claims, 27,000 damaged dwellings, 10,000 claims for bodily injury, including 4,800 industrial accidents and thirty deaths.[15] The total loss, largely insured, has been put at over €2 billion.[16]

The "explosion in production plants" category also includes one of the greatest industrial disasters in human history, namely the escape of methyl

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> complex damages situations. These may pertain to causation, standards of attribution, of responsibility, to the notion of damages and the adjustment of claims.

Harald Koch, *Complex Damages and Their Settlement: Liability Principles, Procedural Economy, or Law's Retreat?*, *in* 6TH INTERNATIONAL LIABILITY FORUM MUNICH 2002, 34 (Munich Re Grp. ed., 2002).

13. Linda S. Mullenix, *Back to the Futures: Privatising Future Claims Resolution*, 148 U. PA. L. REV. 1919, 1919 (2000).

14. *Id.* at 1922.

15. Marlise Simons, *French Search for Cause of Chemical Plant Explosion*, N.Y. TIMES, Sept. 25, 2001, at A3. (stating that the explosion left twenty-nine dead and damaged more than 20,000 homes, apartments and offices). Exactly eighty years earlier, on September 21, 1921, a similar explosion of ammonium nitrate at a plant belonging to BASF in Oppau caused the greatest civil accident in Germany's industrial history: 561 deaths and 1,952 injuries; 800 of the 1,000 buildings of the municipality were destroyed; windows even shattered ninety km away in Frankfurt. *See* http://nzars.org.nz/ld50parl4.html (last visited Mar. 1, 2003) (stating the that explosion was the biggest chemical spill in German history). *See also A Chemical Engineering Timeline*, *at* http://www.che.boun.edu.tr/~che/akman/history/h_time.html (last visited Mar. 1, 2003) (stating that a stockpile of ammonium nitrate exploded, killing 600, injuring 1500, and leaving 7000 people homeless).

16. *The Explosion at Toulouse: Summary of Reports*, *at* http://www.sfc.fr/Guiochon%20VO/descriptionVo.htm (last visited Mar. 1, 2003) (stating that damage costs are estimated to be between $1.5 and $2 billion).

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isocyanate (MIC) from Union Carbide's plant in Bhopal (India).[17] Here, in the early hours of December 3, 1984, a toxic cloud blanketed a city in which most were sleeping and others were still awake in the railway station, teahouses and open-air cinemas, at wedding celebrations and a poetry festival. The case, which was not completely documented, is instructive in all too many respects. To start with, there was an incorrect estimate of the demand from Indian agriculture: an oversized production plant which after a brief period of euphoria was neglected.[18] Unlike with drugs and pesticides, the health risks of an industrial chemical like MIC are not generally investigated as a priority. It was clear, though, that MIC quickly reacts with water, which meant that people's faces and breathing could have been protected with wet cloths.[19] The company did not draw attention to this fact either preventively or when the crisis occurred.[20] Experience gained from treatment was scarcely published.

Some say that the number of victims of the Bhopal disaster has yet to be definitively quantified, with estimates anywhere from 3,000 to 16,000 dead and 200,000 injured.[21] Union Carbide, which came off well with a settlement package of $470 million (of which $200 million was insured),[22] has since been taken over by Dow, and Union Carbide's former Chairman

17. Ryan Jennings, *The Bhopal Disaster: Reporting on the Disaster at the Union Carbide Plant in Bhopal India, 1984*, http://www.uoguelph.ca/~rjenning/disaster.html (last visited Mar. 1, 2003) (calling the disaster the "greatest industrial disaster in history.").

18. United States Chemical Safety & Hazard Investigation Board, *Bhopal Disaster Spurs U.S. Industry, Legislative Action, at* http://www.chemsafety.gov/lib/bhopal01.htm (last visited Mar. 1, 2003) (illustrating the Indian Government's contention that Union Carbide neglected oversight and responsibility insuring that appropriate maintenance had been conducted).

19. Agency for Toxic Substances & Disease Registry, *Medical Management Guidelines (MMGs) for Methyl Isocyanate, at* http://www.atsdr.cdc.gov/MHMI/mmgx14.html (last visited Mar. 1, 2003).

20. *See* Sambhavna Trust Bhopal, *Remember–Bhopal, at* http://lists.essential.org/pipermail/remember-bhopal/2000-July/000130.html (last visited Mar. 1, 2003) (stating that Union Carbide will not disclose the necessary information on its effects, thus implying that the correct medical treatment is not being given because doctors do not know the exact make up of the gas).

21. *See* Gus Constantine, *Narrative of Disaster Explores Bhopal's Pain*, WASH. TIMES, June 22, 2002, at A8; Chris Hedges, *A Key Figure Proves Elusive in a U.S. Suit Over Bhopal*, N.Y. TIMES, Mar. 5, 2000, at A4 (stating that settlement was $470 million). *See also Bhopal Chronology, at* http://www.bhopal.com/chrono.htm (last visited Mar. 1, 2003).

22. Hedges, *supra* note 21. *See also* Douglas McLeod, *Court Sides with Carbide in Guaranty Fund Dispute*, BUS. INS., Feb. 11, 1991, at 2.

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has disappeared.[23] The Indian Government reacted with legislation regarding industrial accidents, information requirements and compulsory liability insurance.[24]

The "utility companies" category includes nuclear power stations. Many lie close to large cities and a few in the surrounding areas of metropolises like Paris, Tokyo, New York or Los Angeles. What becomes particularly clear here is, on the one hand, the limits of disaster plans: evacuation cannot be carried out either as a practice drill or in an emergency. On the other hand, the underinsurance of the obligatory nuclear pools is notorious, their capacity barely exceeding that of the open liability insurance market for other major industrial risks.[25] This is all the more disturbing in view of the fact that September 11th brought to light risks that had evidently been given little previous consideration.

In the "traffic risks" category, by contrast, unlimited cover is usual in some motor liability insurance markets. This practice is under debate given the risk of large losses like the one at Selby in the United Kingdom in February 2001, with liability of around €80 million,[26] the transportation of dangerous goods, fires in tunnels (the cost of the accident in the Mont Blanc Tunnel in 1999 is put at some €100 million)[27] and, possibly, liability risks in connection with terrorism.

b. Natural Hazards

Liability associated with flood damage has always been of great concern to European public entity liability insurers. Generally, the question of public and private liability in the case of natural hazards is increasingly being raised, even in countries with less developed liability

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23. Hedges, *supra* note 21 (stating that the Chairman has apparently gone into hiding to avoid a summons to appear in court); *U.S. Approves Dow Merger*, N.Y. TIMES, Feb. 6, 2001 at C2.

24. Sameera Khan, *Indian Industry Faces Cleanup Pressures*, BUS. INS., Oct. 2, 1995, at G1.

25. *See* Herbert Fromme, *Opinion in Market that State Will Have to Act is Stronger — Munich Re in Favour of German Terror Pool*, INS. DAY, Oct. 18, 2001, at 4. *See also* Rade Thomas Musulin, *Terrorism Cover: An Axis of Uncertainty, Another Perspective*, NAT'L UNDERWRITER PROP. AND CASUALTY, Mar. 4, 2002, at 33.

26. Ben Webster, *Safety Device on Wheels May Have Caused Selby Derailment*, TIMES (LONDON), Aug. 27, 2002, at 2 (stating that the insurance company, Fortis, will set aside fifty million pounds).

27. Marion Schlotmann, *Lack of Tunnel Safety Sparks ADAC Concern*, INS. DAY, May 2, 2000, at 12 (reports that the cost of repairs are estimated to be E123.5m).

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practice, like Turkey or Mexico. In the United States, it has long been a factor in earthquake accumulation scenarios, like those devised for San Francisco or Los Angeles by consulting firms or the Federal Emergency Management Agency (FEMA).[28]

c. Political Risks

In the nineties, attention had already been drawn to a new trend towards large loss scenarios from international terrorism, particularly after the bomb attack aimed at destroying the World Trade Center in 1993.[29] In connection with terrorism, a series of questions relating to liability law arises. What follows from the general and specific principles of liability based on fault and strict liability? And what follows from the rules relating to causality ("cause étrangère") which come into play with fault-based and strict liability alike? In detail, these questions are as follows:

- How far does strict liability go in the case of traffic law (road, rail, air and shipping traffic) and as part of the various types of plant operator's, custodian's, environmental and nuclear liability? Does the risk for which strict liability may attach also include situations involving terrorism?
- How far does liability based on fault go in cases where there is negligent breach of event organizers', building owners' or employers' duties of care in general[30] or in particular in connection with willful

28. *See* H. Marc Tepper, *FEMA's Proposed New Insurance Requirements May Cause Hardship to Small Governments and Non-Profit Organizations, at* http://www.bipc.com/articles-f-m/propinsreq.htm (last visited Mar. 1, 2003) (stating that FEMA wanted to require states to buy insurance for such things as earthquakes if they wanted federal money in the future).

29. *Cf.* BRUCE HOFFMAN, INSIDE TERRORISM 185–213 (1998).

30. Thus, following the collapse of the World Trade Center, responsibilities in connection with the initially suspected massive use of sprayed asbestos were discussed. *See, e.g.*, Karen Matthews, *Some Still Fear Environmental Hazards Near World Trade Site*, ENV. NEWS NETWORK, *at* http://www.enn.com/news/wire-stories/2001/10/10102001/ap_45220.asp (Oct. 10, 2001) (stating that New Yorkers are still worried about asbestos exposure). After it became clear that the use of sprayed asbestos to protect steel girders had stopped from the fortieth floor onwards of the first tower as early as 1971, the discussion shifted more onto the question of whether sprayed asbestos would have protected the steel structures for longer than the replacement product then used, and thus allowed more extensive evacuation. *Id.* (stating that asbestos was used in construction of the World Trade Center up to the fortieth floor, before a ban was placed on its use in 1971). *See also* James N. Rudolph, Editorial, *Protecting Skyscrapers*, N.Y. TIMES, Dec. 28, 2001,

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acts of third parties? It will often be possible to prove such breaches, especially in view of the fact that additional rules of conduct are being developed with respect to terrorism prevention. It seems plausible to limit strict liability to typical operational risks and not to extend it to terrorist acts where political motivation is directed less against the operator than against state or society. Liability based on fault can only be excluded by channeling liability through the state and expressly holding all other parties harmless by law, in the same way that nuclear liability is channeled via the operator.

Hardly any initiatives of this kind are to be seen, with exception of the September 11th Victim Compensation Fund; which means that, overall, liability risks in connection with terrorism remain considerable.[31]

3. Long-term Risks

a. Technology, Product and Service Risks

Because of the risks of change when dealing with the consequences of technology and the side–effects of products, this is probably the most complex category of large loss scenarios. Risks of change arise from new technologies like genetic engineering,[32] from new hazardous substances or, more precisely, from new application of long-used substances: the latex problem of the 1990s as a result of the sudden massive demand for disposable gloves to prevent AIDS,[33] the discovery of dioxin, notorious through the use of herbicides in Vietnam and the Seveso accident in 1976,[34] in many industrial processes, thanks to more accurate detection methods in the 1980s. Extensively used substances become problems because of their persistence (like CHCs and PCBs in the 1980s, and currently MTBE in the United States), typically first of all in specialist circles, then among the general public, which in turn makes new research budgets possible and

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at A18 (wondering whether the continued use of asbestos in the Towers would have allowed more people to escape).

31. The role of tort law in connection with terrorism is the subject of a research project of the European Centre of Tort and Insurance Law, which is scheduled for publication in 2003.

32. *Cf.* MUNICH RE, 5TH INTERNATIONAL LIABILITY FORUM (2001).

33. David S. Shrager and Wayne R. Spivey, *Latex Allergy*, 2 ASSOC. OF TRIAL LAWYERS OF AMERICA, ANNUAL CONVENTION REFERENCE MATERIALS (2000).

34. Nigel Hawkes & Barry Keevins, *Dangers From Feared Dioxins Still Unclear*, TIMES (LONDON), Apr. 23, 2001, at 10.

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results in pressure to take political action.[35] A similar situation exists with respect to pharmaceuticals, when in the sea of side effects and interactions certain relationships are spotlighted and attributed to certain manufacturers. One typical example of this is the case of the cholesterol-lowering drug Lipobay, with insured liabilities running into billions.[36] Historical but by no means closed cases involve the damaging effect of pesticides on agricultural workers and the environment.[37] The biggest liability loss ever—personal injury claims due to asbestos—also falls into this category. On the other hand, the comparably expensive cost of removing asbestos from buildings worldwide has so far had only a marginal effect on the insurance industry, whereas the cost of remedial work on middle and lower-class dwellings in the United States in connection with lead paints and now the problem of toxic mold has placed a considerable burden on United States homeowners and liability insurers. These examples only hint at the great number of relevant scenarios.

b. Liability in Connection With Climatic, Geological and Hydrological Processes

Despite the connection with (1) above, it is advisable to take a separate look at long-term large loss scenarios arising from continuous emissions, waste or infrastructure projects in connection with climatic, geological and hydrological processes. Often it is a matter of historical liabilities like those found at production facilities in the oil or mining industries. Frequently the liabilities are latent or difficult to identify because of diffuse causal relationships. In the late 1950s, claims for compensation for asthma brought against oil companies in Yokkaichi, Japan were recognized on the basis of epidemiological proof of causality, one of the various Japanese environmental liability lawsuits of the time.[38] Comparable "stormy" phases—where the attempt is made to enforce state safety standards through spectacular liability lawsuits—can be seen today, and not only in

35. *Cf. supra* Part I.A.5.

36. *Bayer Doubles Drug-Linked Deaths*, WASH. TIMES, Jan. 19, 2002, at C9.

37. *Cf.* Schinzler, *Zur Haftpflichtversicherung in einer vernetzten Weltwirtschaft* (Liability insurance in a worldwide business environment), *in* 1ST INTERNATIONAL LIABILITY FORUM 24 (Munich Re ed., 1997) (on file with the author).

38. *Cf.* Yutaka Sawai, *Soziale Probleme und Justiz in Japan—Die Wechselwirkungen von Gerichtsentscheidungen und gesellschaftlichem Bewusstsein* (Social problems and justice in Japan—The interaction of court decisions and social awareness), 190 ARCHIV FÜR DIE CIVILISTISCHE PRAXIS 586–608 (1990) (on file with the author).

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new Asian industrialized countries, where the largest disaster potentials are to be found due to risk exposure and concentrations of value. Thus the City of Bogotá is currently being sued, together with utility companies and seventy-six industrial companies, by 3,600 families for damage amounting to $1.5 billion caused by river pollution.[39] The wide variation in environmental standards in different countries is becoming apparent. Greenpeace recently presented in Johannesburg documentation on forty-six industrial disasters and called for uniform standards, not just in the area of prevention, a familiar topic that is often the subject of voluntary commitments made by leading industrial corporations, but also for uniform standards in the area of compensation.[40] It is clear, at any rate, that products and technologies are increasingly producing complex run-off periods under liability law around the world. Actions are filed primarily under domestic law. At the same time, however, there is an increasing number of international liability suits. In the United States, most of the actions pending and based on foreign disasters, are against chemical and petrochemical companies for health and environmental losses in relation to petroleum production and pesticides. The claimants come from a wide cross-section of social and cultural backgrounds: employers, employees, casual workers, and indigenous communities. "Protection of the environment and protection of minorities are political issues which give added impetus to such international liability suits."[41] There are overlaps with (3) below.

c. Liability in Connection With Historical Injustice

A new type of liability should not be ignored: the trend to rework historical injustice from earlier or more recent times with respect to liability law: the "sudden appearance of restitution cases all over the world,"[42]

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39. This is the most spectacular application to date of the "acción popular," an equivalent to the class action in U.S.-law, introduced into Colombian civil law following the new Colombian Constitution of 1991. For an overview of the extensive jurisprudence, see JAVIER TAMAYA JARAMILLO, LAS ACCIONES POPULARES Y DE GRUPO EN LA RESPONSABILIDAD CIVIL (Bogotá 2001) (on file with the author).

40. Environmental crimes by multinational companies. *See Multinational Corporations: Small World/Big Companies*, *at* http://www.globallinksconsulting.com/Global%20Inc/pgs/impacts/impg9.html (last visited Mar. 1, 2003).

41. Schinzler, *supra* note 37.

42. ELAZAR BARKAN, THE GUILT OF NATIONS: RESTITUTION AND NEGOTIATION OF HISTORICAL INJUSTICES IX (2000).

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consequences of war and colonialism, slavery and discrimination. History becomes a field for political struggle; immunities under public international law which protect not only states but also individuals and enterprises are increasingly being breached by criminal and civil liabilities. An interesting example here are the negotiations to compensate an estimated one million "agent orange" victims in Vietnam. In Germany, the forced-labor lawsuits against German industry raised debates about the different roles of social law and liability law.[43] Criticism has been directed at the foundation system solution[44] for failing to clarify the aspect of legal responsibility, i.e. the opportunity has not been seized to work out principles for the twenty-first century that make companies responsible vis-à-vis individual injured parties for exploiting state-enabled injustice. Reference is made to the approaches to civil-law liability in the case of human rights violations under United States law in the1980s and 1990s.[45]

II. ONE DISASTER, DIVERSE APPROACHES: ASBESTOS IN EUROPE

On the one hand there is a whole range of catastrophe scenarios. On the other hand, the same scenario may affect many countries, but in different ways. Toxic torts are a good example. State and private prevention standards vary from country to country and also change over the course of time. The same applies to the social and political perception of risks, to the significance attached to them in the public debate. State and private compensation systems function differently. Thus, the gradually emerging

43. Christian Wolf, *Großschadensregulierung zwischen präventivem Rechtsgüterschutz und sozialrechtlichem Lösungsansatz, dargestellt am Beispiel der Zwangsarbeiterentschädigung, in* Modernes Schadensmanagement bei Grossschäden 125–48 (Harald Koch & Armin Willingmann eds., 1st ed. 2002) (on file with the author). The contribution describes an exemplary liability case from the 1950s that is little known and barely discussed in the literature. *See Wollheim v. I.G. Farben in Liquidation*, Frankfurt District Court, Jun. 10, 1953, court file no. 2/3/0406/51 as an example as it anticipates the current debate.

44. *See* German Economy Foundation Initiative Steering Grp., *Remembrance, Responsibility and the Future, available at* http://www.stiftungsinitiative.de/ (last visited Mar. 1, 2003).

45. This information is based on *Filártiga v. Peña-Irala*, 630 F.2d 876 (2nd Cir. 1980). *See also* BETH STEPHENS & MICHAEL RATNER, INTERNATIONAL HUMAN RIGHTS LITIGATION IN US COURTS (1996); John Terry, *Taking* Filártiga *on the Road: Why Courts Outside the United States Should Accept Jurisdiction Over Actions Involving Torture Committed Abroad, in* TORTURE AS TORT: COMPARATIVE PERSPECTIVES ON THE DEVELOPMENT OF TRANSNATIONAL HUMAN RIGHTS LITIGATION 109, 115 (Craig Scott ed., 2001).

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consequences of asbestos produce a puzzle made up of different liability situations in each European country: social security solutions differ, tort law differs, and the interplay of social law and tort law differs.

A. Social security

Asbestos-related diseases impact social security in all European countries.

1. General Social Security Schemes

Asbestos affects particularly the general health and pension insurance systems, which as in the Netherlands (since 1967) make no distinction between occupational and non-occupational accidents and diseases.[46] This was based on the conviction, held during the period of extensive expansion of the welfare state system in the sixties and seventies, that the victim of an accident or disease has the same need regardless of whether the accident or disease is work-related or not: same injury, same need, same benefits.[47]

2. Workers' Compensation

However, in most countries there are special workers' compensation insurance covers, with their own individual compensation schemes and recognition practices and with their own concepts of preventive functions. The advantage of such specific systems is that occupational risks are perceived more acutely. Side effects are the inevitably controversial matter of distinguishing between occupational and non-occupational accidents and diseases, and also the lack of coordination sometimes observed between prevention that focuses on the workplace and environmental protection or product safety.

The performance of German workers' compensation insurance[48] in asbestos cases is notable. The number of diagnosed cases of mesothelioma and lung cancer is rising: currently close to 1,000 each per year.[49] The number of deaths due to asbestos has become higher than that from fatal

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46. C. ARTHUR WILLIAMS, JR., AN INTERNATIONAL COMPARISON OF WORKERS' COMPENSATION 138–43 (1991).

47. *See id.*

48. Workers' compensation insurance in Germany is provided by "Berufsgenossenschaften" (BG), i.e. monopoly insurance associations organized according to the different branches of industry.

49. *See BGs: Average Premium Remains Constant: Accident Statistics at New Record Low, at* http://www.hvbg.de/e/pages/presse/preme/jpk.htm (Nov. 6, 2002).

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accidents at work.[50] Prophylactic examinations now cover half a million workers formerly exposed to asbestos. The average cost of a case of asbestos related cancer is around $ 250,000 (and seems to be similar to the United States.)[51] The handling of asbestos cases under the pay-as-you-go system is efficient—the burden has been barely perceived so far by those paying in. Will the situation stay this way? Some branches of industry, such as the construction industry, are beginning to feel the impact on premiums. In the context of EU–wide competition, the acceptance of national or branch-wide solidarity is diminishing. The same applies to solidarity for the historical liabilities, particularly of now-defunct companies, in the pay–as–you–go system.

B. Tort Law

Tort law is affected by asbestos-related diseases in widely varying ways. Product liabilities and environmental liabilities (towards neighbors, subcontractors or employees' family members) based on basis principles of tort law come into consideration everywhere, even if such liabilities still play only a small part in the legal practice of European countries with regard to asbestos. At the center of corporate liability stands the liability of employers, who are primarily responsible for safety at the workplace. No area of tort law is handled in such different ways as employers' liability. Every legal system has its own way of answering the question of how far employers are to be exposed to employees' claims in addition to or instead of the social security institutions of workers' compensation, health and pension insurers, and how far they are liable with regard to the recourse action of social insurance carriers or third parties. This also applies even within the European Union, where no signs of harmonization are currently apparent.[52]

50. *See id.*

51. Rebekah Devlin, *Families in Call For New Work Death Laws*, ADVERTISER, Apr. 28, 2001, at 27.

52. *Cf. Comparative Overview of Employers' Liability Systems*, *in* EMPLOYERS' LIABILITY 24–28 (Munich Re. ed., 1994) [hereinafter EMPLOYERS' LIABILITY]; Parsons, Liability Rules, Compensation Systems and Safety at Work in Europe, in: The Geneva Papers on Risk and Insurance Theory, Vol. 27 No.3, July 2002, 358–82 (on file with the author); FELICE MORGENSTERN, DETERRENCE AND COMPENSATION: LEGAL LIABILITY IN OCCUPATIONAL SAFETY AND HEALTH 37–39 (1982).

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1. Employers' Immunity: Liability for Intent Only

A policy of immunity for employers, of replacing liability with workers' compensation insurance, has led in some countries to employees' claims against their employers being admissible only in the case of intent: this is the case in Germany,[53] Austria,[54] and Belgium.[55] The same applies in the United States, Canada and Mexico, i.e. the whole NAFTA area.[56]

Legal systems react in various ways to such immunity. In Canada, employers' immunity applies not only between the individual employers and its employees but also between all employers and all employees in the same province.[57] In the United States, the shifting of liability from employers onto third parties means that third parties are made fully liable without consideration of any contributory negligence on the part of the employers.[58] This is different in Germany, where the liability of third parties is reduced correspondingly.[59] This may be one further reason that the shifting of liability to third parties, to manufacturers for example, is uncommon in the case of occupational diseases. The dividing line between workers' compensation insurance and tort law is kept flexible by a singular rule in the German Social Security Code.[60] This makes it possible to grant workers' compensation insurance cover (and exclude tort law) in the increasingly nebulous area of quasi-employees. In the many asbestos bystander cases, attempts have been made on this basis—but so far without success—to include family dependants in workers' compensation

53. § 104 exp. 1 SGB VII.

54. § 333 ASVG.

55. Art. 46 Loi sur les accidents de travail of April 10, 1971 Art. 51 Loi sur les maladies professionnelles of March 6, 1970.

56. Other examples outside of Europe are in Asia, the Philippines, showing the influence of United States law in this respect, in South America, and in Argentina (Art. 39 Ley de riesgos de trabajo of 13th September 1995) with the particular feature that the employers' liability has been eliminated without any extension of workers' compensation cover, on the basis of dubious figures on the costs of employers' liability. *Cf.* Cornaglia, *Crueles efectos del economicismo en el juicio por infortunio obrero*, Doctrina laboral (111) Nov. 1994, Buenos Aires, 901–12 (on file with the author). This is a rare example of neo-liberal economic policy encroaching upon not only social security but also tort law.

57. Richard J. Tingley, Q.C., *Immunity from Suit and Working Extra-Jurisdictionally in Canada*, AMER. ASSOC. OF STATE COMPENSATION INSURANCE FUND, *at* http://www.aascif.org/public/archive/winter02/3.2.10_winter02.htm (last visited Mar. 1, 2003).

58. *See* WILLIAMS, *supra* note 46, at 187–94.

59. *Id.*

60. § 2 exp. 2 SGB VII.

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insurance, which certainly reflects the German approach of favoring social security solutions.

2. Liability for Gross Negligence

In France[61] and Switzerland,[62] employees are entitled to unlimited tort law compensation in case of gross negligence as well as in case of intent. Here, too, the approach seems to be based on the principle that occupational accidents and diseases should be dealt with principally under social law, only involving liability law in exceptional cases. However, in a recent decision of France's highest court, the application of "faute inexcusable" or inexcusable and deliberate fault, was greatly expanded in a decision which found that a number of employers were liable for gross negligence for their part in their employees' asbestos-related injuries.[63] This holding, which seems to have established a kind of employers-employee safety guarantee, has reversed the century-old relationship between rule and exception, although this move did not come as a complete surprise. In view of the more pronounced development of tort-law compensation compared with social-security compensation, for many years the question was being discussed in France as to whether the replacement of liability established by the industrial accidents law of 1898 did not in fact now discriminate against employees instead of fulfilling its original purpose of favoring them ("les premiers seront les derniers").[64]

3. Liability for Ordinary Negligence

In some countries, employers' liability is a traditional field of tort law compensation: the United Kingdom and Ireland, Spain, Italy, Turkey, even some of the ex-socialist transition countries (Czech Republic, Hungary). In many other countries, the de facto displacement of tort law by workers' compensation, health insurance and pension insurances has for many years hidden the fact that tort law can also be applied in the relationship between employer and employee—its application has never been abolished formally and can be revived at any time. Depending on the limits of what social insurance systems can bear, such application could occur particularly in

61. A.L. 452-1 C.S.S.

62. Art. 44 II UVG.

63. *See Asbestos: Decisions, Decisions*, REINSURANCE MAGAZINE., Aug. 13, 2002, at 26.

64. Gerard Lyon-Caen, *Les victimes d'accidents du travail, victimes aussi d'une discrimination?* DROIT SOCIAL, Sept./Oct.1990, at 737–39 (on file with the author).

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connection with asbestos-related diseases, manifestation of which is increasing year by year. In the United Kingdom, since the 1970s, asbestos claims have been settled within the framework of the well-developed compulsory employers' liability insurance.[65] The number of claims in the United Kingdom is growing—"1,500 claims per year and rising—and is likely to go on increasing."[66] As such cases frequently involve more than one employer, the House of Lords saw the necessity to clarify the extent of joint and several liability in a recent decision.[67] The point at issue is not the limiting of employers' liability, but rather a reform of current, all too consistent, loss-producing insurance practice in the case of occupational diseases. In the Netherlands, employers' immunity ended–at first without any consequences—when in 1967 the traditional workers' compensation insurance was integrated into the general health and pension insurance system.[68] The dismantling of the Dutch welfare state and the ongoing development of tort law have—with the factual increase in asbestos-related occupational diseases since the end of the 1980s—led to asbestos cases being increasingly compensated under tort law. Employers' liability has never been covered in a separate policy as it is in the compulsory United Kingdom scheme but is included tacitly in public liability insurance, in which the triggers are unclear, as is the application of claims series clauses. This is true of many other countries too, such as Spain, where in the nineties, employers were for the first time sued in asbestos cases.[69]

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65. *Asbestos Risks in the UK*, FRESHFIELDS BRUCKHAUS DERINGER, *at* http://www.legal500.com/devs/uk/ev/ukev_075.htm (last visited Mar. 1, 2003).

66. This information is available on the site of the United Kingdom Parliament, http://www.parliament.the-stationary-office.co.uk/pa/cm200102/cmhansrd/cm021024/debtext/21024-32.htm (last visited Mar. 1, 2003).

67. Fairchild v. Glenhaven Funeral Servs. Ltd. & Others, UKHL 22 (2002).

68. *Cf. supra* Part II.A.1; WILLIAMS, *supra* note 46, at 138.

69. On the complex questions of fault-based compensation of asbesos-related occupational diseases in Spain, see Òscar Buenaga Ceballos, Seguridad social y responsabilidad civil. Algunas reflexiones en torno al artículo 127.3 de la Ley General de la Seguridad Social, Madrid 2002; Comsiones Obreras (ed. Angel C. Cárcoba Alonso), El amianto en España, Madrid 2000; Antonio Blasco Mayor, Daños derivados del trabajo, Madrid 2001; El país, April 29th 2001, "IU y CCOO exigen que el gobierno prohíba el uso del amianto antes del 2003", with reference to the judgement against the asbestos manufacturer Uralita end of 2000; Lahnstein, Seminario sobre la responsabilidad civil patronal, Madrid, Barcelona 1994, p. 22, 23 (on file with the author).

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4. Recourse or Subrogation Against Employers

Even more varied than the employees' claims for damages are the arrangements whereby workers' compensation insurers can take recourse against the employer.

Sometimes state health or pension insurers—de lege or de facto—do not take recourse at all. But such areas of national solidarity are reduced by privatization and international system competition—in the United Kingdom, for example, this is reflected in the increasing admissibility of recourse action by the Industrial Injuries Scheme and the National Health Service.[70]

Sometimes recourse is limited to intentional acts of the employer. So the practical significance is marginal. Sometimes, as in Switzerland,[71] Germany,[72] and Austria,[73] recourse is limited to gross negligence of the employer, a compromise solution, which requires a greater element of blame and considers the aspects of sanction and prevention: relief, but no release from liability. In many countries—Spain, Italy, Hungary, now also the United Kingdom—systematic recourse based on ordinary negligence is admitted to a wide extent. If, as is usually the case, workers' compensation insurance is financed by the employers and not by taxes, recourse also means a more finely tuned allocation of costs within the risk community, as may be seen in connection with the different organizational and tariff structures of the workers' compensation insurance systems.

III. AN OUTSIDER'S PERCEPTIONS ON THE COMPENSATION OF ASBESTOS-RELATED DISEASES IN THE UNITED STATES

What features stand out when, having examined the historical jungles of European social and tort law, one looks again at the approach of the United States to compensate asbestos–related diseases?

There are two obvious factors: the massively used compensation route of product liability, which de facto replaces employers' liability, and the modest role of workers' compensation.

70. *See* WILLIAMS JR., *supra* note 46, at 126–37.

71. Art. 44 II UVG.

72. § 110 exp. 1 SGB VII.

73. § 334 ASVG.

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A. Circumventing United States' Employers' Immunity

At the center of compensation for asbestos-related claims in Europe are safety-at-work aspects. In Germany, it is workers' compensation insurance that covers these claims. In the United Kingdom, employers' liability is to the fore. In other countries the two approaches are mixed, in varying degrees. This is appropriate to the problem, given that the asbestos issue in fact mainly involves safety at work. Admittedly, the public sometimes sees this differently when it overemphasizes environmental aspects. Political pressure has led to expenditure for asbestos-removal that was regarded[74] as a waste of economic resources. But this expenditure affected neither insurers nor tort law.

In the United States, product liability is to the fore. Of course, product liability had the historical role of uncovering the manufacturers' policy of silence.[75] And it is still the more appropriate compensation route in cases involving exposed consumers, workers from small firms or informal undertakings. But in an increasing number of situations, product liability is not the appropriate means for causal allocation of bodily injuries. Many of the asbestos-processing companies currently being sued may be blamed for having endangered their own employees. This blame provides no grounds for liability (employers' liability having been substituted by workers' compensation insurance). However, these companies can often not be blamed for having harmed third parties through their products that contain asbestos.

B. The Role of Workers' Compensation

Following the passionate debates on the replacement of employers' liability by workers' compensation insurance in the United States, first in connection with coal-mining and other occupational accidents at the beginning of the twentieth century,[76] then in connection with silicosis and

74. By the president of the German Federal Administrative Court. *Cf.* Franßen, Krebsrisiko und Luftverunreinigung (cancer risk and air pollution), Dokumentation zur 16 wissenschaftlichen Fachtagung der Gesellschaft für Umweltrecht (documentation on the 16th scientific conference of the Environment Law Society) (1992).

75. *Cf. supra* Part I.A.2.

76. Anthony Bale, *America's First Compensation Crisis: Conflict Over the Value and Meaning of Workplace Injuries Under the Employers' Liability System, in* DYING FOR WORK, WORKERS' SAFETY AND HEALTH IN TWENTIETH-CENTURY AMERICA 34–52 (David Rosner & Gerard Markowitz eds., 1987).

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other occupational diseases since the thirties,[77] one would think that workers' compensation is the institution that would primarily deal with compensation for asbestos-related bodily injuries. Workers' compensation insurance was not only the first piece of social security in the United States but continues today to be a respectable part of the modern welfare state. The premium income of approximately $40 billion annually is remarkable, even if it has declined in the late 1980s and the 1990s.[78] Costs assumed in individual cases can be very high, sometimes in the region of between six and eight million dollars. But asbestos does not appear to be an issue in all this as no NCCI study is available.

The reasons seem to be manifold and often of a historical nature. The deficiencies listed by the National Commission on State Workmen's Compensation Laws of 1972 included the practice of compensation—or non-compensation—of occupational diseases.[79] But little change, in this point, seems to have occurred since then. For older disabled persons, another part of the United States welfare state remains responsible—the Medicare system, which is equally applicable to occupation related diseases and others. I refer in this connection to the considerations of Tom Baker on "insurance and the distribution of responsibility."[80] If workers' compensation insurance covers asbestos risks without then really bearing the consequences, how is the question of the financial, moral or legal "accountability" of this insurance system to be regarded? How are the "causation decisions" to be judged, "made in respect to the overlaps among workers' compensation and other payment systems . . . disability insurance and tort liability?"

If the asbestos complex is considered to be a national disaster, a federal system would certainly be better suited to meeting the challenge. But the first piece of social security came too early for that. When, in the thirties, federal social security structures were being developed, workers' compensation insurance was disregarded. Competition between private insurers in the individual states and between the individual states

77. *Cf.* EMPLOYERS' LIABILITY, *supra* note 52, at 24–28.

78. *Cf.* Martha McCluskey, *Rhetoric of Risk and the Redistribution of Social Insurance*, *in* EMBRACING RISK, THE CHANGING CULTURE OF INSURANCE AND RESPONSIBILITY 146–70 (Tom Baker & Jonathan Simons eds., 2002).

79. WILLIAMS, *supra* note 46, at 43.

80. Tom Baker, *Risk, Insurance, and the Social Construction of Responsibility*, *in* EMBRACING RISK, THE CHANGING CULTURE OF INSURANCE AND RESPONSIBILITY 38–51 (Tom Baker & Jonathan Simons eds., 2002).

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themselves with regard to good investment conditions probably also militate against a nationwide solution. Federal involvement as in the case of the black-lung fund of 1969 is evidently the great exception.[81] The Agent Orange settlement, mainly at the expense of seven chemical firms, points in the same direction—no involvement of the Federal Government.

So one has to accept the curious situation that with workers' compensation a first-class "no fault" system is available as an alternative to the tort system but is not fully utilized. Specialists for mass tort settlements have to keep trying anew to find alternatives to this alternative. They know how difficult that is without involving the United States legislators. And legislators worldwide, unlike one-hundred years ago and unlike thirty or forty years ago, seem to have other interests and priorities today.

CONCLUSION

The tragedy of September 11, 2001 has prompted many within the insurance and reinsurance industries, as well as within governments worldwide, to reexamine the various approaches to dealing with catastrophic loss. In the particular instance of terrorism, the relationship between liability and compensation for victims is a complex one, and one that many in the United States had largely not yet been accustomed to dealing with. As world governments and insurers attempt to address the ever-changing risks and the new political realities of the twenty-first century, the widely varied approaches to liability, tort law, and compensation systems across international borders is perhaps more sharply distinct.

This Article has attempted to briefly distinguish how state and private prevention standards and liability systems vary from country to country and also change over the course of time. This is nowhere more apparent than in the area of asbestos liability where the gradually emerging consequences produce a puzzle made up of different liability situations in each European country: social security solutions differ, tort law differs, and the interplay of social law and tort law differs. The challenge for an international insurer or reinsurer is merely to understand how the various parts of these puzzles may be pieced together.

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81. Federal Coal Mine Health and Safety Act, Pub. L. No. 91–173, 83 Stat. 742 (1969). *See* ALAN DERICKSON, BLACK LUNG, ANATOMY OF A PUBLIC HEALTH DISASTER (1998).

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HOLDING LIABILITY INSURERS ACCOUNTABLE FOR BAD FAITH LITIGATION TACTICS WITH THE TORT OF ABUSE OF PROCESS

Francis J. Mootz III[*]

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INTRODUCTION

A person injured by the negligent acts of another party might find that an old vaudeville gag best captures the situation in which she finds herself: "the good news is that the wrongdoer has insurance; the bad news is that the wrongdoer has insurance." It is easy to understand why the news is good: the existence of liability insurance means that the claim will be handled professionally and that money will be available to compensate the injured person. This may be of paramount importance, because injuries caused by the wrongdoer can have a devastating effect on the injured person's life. Medical bills quickly can threaten to bankrupt her, and obtaining adequate care may be difficult without the resources to pay for that care. She may be unable to work for an extended period of time, and her loss of income can soon cause severe financial distress that leads to emotional distress. Finally, she might suffer property loss, as would be the case if her car is totaled in an automobile accident caused by the wrongdoer. If the injured person is prudent and has the resources to pay the premiums, she will own first-party insurance products—such as health insurance, disability insurance, and property insurance—that can mitigate these losses. But if she does not own applicable first-party insurance policies, or if her coverage is insufficient to make her whole, she will be looking to the wrongdoer for compensation.[1] The wrongdoer's third-party liability insurance can make receiving such compensation as straightforward as making and documenting a claim.

However, the fact that the wrongdoer has insurance can also be bad news for the injured party. Because liability insurance policies generally give the insurer the sole right to settle a claim and to withhold coverage if the insured fails to cooperate in the defense of the action, the injured party can receive compensation only if the liability insurer decides to make a payment. In other

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1. In a case where the injured party has received compensation from her insurers, they likely will be subrogated to her claims against the wrongdoer and, therefore, the injured party's insurance carrier will be pressing the claims with the wrongdoer's insurance carrier. My guess is that an empirical study (if it is feasible to conduct such a study) would reveal that liability insurers adopt an entirely different approach when they deal with other insurers, even if their focus on decreasing payouts remains paramount. Given the lack of financial and emotional leverage over another insurance company, I would expect that liability insurers would not incur the costs (including attorneys fees) associated with stonewalling tactics. Of course, one would expect that legitimate disputes over coverage or damages would be equally hard-fought.

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words, even if the wrongdoer recognizes his liability and wishes to compensate the party he injured, the wrongdoer can be precluded from doing so by a recalcitrant liability insurer. The presence of insurance will be bad news for the claimant if the liability insurer refuses to settle a properly documented claim, forcing her to bring suit and engage in protracted and expensive litigation. The liability insurer loses very little by delaying payments for as long as possible, but it might gain a great deal. To the extent that the injured party is experiencing physical, emotional and financial problems as a result of the accident, delay in receiving compensation will exacerbate these pressures and will lead her to accept a lower settlement out of necessity.

Liability insurers are relatively free under current law to refuse to settle legitimate claims made by injured parties and to use the costly and time-consuming litigation process to wear them down until they accept low settlements. Although such behavior might violate the state's unfair insurance practices statute and, in extreme cases, be subject to administrative investigation and sanction, the injured party would have no basis for asserting a claim against the liability insurer for the additional losses caused by this wrongful behavior. In a recent article, I argued that considerations of public policy justify holding insurers liable in tort for their bad faith practices in settling claims filed against their insureds.[2] That proposal provides a comprehensive response to the problem of liability insurers refusing to deal with injured parties honestly and fairly, and by virtue of its comprehensiveness it directly challenges time-honored common law rules that effectively insulate liability insurers from any liability to third-party claimants.

In the present Article, I advocate the less radical, but also less comprehensive, strategy of holding liability insurers accountable for bad faith litigation tactics under the tort of abuse of process. Liability insurers that use the litigation process to strong-arm more favorable settlements with third-parties often utilize civil process in a manner that should be regarded as tortious under well-established principles. Although my thesis is relatively narrow and is not premised on any fundamental changes in legal doctrine, the case is not easily made. I begin by describing, in Part I, the background common law rule that absolves liability insurers of any contract obligations or

2. Francis J. Mootz III, *The Sounds of Silence: Waiting for Courts to Acknowledge That Public Policy Justifies Awarding Damages to Third-Party Claimants When Liability Insurers Deal with Them in Bad Faith*, 2 NEV. L.J. 443 (2002).

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tort duties owed to injured third-party claimants. In Part II, I outline the strong public policy considerations, as articulated by state legislatures and recognized in judicial decisions, that demand that liability insurers act fairly and reasonably in settling claims by injured third parties. Against this public policy backdrop, in Part III, I argue that liability insurers who use motion practice and discovery primarily for the purpose of avoiding their obligation to make fair and timely payments to injured parties should be subject to liability for abuse of process. I note the doctrinal and practical difficulties confronting a third-party claimant seeking damages for abuse of process, but conclude that recent decisions point the way toward a reasonable application of the tort of abuse of process in this setting.

I conclude that abuse of process can play an important, even if limited, role in the battle against liability insurers who act contrary to public policy and thereby cause additional harm to injured third-party claimants. In light of strong public policy considerations, courts might legitimately choose to construe the elements of abuse of process in a manner favoring liability against insurance carriers in the insurance defense setting. However, even a straightforward application of the tort should provide grounds for imposing liability in a number of cases that involve paradigmatic insurer bad faith. By holding liability insurers accountable under the tort of abuse of process, courts might increase the odds that the existence of insurance will prove to be good news for injured parties.

I. CURRENT LAW GENERALLY INSULATES LIABILITY INSURERS FROM CLAIMS BY THIRD PARTIES THAT THE INSURER FAILED TO HANDLE A LEGITIMATE CLAIM AGAINST THE INSURED IN GOOD FAITH

A long-standing and virtually unchallenged doctrinal rule provides that a liability insurance carrier owes no duties in tort or contract to a third-party claimant injured by its insured. The absence of any duty to claimants stands in sharp contrast to the heightened duty of good faith that insurers owe to their insureds when they undertake the defense of claims. In a classic statement of this rule, the Georgia Court of Appeals explained:

> While an automobile liability insurance company may be held liable for damages to its insured for failing to adjust or compromise a claim covered by its policy of insurance, where the insurer is guilty of negligence or of fraud or bad faith in failing to adjust or compromise the claim to the injury of the insured . . . it does not follow that a person injured by the insured and who is not a party to the insurance contract may complain of the negligence or bad faith of the insurer towards

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its policyholder in failing to adjust or compromise a claim against such policyholder, for the duty of the insurance company to use ordinary care and good faith in the handling of a claim against its insured arises out of the relationship between the insurer and the insured created by the contract or policy of insurance, and there is no fiduciary relationship or privity of contract existing between the insurer and a person injured by one of its policyholders.[3]

A decision of the Appellate Court of Illinois, *Scroggins v. Allstate Insurance Co.*,[4] provides a succinct illustration of the real world effects of the current state of the law.[5] The case was brought by two pedestrians who suffered injuries when Allstate's insured saw an acquaintance walking down the sidewalk and decided to "goof off" by increasing his speed and directing

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3. Francis v. Newton, 43 S.E.2d 282, 284 (Ga. Ct. App. 1947). The California Court of Appeals noted that the insurance bad faith cases make no mention "of a duty to the adversary in the litigation between the injured party and the insured to settle the former's claim against the latter," and concluded that the claimant has no "right to require the insurer to negotiate or settle with him prior to the establishment of the insured's liability." Zahn v. Can. Indem. Co., 129 Cal. Rptr. 286, 288 (Ct. App. 1976). The California Supreme Court later explained in a unanimous opinion that an insurer's bad faith refusal to settle a claim ultimately works to the claimant's advantage:

> Unlike a failure to investigate the representations of the insured, a breach of the duty to settle does not involve the risk that a person injured by a negligent motorist will fail to receive the compensation called for by [financial responsibility laws]. Breach of the duty to settle will, if anything, allow the injured party to recover the amount of the offered settlement, perhaps an additional sum to the extent of the policy limits, and sums in excess of those limits from the negligent motorist. Because an insurer's refusal to accept a reasonable settlement does not diminish the injured claimant's recovery, the policy of compensating persons injured by a negligent motorist is not frustrated.

Murphy v. Allstate Ins. Co., 553 P.2d 584, 589 (Cal. 1976).

> Not only is company without any duty to claimant to accept claimant's reasonable settlement offer, but also, if there is a sizable disparity between the settlement offer and the amount of the judgment obtained in the trial which follows refusal of the offer, claimant is benefited rather than harmed by company's refusal to settle.

Robert E. Keeton, *Liability Insurance and Responsibility for Settlement,* 67 HARV. L. REV. 1136, 1176 (1954).

4. 393 N.E.2d 718 (Ill. App. Ct. 1979).

5. The following facts were alleged by the plaintiffs and were accepted as true for purposes of the motion to dismiss for failure to state a cognizable claim. *Id.* at 719–20, 725.

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his car towards her.[6] The driver lost control of his car when he swerved at the last minute to avoid his friend, causing him to run into the two plaintiffs who were standing on the other side of the street.[7] The plaintiffs submitted copies of statements by witnesses regarding the accident and itemized their special damages.[8] However, Allstate offered an unreasonably low settlement despite the clear evidence of liability and damages.[9] The plaintiffs alleged that they suffered embarrassment at being unable to pay their medical expenses, that they were forced to incur the additional costs of a lawsuit to seek proper recovery, and that they suffered emotional distress.[10] The claim was predicated on a straightforward rationale: Allstate had no reasonable, good faith reason to avoid paying the claims in light of the clear evidence of fault and damages, and its refusal to pay the claim caused additional injuries to the victims of the automobile accident.[11]

The court affirmed the dismissal of the action, holding that Allstate owed no duties to the plaintiffs to settle their claims in good faith, even if Allstate's actions constituted a breach of the duty of good faith that Allstate owed to its insured. The court reasoned:

> In the instant case . . . plaintiffs are suing in their own right, as third party claimants against the insured, for the insurer's allegedly wrongful refusal to settle their claim. Even assuming arguendo that they have adequately alleged a breach of the duty of good faith and fair dealing on the part of the insurer, that duty is one which the insurer owes to its insured, not to third parties. Yet it is elementary that in an action founded on a breach of duty, the plaintiff must allege facts showing a breach of a duty owed to him. Thus, the rule in Illinois and nearly all jurisdictions is that in the absence of statutory or contractual language sanctioning a direct action, an injured third party has no action against the insurer for breach of the duty to exercise good faith or due care by virtue of his standing as judgment creditor of the insured. For the same reason, because the duty is intended to benefit the insured and

6. *Id.* at 719.
7. *Id.*
8. *Id.*
9. *Id.*
10. *Id.*
11. *Id.*

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> not third parties, actions by injured claimants founded on third party beneficiary principles have not been permitted.[12]

The court noted that the legislature had "increasingly broadened the duties imposed on insurers in the Insurance Code" to treat claimants fairly and in good faith, but concluded that this legislative development could not "justify quasi-legislative extension of those duties, and creation of new duties, by the judiciary."[13] What is painfully missing from the opinion is any justification for the practical effect of the holding, which recognizes no common law rights in innocent injured parties who suffer additional losses when they are treated unfairly by the tortfeasor's liability insurer.

As a matter of doctrinal consistency and logic, the traditional rule expressed in these two cases makes perfect sense. The liability insurer has no contractual relationship with the injured claimant.[14] Moreover, because the

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12. *Id.* at 720–21 (citations omitted).

13. *Id.* at 724. A similar justification for the traditional rule that insurers owe no duty of good faith to third-party claimants was voiced by the Wisconsin Supreme Court:

> These cases stress a constant theme: an insurer owes no duty to the third-party claimant to settle or to negotiate in good faith. It is clear in the instant case that the injury for which the petitioner seeks compensation is . . . for whatever injuries result from an insurer's refusal to settle when the claimant thinks it should, for the distress caused by what the claimant thinks are unfair tactics, and for the deprivation of the funds to which the claimant thinks he is entitled. To declare the existence of a cause of action in favor of the claimant against the insurer for these injuries would be to expose an insurer to liability for failing to satisfy a claim before the fundamental predicate to its duty to do so has been established—the determination of the insured's legal liability. . . . The insurer's duty of good faith and fair dealing arises from the insurance contract and runs to the insured. No such duty can be implied in favor of the claimant from the contract since the claimant is a stranger to the contract and to the fiduciary relationship it signifies. Nor can a claimant reasonably expect there to be such a duty, inasmuch as the insurer and the insured are aligned in interest against the claimant. In the absence of any such duty, the third-party claimant cannot assert a claim for failing to settle his claim, and we therefore decline to recognize such a claim for relief under common law tort principles.

Kranzush v. Badger State Mut. Cas. Co., 307 N.W.2d 256, 265 (Wis. 1981) (following these seemingly self-evident premises and affirming the dismissal of a claim maintained by the claimant's administrator, despite allegations that the insurer used meaningless discovery and other delay tactics because it knew the claimant was dying of cancer). For Justice Abrahamson's critique of this majority opinion, *see infra* notes 37–41and accompanying text.

14. Claimants have argued that they are a third party intended beneficiary of the insurance contract, but the courts consistently find that the insurance contract is intended to benefit only

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liability insurer steps into the shoes of the tortfeasor during the claims process (and thereby has an adversarial relationship with the claimant) it appears nonsensical to claim that the insurer owes a duty of good faith to the claimant.[15] Following this seemingly unimpeachable logic, courts consistently have held that liability insurers are entitled to minimize their payments on claims by acting as aggressively and strategically as the insured tortfeasor would be permitted to act, at least until the judgment against the tortfeasor becomes final.[16]

II. CLEARLY ESTABLISHED PUBLIC POLICY DEMANDS THAT LIABILITY INSURERS ACT FAIRLY AND REASONABLY TOWARD THIRD-PARTY CLAIMANTS

Although the logic and consistency of the doctrinal rule that insurers owe no duties to third-party claimants is popular and appealing, it is deceptive. Liability insurers are contractually obligated to defend their insureds, but it is a conceptual abstraction to equate them with their insureds and conclude that they have the right to maximize their own financial well-being by refusing to pay on legitimate claims. Even if the law countenances the legal right of self-insured corporate defendants to vigorously fight every claim brought against them with the single-minded goal of minimizing expenses, it is a different

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the insured, and that the claimant becomes a beneficiary of the insurance policy only when the insured suffers a judgment in favor of the claimant. *See, e.g.*, Page v. Allstate Ins. Co., 614 P.2d 339, 340 (Ariz. Ct. App. 1980); Chapell v. LaRosa, CV990552801, 2001 WL 58057, at *2–*4 (Conn. Super. Ct. Jan. 5, 2001).

15. In the words of one court, "[a]n insurer can hardly have a fiduciary relationship both with the insured and a claimant because the interest of the two are often conflicting." O.K. Lumber Co., Inc. v. Providence Wash. Ins. Co., 759 P.2d 523, 526 (Alaska 1988). Simply put, "[t]he insurer has a fiduciary duty to the insured but an adversary relationship with the victim." *Chapell*, 2001 WL 58057, at *4 n.2 (quoting Long v. McAllister, 319 N.W.2d 256, 262 (Iowa 1992)). Thus the insurer has the "right" to force the claimant to prove his or her case at trial before becoming obligated to make a payment, even if the insurer allegedly is employing hardball litigation tactics. *See* Linscott v. State Farm Mut. Auto. Ins. Co., 368 A.2d 1161, 1163–64 (Me. 1977).

16. *See* Mootz, *supra* note 2, at 448–56, 464–71 (describing the courts' reluctance to permit third parties to recover under a variety of theories, except under the most extreme circumstances). Jeff Stempel suggested that my argument against the traditional rule fits well with a more general theme in the insurance law literature, a theme that Peter Swisher has characterized as a movement by courts in certain instances away from formalism and toward functionalism. *See, e.g.*, Peter Nash Swisher, *Judicial Rationales in Insurance Law: Dusting off the Formal for the Function*, 52 OHIO ST. L.J. 1037 (1991).

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matter entirely when a liability insurance carrier is controlling the claims and litigation process pursuant to its duty to defend the tortfeasor. The most obvious difference is the greater impact that insurers will have on the public interest in compensating injured parties. A large liability insurer that withholds payment for compensable injuries and uses all available means to coerce low settlements obviously will interfere with the strong public policy of making injured parties whole to a much greater degree than a single tortfeasor pursuing the same strategy. More importantly, although a tortfeasor might legitimately argue that it should be entitled to defend its limited assets, even as to unquestionably valid claims, until these claims have been reduced to a binding judgment, liability insurers charge regulated premiums that have been approved at a level that ensures a fair profit after they have paid all valid claims against their insureds. To state the obvious, it is the very business of liability insurers to pay claims.

A recent first-party bad faith case provides a set of facts that vividly demonstrate the disastrous effects that can result when an insurer acts in its own economic interests rather than settling legitimate claims against its insureds. In *Campbell v. State Farm Mutual Automobile Insurance Co.*,[17] the Utah Supreme Court affirmed a verdict of $1 million in compensatory damages and $145 million in punitive damages, awarded to an insured for State Farm's malicious and reprehensible behavior while adjusting and litigating a claim against the insured.[18] In the underlying tort action, the jury determined that Mr. Campbell's negligence was solely responsible for an accident that killed one driver and disabled another.[19] State Farm defended Mr. Campbell pursuant to his automobile policy, but refused to settle the claims against Mr. Campbell for the policy limit of $25,000, despite repeated offers by the claimants both before and after the trial commenced,[20] and despite State Farm's knowledge that Mr. Campbell was responsible for their injuries.[21] Mr. Campbell suffered an excess verdict, and he believed that his personal assets would need to be liquidated to satisfy the $160,000 excess

17. No. 981564, 2001 WL 1246676 (Utah Oct. 19, 2001), *cert. granted,* 122 S. Ct. 2326 (2002). The Supreme Court granted certiorari to consider Allstate's claim that the award of punitive damages is unconstitutional because it was imposed in part to punish Allstate for actions occurring outside Utah, and also that the award was grossly excessive.

18. *Id.* at *1.

19. *Id.* at *2.

20. *Id.* at *1.

21. *Id.* at *2 (describing State Farm's efforts to alter and hide its own investigator's conclusions about Mr. Campbell's responsibility for the accident).

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judgment,[22] until some six years later when State Farm (facing an assignment of Mr. Campbell's bad faith claims to the injured parties) paid the entire verdict against Mr. Campbell once the judgment against him became final.[23] Mr. Campbell then sued State Farm for bad faith, fraud and intentional infliction of emotional distress, notwithstanding State Farm's belated satisfaction of the entire judgment against him.[24]

Mr. Campbell's litigation revealed that State Farm's behavior was not isolated, but rather was the "result of a national scheme to meet corporate fiscal goals by capping payouts on claims company wide," [25] according to which "State Farm specifically calculated and planned to avoid full payment of claims, regardless of their validity."[26] The court concluded that the large punitive damages award was justified, in part, by State Farm's egregious and malicious nationwide scheme of fraudulent claims handling:

> First, State Farm repeatedly and deliberately deceived and cheated its customers via the PP & R scheme ["Performance, Planning and Review"]. For over two decades, State Farm set monthly payment caps and individually rewarded those insurance adjusters who paid less than the market value for claims. Agents changed the contents of files, lied to customers, and committed other dishonest and fraudulent acts in order to meet financial goals. For example, a State Farm official in the underlying lawsuit in Logan instructed the claim

22. *See id.* The court's report of State Farm's post-verdict behavior toward its insured is chilling:

> In light of [defense counsel] Bennett's numerous reassurances to both Mr. and Mrs. Campbell that their assets were safe, that they had no liability for the accident, that he would represent their interests, and that they did not need to procure separate counsel, the Campbells were utterly dismayed. To their expressions of dismay, Bennett responded by telling the Campbells that "[y]ou may want to put for sale signs on your property to get things moving," making it clear that State Farm did not intend to pay the excess judgment against the Campbells. Furthermore, State Farm declined to post a supersedeas bond on appeal in excess of their $25,000 policy limit. The Campbells immediately acquired other counsel and learned that their situation was indeed grave.

Id.

23. *Id.* at *3.

24. *Id.*

25. *Id.*

26. *Id.* at *10.

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adjuster to change the report in State Farm's file by writing that [third-party claimant] Ospital was "speeding to visit his pregnant girlfriend." There was no evidence at all to support that assertion. Ospital was not speeding, nor did he have a pregnant girlfriend. The only purpose for the change was to distort the assessment of the value of Ospital's claims against State Farm's insured. As the trial court found, State Farm's fraudulent practices were consistently directed to persons—poor racial or ethnic minorities, women, and elderly individuals—who State Farm believed would be less likely to object or take legal action.

Second, State Farm engaged in deliberate concealment and destruction of all documents related to this profit scheme. State Farm's own witnesses testified that documents were routinely destroyed so as to avoid their potential disclosure through discovery requests. Such destruction even occurred while this litigation was pending. Additionally, State Farm, as a matter of policy, keeps no corporate records related to lawsuits against it, thus shielding itself from having to disclose information related to the number and scope of bad faith actions in which it has been involved.

Third, State Farm has systematically harassed and intimidated opposing claimants, witnesses, and attorneys. For example, State Farm published an instruction manual for its attorneys mandating them to "ask personal questions" as part of the investigation and examination of claimant in order to deter litigation. Several witnesses at trial, including Gary Fye and Ina DeLong, testified that these practices had been used against them. Specifically, the record contains an eighty-eight page report prepared by State Farm regarding DeLong's personal life, including information obtained by paying a hotel maid to disclose whether DeLong had overnight guests in her room. There was also evidence that State Farm actually instructs its attorneys and claim superintendents to employ "mad dog defense tactics"—using the company's large resources to "wear out" opposing attorneys by prolonging litigation, making meritless objections, claiming false

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> privileges, destroying documents, and abusing the law and motion process.[27]

Based on these factual findings, the justification for the award of damages—including large punitive damages—in favor of Mr. Campbell is clear. But it is equally clear that numerous innocent claimants across the country suffered even more grave harm as a result of State Farm's odious conduct. After having been disabled or killed in an automobile accident for which legal responsibility was reasonably clear, State Farm's scheme meant that innocent claimants would be forced to wait for years before receiving any compensation, during which time they (and their families) would be facing obvious financial pressures. Although Mr. Campbell was sophisticated enough to pursue his bad faith action and ensure that the excess verdict was paid by State Farm, countless third-party claimants undoubtedly were pressured by financial exigency to settle their cases against other State Farm insureds for a substantial discount rather than continue to fight against State Farm's unreasonable "mad dog" tactics. Even if they persisted in suing for adequate compensation, the baseline doctrinal rule that insurers owe no duties to third party claimants means that they would have no recourse against State Farm for the additional losses suffered as a result of its tactics.

If Mr. Campbell were self-insured and chose to defend the claims against him vigorously despite their merit, this would certainly have an impact on the unfortunate two persons he injured, who would face an expensive and emotionally draining battle to secure appropriate compensation through litigation. However, when State Farm refused to pay valid claims on a nationwide basis, there can be little doubt that thousands of claimants were precluded from recovering full and timely compensation for their injuries. Simply due to the magnitude of its behavior, State Farm substantially interfered with the important public policy goal of making injured persons whole. As the trial judge concluded in upholding the punitive damages verdict: "[t]he harm is minor to the individual [policyholder], but massive in the aggregate."[28] Moreover, there is no countervailing justification for this self-interested behavior when an insurer is involved, since State Farm has

27. *Id.* at *9–*10 (citations omitted).
28. *Id.* at *11.

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been permitted to charge premiums that provide sufficient resources to pay valid claims.[29]

It is not revolutionary to argue that liability insurers should be regulated to advance the public interest in compensating persons who have suffered injuries or losses. The question is whether courts will acknowledge their legitimate and necessary role in this regulatory endeavor through the application of general tort concepts. The law expressly and plainly recognizes the vitally important role that liability insurers play by making payments to those who suffer losses that otherwise could cause them and their families financial distress. Perhaps the most prominent example is the common practice by states to require owners of automobiles to maintain minimal levels of liability insurance. These requirements are not motivated primarily by concern for the financial health of the vehicle owner, but instead represent the strong public interest in ensuring that some funds are available to compensate those who may suffer injuries or property damage due to the negligent operation of the vehicle.[30]

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29. The court emphasized that State Farm's fraudulent behavior "created market disadvantages for other honest insurance companies" by unfairly increasing its profits, thereby placing pressure on other insurers to adopt equally reprehensible tactics. *Id.* at *12.

30. Numerous cases support this obvious proposition in a variety of contexts. For example, the Oklahoma Supreme Court recently has explained that otherwise valid defenses against an insured under a liability policy are unenforceable to the extent that they will operate to preclude statutorily mandated coverage that benefits injured third parties.

First, the court held that public policy considerations override coverage defenses that are based on the insured's misrepresentations to the insurer during the application process. Harkrider v. Posey, 24 P.3d 821, 830 (Okla. 2000) (holding that a misrepresentation in the application cannot defeat the third party victim's right to receive compensation). The court reasoned:

> Under Oklahoma's mandatory automobile liability insurance scheme, liability insurance is not issued simply to protect the assets of the insured in the event liability for an accident is incurred, but also, if not primarily, to protect members of the public from the potentially disastrous financial consequences of using the roadways in our automobile-dependent society. To effectuate this policy, the legislature has required the purchase and maintenance of insurance as a precondition for vehicle registration and has prohibited the operation of uninsured vehicles on Oklahoma's roads. The enactment of mandatory liability insurance has, in effect, transformed what was a private insurance arrangement into a quasi-public obligation. To permit post-loss rescission of a voidable policy of liability insurance would render a registered vehicle uninsured for a period of time in the past with no opportunity for the vehicle's owner or operator to remedy the absence of insurance. The innocent victim's statutory protection would be thwarted. It

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Critics might object that compulsory insurance laws primarily are intended to ensure that funds are available to satisfy tort verdicts, arguing that these laws do not place any restrictions on vigorous defense tactics used by insurers during both the claims handling and litigation of the dispute. After all, many financial responsibility laws permit individuals to self-insure if they have sufficient personal funds to cover potential liabilities, suggesting that the states are concerned more with satisfying judgments rather than encouraging

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> is inconceivable that the legislative policy expressed in our mandatory insurance regime might be so easily defeated.

Id. at 829–30 (internal citations omitted). *See also* Fisher v. N.J. Auto. Full Ins. Underwriting Ass'n, 540 A.2d 1344, 1347 (N.J. Super. Ct. App. Div. 1988) (holding that insured's failure to register automobile rendered insured ineligible for insurance under the Automobile Full Insurance Availability Act but that insurer could not avoid liability to passenger for PIP coverage by declaring policy "null and void after accident").

In the following year, the court held that otherwise valid policy exclusions also are trumped by the public policy favoring compensation. Hartline v. Hartline, 39 P.3d 765, 773(Okla. 2001) (invalidating the "named insured exclusion" when it leaves injured resident family member parties with no recovery). The court reasoned:

> The principal purpose of law-mandated liability insurance is the protection of the public from the financial hardship which may result from the use of automobiles by financially irresponsible persons.... This clearly articulated public policy overrides contrary private agreements that restrict coverage where the contractual strictures do not comport with the purpose of the Act. Extant jurisprudence consistently holds that insurance policy clauses which operate to deny coverage to the general public are void as contrary to statutorily articulated public policy.

Id. at 771–72. *See also* Marcus v. Hanover Ins. Co., 740 So. 2d 603, 608–09 (La. 1999) (holding that invalidation of business use exclusion required the insurer to provide coverage up to statutory minimum).

Although certainly not a unanimous rule, some jurisdictions have gone so far as to hold that the public policy of compensating victims of negligence as embodied in compulsory insurance laws outweighs even the strong public policy against the moral hazard of permitting insurance coverage for intentional acts. *See, e.g.,* Nationwide Mut. Ins. Co. v. Roberts, 134 S.E.2d 654, 659 (N.C. 1964):

> The primary purpose of compulsory motor vehicle liability insurance is to compensate innocent victims who have been injured by the negligence of financially irresponsible motorists. Its purpose is not, like that of ordinary insurance, to save harmless the tortfeasor himself. Therefore, there is no reason why the victim's right to recover from the insurance carrier should depend upon whether the conduct of its insured was intentional or negligent.

See also State Farm Fire & Cas. Co. v. Tringali, 686 F.2d 821, 824 (9th Cir. 1982), *implicit overruling noted by* State Farm Mut. Auto. Ins. Co. v. Pichay, 834 F. Supp. 329 (D. Haw. 1993); Milwaukee Mut. Ins. Co. v. Butler, 615 F. Supp. 491, 495 (D. Ind. 1985).

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good faith settlement behavior. However, liability insurers generally are directly regulated by statute with respect to their claims handling and litigation conduct. Virtually all states have enacted versions of the Model Unfair Claims Settlement Practices Act developed by the National Association of Insurance Commissioners.[31] The Unfair Claims Settlement Practices Act clearly establishes that liability insurers owe duties to third-party claimants during the claims and litigation process. The most recent version of the Model Act (April 2002) provides, in relevant part:

> §4. Unfair Claims Practices Defined
>
> Any of the following acts by an insurer, if committed in violation of Section 3, constitutes an unfair claims practice:
>
> A. Knowingly misrepresenting to claimants and insureds relevant facts or policy provisions relating to coverages at issue;
>
> . . . .
>
> C. Failing to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies;
>
> D. Not attempting in good faith to effectuate prompt, fair and equitable settlement of claims submitted in which liability has become reasonably clear;
>
> E. Compelling insureds or beneficiaries to institute suits to recover amounts due under its policies by offering substantially less than the amounts ultimately recovered in suits brought by them;
>
> F. Refusing to pay claims without conducting a reasonable investigation; [and]
>
> . . . .
>
> L. Failing in the case of claims denials or offers of compromise settlement to promptly provide a reasonable and accurate explanation of the basis for such actions[.]

Under these rules, it is clear that insurers are not free to dispute claims on pretext, or to force claimants to litigate valid claims to judgment in the hope of wearing them down to accept a settlement for less than the value of the losses.

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31. The NAIC reports that the following jurisdictions (including only four states) have not adopted a version of the Model Act: Alabama, Guam, District of Columbia, Illinois, Iowa, Mississippi, and the Virgin Islands. *See* Nat'l Ass'n of Ins. Comm'rs, NAIC 900–05 (2002).

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The only question, then, is whether courts should enforce this clear statement of legislative policy through the development of common law causes of action. Although the obligations of the Unfair Claims Practices Act are subject to administrative enforcement by the state agency charged with regulating the business of insurance, nothing in the Act provides that administrative enforcement is the exclusive remedy for violations of the Unfair Claims Practices Act. In its infamous *Royal Globe*[32] decision, the California Supreme Court implied a cause of action for third-party claimants under its state Unfair Claims Practices Act,[33] only to reverse this decision nine years later as being unsupported by the statutory scheme of the Act.[34] But in holding that third-party claimants had no implied right under the Act to sue liability insurers for violating the provisions of the Act, the court emphasized that it was not precluding third-parties from suing insurers under common law theories:

> Moreover, apart from administrative remedies [available against insurers for violating provisions of the Act], the courts retain jurisdiction to impose civil damages or other remedies against insurers in appropriate common law actions, based on such traditional theories as fraud, [and] infliction of emotional distress . . . . Punitive damages may be available in actions not arising from contract, where fraud, oppression or malice is proved. In addition, prejudgment interest may be awarded where an insurer has attempted to avoid a prompt, fair settlement.[35]

Unless specifically precluded by the state's Unfair Claims Practices Act,[36] courts should be free to develop common law remedies that advance this

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32. Royal Globe Ins. Co. v. Superior Court, 592 P.2d 329 (Cal. 1979), *overruled by* Moradi-Shalal v. Fireman's Fund Ins. Co. 758 P.2d 58 (Cal. 1988).

33. *Royal Globe*, 592 P.2d at 332.

34. *Moradi-Shalal*, 758 P.2d at 75.

35. *Id.* at 68–69.

36. To my knowledge, in the post-*Royal Globe* era no state legislature has amended its insurance code to expressly insulate liability insurance carriers from common law theories of recovery.

Three states responded to the judiciary's reluctance to imply a cause of action by expressly amending the insurance code to provide a private right of action in favor of third-party claimants. *See* MONT. CODE ANN. § 33-18-242 (2001) (providing that insureds and third-party claimants may recover actual damages for a violation of certain provisions of the unfair claims practices act without having to prove that the violations were so frequent as to indicate a general business practice; but precluding common law actions alleging bad faith), N.M. STAT.

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ANN. § 59A-16-30 (Michie 2002) (permitting any person injured by a violation to bring an action for actual damages, in addition to any available common law remedies), *and* LA. REV. STAT. ANN. § 22:1220 (West 1995) (providing a cause of action for certain defined bad faith actions in settling third party claims). My argument that courts should use the tort of abuse of process to provide remedies to third-party claimants in certain circumstances obviously is superfluous as to jurisdictions that have expressly granted statutory rights to third-party claimants.

Some state legislatures amended their code to provide an express cause of action only for insureds. *See, e.g.*, NEV. REV. STAT. ANN. 686A.310(2) (Michie 1997) (establishing cause of action for insureds) *and* Gunny v. Allstate Ins. Co., 830 P.2d 1335, 1336 (Nev. 1992) (holding that the statutory cause of action is limited to insureds and is not available to third-party claimants). Consequently, the question of the rights of third-party claimants remains unanswered in the statute and is left to common law development.

A number of states have amended their insurance codes in a variety of ways to state expressly that there is no private cause of action under the Unfair Claims Practices Act, leaving open the question of the extent to which injured parties can recover under common law theories. Some states parallel the holding of *Moradi-Shalal* by stating that the unfair claims practices act has no effect on whatever rights a claimant might otherwise have under common law. *See* MD. CODE ANN. § 27-301(b)(2) (2002) ("This subtitle does not provide or prohibit a private right or cause of action to, or on behalf of, a claimant or other person in any state."). This clearly leaves courts free to develop common law remedies for aggrieved parties. Many states simply have amended their statutes to state clearly that there is no private right of action under the unfair claims practices act. *See, e.g.*, ALASKA STAT. § 21.36.125(b) (Michie 2002) ("The provisions of this section do not create or imply a private cause of action for a violation of this section."); ARIZ. REV. STAT. § 20-461(D) (2002):

> Nothing contained in this section is intended to provide any private right or cause of action to or on behalf of any insured or uninsured resident or nonresident of this state. It is, however, the specific intent of this section to provide solely an administrative remedy to the director for any violation of this section or rule related thereto.

See also GA. CODE ANN. § 33-6-37 (1998) ("Nothing contained in this article shall be construed to create or imply a private cause of action for a violation of this article."); ME. REV. STAT. ANN. tit. 24-A, § 21-64-D(8) (West 2000) ("This section may not be construed to create or imply a private cause of action for violation of this section."); TENN. CODE ANN. § 56-8-104(8) (2002) ("[A] private right of action shall not be maintained under this subdivision . . . ."). Other states make clear that actions under the statute may be initiated only by the insurance commissioner. *See, e.g.*, HAW. REV. STAT. § 431:13-107 (1993) ("All remedies, penalties and proceedings set forth in this article are to be invoked solely and exclusively by the commissioner."). Some states provide only that injured parties may file a complaint with the commissioner. *See, e.g.*, IND. CODE § 27-4-1-5.6(a) (1999) ("A person who believes the person has been adversely affected by an unfair claim settlement practice . . . may file a complaint with the commissioner."); OHIO REV. CODE ANN. § 3901.22(A) (Anderson 2002) ("Any person aggrieved with respect to any act that the person believes to be an unfair or deceptive act or practice in the business of insurance . . . may make written application to the superintendent for a hearing to determine if there has been a violation . . . .").

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legislative statement of public policy, especially since the importance of this public policy is reinforced by compulsory insurance laws and other indications of the important public interest in providing insurance payments to injured parties.

Finally, the facile doctrinal conclusion that a third-party claimant cannot be owed any duties because the insurer owes contractual and fiduciary duties to its insured falls apart on closer inspection. Twenty years ago, Justice Shirley Abrahamson of the Wisconsin Supreme Court persuasively argued that insurers should owe duties to third-party claimants, although she concurred in the majority's determination that the claimant in the case before the court had not stated a cause of action.[37] Because her analysis carefully uncovers the public interests that support imposition of tort duties on liability insurers, it merits lengthy quotation.

Justice Abrahamson begins by rejecting the simplistic notion that the absence of a direct contractual relationship between the parties precludes the existence of a duty:

Finally, some state legislatures have considered adding an express private cause of action to their Unfair Claims Practices Act, but have declined to do so, leading courts to interpret this as a legislative decision to preclude private rights of action. *See, e.g.,* Allstate Ins. Co. v. Watson, 876 S.W.2d 145, 149 (Tex. 1994). In *Watson*, the court noted that "in 1991, the legislature deleted a provision from H.B. 2 that would have provided a private cause of action . . . to any 'claimant' for unfair claim settlement practices," and concluded:

> [W]e cannot ignore the legislature's refusal to create a statutory private cause of action for unfair claim settlement practices for third party claimants . . . [and therefore] [w]e will not construe [the statutory cause of action for unfair competition and unfair business practices] to permit, indirectly, a third party claimant to sue an insurer for unfair claim settlement practices . . . where she may not do so directly and where the legislature has specifically refused to create such a cause of action.

Id. Although legislative inaction typically is unreliable guidance for interpreting a previously enacted statute, it seems plausible that, when faced with similar circumstances, courts may choose not to permit common law recovery for activity regulated under the state Unfair Claim Practices Act if it concludes that the legislature considered and rejected the idea that claimants should recover damages.

37. Kranzush v. Badger State Mut. Cas. Co., 307 N.W.2d 256, 271 (Wis. 1981) (Abrahamson, J., concurring) (the rationale in the majority opinion is quoted above, *supra* note 13). The plaintiff's administrator alleged that Badger delayed settling the plaintiff's claims for injuries caused by Badger's insured, knowing that the plaintiff was dying of cancer. *Id.* at 258. Given her willingness to impose duties on liability insurers in their dealings with third-party claimants, it is not clear from her concurring opinion why Justice Abrahamson agreed with the majority that the plaintiff's allegations did not state a claim for relief. *Id.* at 273.

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> For the majority to assert that the duty does not exist because there is no privity of contract is simply to restate the question presented to the court as a conclusion. . . .
>
> [I]n my view the insurance contract places the insurer in such a relationship with the victim that the victim is a third-party beneficiary of the insurance contract. . . .
>
> Our society regards the victim as a beneficiary of the insurance contract. . . .
>
> Legislative endorsement of this societal construction of insurance is shown by the enactment of direct action statutes, compulsory automobile liability insurance laws, and financial responsibility laws. These laws are predicated on the theory that the third-party victim is a third-party beneficiary of the insurance contract.[38]

In short, Justice Abrahamson takes a broader view of the insurance contract and rejects the narrow application of intended beneficiary principles.[39]

Even if courts refuse to impose a duty of good faith on insurers by recognizing that claimants are the intended beneficiaries of liability insurance contracts, Justice Abrahamson argues that there is good reason to find that insurers owe tort duties directly to third-party claimants. She reasons:

> The equitable principles of conscience and good faith are not by their nature limited to contractual relationships; these principles govern other relationships as well. Thus the question presented in this case is whether these concepts of fair dealing and public policy dictate that the court impose a duty of good faith on the insurer while negotiating with the third-party victim and liability for the tortious breach of the duty. . . .
>
> There are public policy reasons justifying the recognition of the insurer's duty of good faith to the third-party victim. Society has an interest in the just settlement of insurance claims, and this societal interest is substantially the same whether the injured party is the insured or a third-party.
>
> A third-party victim seeking recovery from the insurer is, as I see it, in substantially the same position as the first-party insured seeking benefits under a casualty policy. Both parties

38. *Id.* at 272–73.

39. As indicated in note 14, *supra*, courts have regularly rejected the claim that third-party claimants are the intended beneficiaries of liability insurance policies.

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> have been injured and both parties look to the insurance company for payment. When seeking payment under the policy both parties are in an adversarial relation with the insurance company. Both parties are generally in a relatively weaker bargaining position than the insurance company. Both parties can suffer as a result of the insurer's bad faith in settlement practices, and both parties may incur additional damage if payment of the claim is delayed. I recognize that the insured does buy the policy and pay the premiums and that the insurer and insured have obligations to each other under the contract which they do not have to the victim and which the victim does not have to them. Although the majority apparently takes the opposite view, I do not believe that the mutual obligations of the insurer and the insured are inconsistent with imposing on the insurer a duty to negotiate with the third-party victim in good faith.
>
> I conclude that the interests of the insured and the third-party victim as to the settlement practices of the insurer are largely the same and that the public has an interest in the settlement practices of the insurer whether the insurer is dealing with the insured or with a third-party victim. Insurance holds an important place in our industrial society. Insurance is recognized by the insured, the victim, the legislature and the public as a system for compensating the third-party victim for injuries caused by another. Imposing a duty on the insurer to negotiate in good faith with the third-party victim is consistent with the intent of the first-party insured and of the legislature and with the popular concept of insurance which views the third-party victim as an intended third-party beneficiary of the insurance contract.[40]

Justice Abrahamson acknowledges "that there are significant countervailing public policy considerations," but she notes that "these same arguments against third-party victims' bad faith claims are applicable to the court-recognized first-party insured's bad faith suit, and to the court-recognized employee workers compensation bad faith claim."[41]

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40. *Kranzush*, 307 N.W.2d at 274–75 (Abrahamson, J., concurring in the judgment).

41. *Id.* at 275 (citation omitted). Justice Abrahamson rejects the undefended decision by the majority to distinguish third-party claimants who are similarly situated to these other classes

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In summary, there are strong reasons grounded in well-articulated considerations of public policy to reject the uniform doctrinal rule that third-party claimants are owed no duties by liability insurers. Given the unanimity of this rule and its seemingly inescapable logic, however, it is unlikely that courts will choose to impose a broad duty of good faith on liability insurers in the absence of a decision by the legislature to create an express statutory cause of action for third-party claimants.[42] However, more narrow tort theories,

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of persons for all practical effects, notwithstanding the absence of a contract or a special statutory scheme of exclusive compensation for injured workers. *Id.* at 274–75.

42. After *Royal Globe* was reversed by *Moradi-Shalal*, consumer interest groups successfully lobbied the California legislature to provide a statutory cause of action for third-party claimants. Despite seemingly long odds, in 1999 the California legislature enacted the Fair Insurance Responsibility Act of 2000 (FAIR). 1999 Cal. Stat.720 (S.B. 1237). The Act was signed into law by Governor Davis on October 10, 1999, to become effective on January 1, 2000. FAIR survived the legislative process only because it was a compromise bill crafted with the assent of several large insurance carriers. *See* Henry B. LaTorraca, *Collision Course*, 23 L.A. LAW. 50, 52 (Mar. 2000) ("The final compromise legislation was supported by the Consumer Attorneys of California, Mercury Insurance Group, and several commercial lines insurers including AIG, Travelers, and the American Insurance Association."). FAIR did not fully restore the rights created by *Royal Globe*, but it did provide for direct actions by third-party claimants in certain circumstances.

However, FAIR did not survive long. The remaining industry opponents of the law gathered enough signatures to submit the new statute to the voters by referendum. *See* CAL. CONST. art. II, § 9(b). Subsequently, FAIR was rejected by a margin slightly exceeding 2–1. *See California Rejects Bad Faith Laws*, INS. ACCT., Mar. 13, 2000, *available at* 2000 WL 8649961. As might be expected, the sophisticated insurance lobby ran a well-financed campaign to defeat the Act, leading some newspaper editorial pages to charge that the insurers were engaging in deceptive tactics to avoid being held accountable for bad faith practices. *See, e.g., California Propositions—from 1A to 31*, S. F. EXAM'R, Mar. 6, 2000, at A17 ("Out-of-state insurance companies are spending $50 million trying to defeat [FAIR]. Their front organizations say a 'no' would save Californians from higher auto premiums. That is misleading drivel."); Paul Gullixson, *Vote Yes to Say No to This Scheme*, SANTA ROSA PRESS DEMOCRAT, Mar. 5, 2000, at G1:

> The worst example [of 'hyperbole—if not bare-faced lying' in] this [election] has been the campaign ads in opposition to [FAIR]. . . . [Insurers have] raised more than $50 million to make sure they win. All of this to defeat a state law designed to hold them accountable for following fair business practices.

Discerning a lesson in this tangled political storyline is difficult, to say the least. Although the legislature reacted favorably to the arguments by FAIR's proponents, it remains doubtful that there will be additional legislative action in light of the unsuccessful voter referendum. Other than a few states that already have enacted a private right of action as part of the state's unfair insurance claims practices act, *supra* note 36, it seems unlikely that there will be legislative action that obviates the need for a common law remedy.

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when interpreted in the context of the public policies at stake in the liability insurance setting, should provide some measure of relief for tort victims who suffer a second injury at the hands of a liability insurer seeking to maximize its profitability by refusing to settle valid claims. In the remainder of this Article, I argue that the relatively obscure tort of abuse of process might effectively be used to police some of the more egregious forms of bad faith by liability insurers.

III. A CONSERVATIVE PROPOSAL FOR VINDICATING THE IMPORTANT PUBLIC POLICY FAVORING GOOD FAITH HANDLING OF THIRD-PARTY CLAIMS: USING THE TORT OF ABUSE OF PROCESS TO HOLD LIABILITY INSURERS ACCOUNTABLE FOR BAD FAITH LITIGATION TACTICS DESIGNED TO FRUSTRATE LEGITIMATE CLAIMS BY THIRD-PARTY CLAIMANTS

Abuse of process provides a viable cause of action only for some of the extreme cases of insurer bad faith in the settlement of claims, and will not reach all instances in which an insurer refuses to deal fairly and expeditiously with a claimant solely for the insurer's financial gain. For example, an insurer that strings along an injured third-party claimant for many months without having any intention of offering a reasonable settlement until the claimant brings suit, and solely for the purpose of frustrating the claimant and motivating a reduced settlement, might be acting contrary to public policy but would not be abusing legal process in the course of this conduct. Similarly, an insurer would not be abusing legal process by aggressively investigating the third-party claimant's background for the purpose of causing embarrassment and distress, although certainly this conduct might violate important public policies.[43] Consequently, I characterize abuse of process as a "conservative" tool for vindicating the underlying public policy.

Beyond the limited scope of abuse of process generally, there are more specific doctrinal rules that make it a somewhat cumbersome tool in this setting. First, courts have attempted to narrow the tort by requiring some positive act beyond simply using legal process with an improper motive. Although this doctrinal position may be waning, it would pose serious problems for a claimant attempting to use abuse of process in a typical scenario of insurer bad faith. Additionally, liability insurers act in the context

43. *See generally* Kirchner v. Greene, 691 N.E.2d 107, 117 (Ill. App. Ct. 1998) (holding that there can be no abuse of process where no court process is involved).

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of providing a defense for their insured in the underlying dispute with the claimant, and courts generally have been wary of permitting the tort of abuse of process to thwart a defendant's right to mount a vigorous defense. Finally, the strong doctrinal rule that insulates liability insurers from tort liability for their bad faith claims settlement practices inevitably shapes the application of abuse of process in this setting. Courts are likely to be reluctant to permit claimants to use abuse of process to undermine the longstanding rule that liability insurers owe no duties to claimants. After discussing each of these doctrinal difficulties in turn, I conclude that abuse of process can and should play an important role in policing insurer conduct.

A. The Elements of the Tort of Abuse of Process

As defined in the *Restatement (Second) of Torts*, a party is liable for an abuse of process if that party uses civil or criminal process "against another primarily to accomplish a purpose for which [the process] is not designed."[44] The comment explains that the gravamen of the action is misusing properly obtained legal process to pursue improper objectives, rather than improperly securing the process itself. "Therefore, it is immaterial that the process was properly issued, that it was obtained in the course of proceedings that were brought with probable cause and for a proper purpose, or even that the proceedings terminated in favor of the person instituting or initiating them."[45] The party's liability rests on a "perversion" of the otherwise properly secured process.[46]

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44. RESTATEMENT (SECOND) OF TORTS § 682 (1977).

45. *Id.* at comment a. *See also* Friedman v. Dozork, 312 N.W.2d 585, 594–95 (Mich. 1981).

46. In the words of one court, "in addition to ulterior motive, one must . . . prove that there has been a perversion of the judicial process and achievement of some end not contemplated in the regular prosecution of the charge." Morowitz v. Marvel, 423 A.2d 196, 198 (D.C. 1980). *See also* D.D. v. C.L.D., 600 So. 2d 219, 221 (Ala. 1992) (stating that "it is the malicious perversion of a regularly issued process to accomplish a purpose whereby a result not lawfully or properly obtainable under it is secured."); Younger v. Solomon, 113 Cal. Rptr. 113, 118 (Cal. Ct. App. 1974) (explaining that liability attaches for "an act done under the authority of the court for the purpose of perpetrating an injustice, i.e., a perversion of the judicial process to the accomplishment of an improper purpose."); Cisson v. Pickens Sav. & Loan Ass'n, 186 S.E.2d 822, 826 (S.C. 1972) (explaining that "it is the malicious misuse or perversion of the process for an end not lawfully warranted by it that constitutes the tort known as abuse of process."). This characterization of the tort was acknowledged by the Supreme Court in *Heck v. Humphrey*, 512 U.S. 477, 486 n.5 (1992) (recognizing that the "gravamen of [the] tort is not the wrongfulness of the prosecution, but some extortionate perversion of lawfully initiated process to illegitimate ends.").

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This tort would seem to encompass the use of legitimate process by liability insurers for an improper purpose, as would be the case if the insurer initiated extensive discovery and filed excessive motions primarily to wear down the third party claimant and induce a discounted settlement rather than for the purpose of obtaining relevant information regarding the dispute. However, this seemingly straightforward basis for imposing tort liability has been obscured in the case law. Courts have specified more detailed "elements" of the tort in order to narrow its application and prevent every lawsuit from endlessly cycling through subsequent litigation attacking the conduct of one's opponent in the previous litigation. In particular, many jurisdictions have required some act additional to the issuance of process before liability will attach. This additional requirement typically is expressed in the following manner:

> To recover upon a theory of abuse of process, a plaintiff must prove (1) an ulterior purpose and (2) an act in the use of process which is improper in the regular prosecution of the proceeding. An example of a meritorious abuse of process claim is where the defendant has used a proper legal procedure for a purpose collateral to the intended use of that procedure. A bad motive alone will not establish an abuse of process. Rather, there must be some corroborating act that demonstrates the ulterior motive.[47]

This leads courts to conclude that when "nothing more than carrying out the process to its authorized conclusion has occurred, no cause of action for abuse of process exists."[48] Consequently, it "is frequently said that an additional

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47. Schohl v. Lodge & Shipley Co., No. 180137, 1997 Mich. App. LEXIS 1479, at *12–*13 (June 13, 1997) (citations omitted). *See also* Brishky v. State, 479 N.W.2d 489, 494 (S.D. 1991); Thompson v. Beecham, 241 N.W.2d 163, 166 (Wis. 1976).

48. Humphrey v. Herridge, 653 A.2d 491, 494 (Md. App. 1995). *See also* Wells. v. Orthwein, 670 S.W.2d 529, 533 (Mo. Ct. App. 1984) (explaining that "no liability is incurred when the defendant has done nothing more than pursue the lawsuit to its authorized conclusion regardless of how evil his motive may be."); Toltec Watershed Improvement Distrib. v. Johnston, 717 P.2d 808, 811 (Wyo. 1986):

> Some definite act or threat not authorized by the process, or aimed at an objective not legitimate in the use of the process, is required; and there is no liability where the defendant has done nothing more than carry out the process to its authorized conclusion, even though with bad intentions.

(citations and internal quotations omitted). *See generally,* FOWLER V. HARPER, FLEMING JAMES JR., & OSCAR S. GRAY, 1 THE LAW OF TORTS § 4.9 at 4:89–4:105 (3d ed. 1996 & Supp. 2002) [hereinafter LAW OF TORTS].

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willful act is required, after the issuance of the process, an act not proper in the normal course of execution or conduct of the process and in furtherance of the collateral objective."[49]

The motivation for this requirement is clear: given that the process was legally issued, if courts did not require an additional act (such as a threat to institute or maintain the process unless the victim agrees to an unrelated concession) the tort would amount to punishing bad motives and conceivably could lie with respect to every civil case. The classic explanation offered by courts makes clear the intent to free parties from potential liability based on alleged hidden motives of ill will:

> It is not enough that the actor have an ulterior motive in using the process of the court. It must further appear that he did something in the use of the process outside of the purpose for which it was intended. Every one has a right to use the machinery of the law, and bad motive does not defeat that right. There must be a further act done outside the use of the process—a perversion of the process.[50]

But even within this classic statement, the court immediately goes on to acknowledge that the requirement of an "additional act" might be satisfied solely by the party's use of the process to achieve an aim that is not the legitimate purpose of the process:

> If he uses the process of the court for its proper purpose, though there is malice in his heart, there is no abuse of the process. . . . As soon as the actor uses the process of the court, not to effect its proper function, but to accomplish *through it* some collateral object, he commits this tort.[51]

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49. LAW OF TORTS, *supra* note 48, at 4:90. *See Friedman*, 312 N.W.2d at 595 (explaining that the court need not determine whether the defendant acted with an ulterior purpose, "since it is clear that the plaintiff clearly has failed to allege that the defendants committed some irregular act in the use of process."); Reynolds v. McEwen, 416 So. 2d 702, 706 (Ala. 1982) (stating that an ulterior purpose must be accompanied by "a willful act in the use of the process not proper in the regular conduct of the proceeding.").

50. Hauser v. Bartow, 7 N.E.2d 268, 269 (N.Y. 1937) (citations omitted), *quoted in* LAW OF TORTS, *supra* note 48, at 4:89–90, n.19.

51. *Id.* (emphasis added). Similarly, after stating the requirement of an additional act, one court hastened to note:

> We add that where there is a genuine issue as to whether a defendant's "further acts" were maliciously intended as an abuse of process, the plaintiff may demonstrate that defendant had secured issuance of the process without

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Read in its entirety, the statement of the rule seems to suggest that using process to achieve a collateral (and wrongful) objective should give rise to liability notwithstanding the required additional act.

As argued in the recently revised Harper, James & Gray treatise, *Law of Torts*, the requirement of an act additional to the process itself may be a misleading and inaccurate requirement, since the actor may achieve an improper goal simply by initiating process and letting it play out in the ordinary course.[52] This reasoning challenges the traditional rule as defended in Prosser and Keeton's treatise,[53] and has been adopted in some jurisdictions. The Iowa Supreme Court has expressly jettisoned the traditional requirement of an additional act:

> We do not believe the tort requires any subsequent action. . . . Such activity may be very probative in determining the intent to abuse; however, there need not be such a subsequent action to commit the tort. To rule otherwise would protect the tortfeasor when the abuse is most effective—where the issuance of the process alone is sufficient to accomplish the collateral purpose.[54]

> reason or probable cause as evidence that his ultimate intent was to use it for a purpose ulterior to the one for which it was designed.

Tedards v. Auty, 557 A.2d 1030, 1035 (N.J. Super. Ct. App. Div. 1989).

52. As they explain:

> Process could be issued with the primary objective of achieving an improper collateral purpose through its normal application, although a formally correct ostensible purpose is pursued incidentally. If the process is thus used for both a proper and an improper purpose, but it can be proved that the user's motivation is primarily the attainment of the latter, misuse would appear to be inherent in the normal use of the process itself. . . . [I]t is by no means clear why in such a case the actor must do something "in the use of the process outside the purpose for which it is intended." A "further act done outside the use of the process" is hardly necessary to establish "perversion of the process."

LAW OF TORTS, *supra* note 48, at 4:90–91 n.21 (quoting *Hauser*, 7 N.E.2d at 269, discussed in text accompanying note 50, *supra*).

53. *Id.* at 4:91 n.21 (challenging analysis in W. PAGE KEETON ET AL, PROSSER AND KEETON ON THE LAW OF TORTS 898 (5th ed. 1984)).

54. Mills County State Bank v. Roure, 291 N.W.2d 1, 5 (Iowa 1980).

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Other courts have endorsed this reasoning and grounded the imposition of liability on the use of process for an illegitimate purpose, rather than requiring an act in addition to the process itself.[55]

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55. *See* Givens v. Mullikin, 75 S.W.3d 383, 403 (Tenn. 2002) (quoting *Mills*, 291 N.W.2d at 5); Richardson v. Rutherford, 787 P. 2d 414, 421 (N.M. 1990) (quoting *Mills*, 291 N.W.2d at 5); Vittands v. Sudduth, 730 N.E.2d 325, 332 (Mass. App. Ct. 2000):

> The essential elements of the tort of abuse of process are "(1) 'process' was used; (2) for an ulterior or illegitimate purpose; (3) resulting in damage." . . . Further, "the ulterior motive may be shown a direct demand for collateral advantage; or it may be inferred from what is said or done about the process."

Id. at 332 (citations omitted); Bd. of Educ. of Farmingdale Union Free Sch. Dist. v. Farmingdale Classroom Teach. Ass'n, 343 N.E.2d 278, 283 (N.Y. 1975) (specifying that the three essential elements of the tort are: "regularly issued process," by a person "moved by a purpose to do harm," by "seeking some collateral advantage of corresponding detriment to the plaintiff which is outside the legitimate ends of the process.").

A case decided earlier this year exemplifies the state of flux on this doctrinal point. In *Food Lion, Inc. v. United Food & Commercial Workers Int'l Union*, 567 S.E.2d 251 (S.C. Ct. App. 2002), the court affirmed the dismissal of a claim of abuse of process brought by a grocery chain alleging that a union had funded and directed employment litigation against the grocer for collateral purposes, holding that the grocer had not sufficiently pleaded a "willful act" in the use of process beyond the mere issuance of process. The court's reasoning appears to endorse the traditional requirement of an "additional act" beyond mere ulterior motive:

> Food Lion's argument is premised on its belief that alleging the Union undertook the acts "for collateral purposes" sufficiently alleges the improper nature of the acts. We disagree. An allegation of an ulterior purpose or "bad motive," standing alone, is insufficient to assert a claim for abuse of process.
>
> . . .
>
> Furthermore, although an ulterior purpose may be inferred from an improper willful act, "the inference is not reversible and it is not possible to infer [improper] acts from the existence of an improper motive alone."

Id. at 255 (quoting W. PAGE KEETON, PROSSER AND KEETON ON THE LAW OF TORTS, § 121 at 899 (5th ed. 1984)). However, the court was merely reaffirming that liability attaches only if the process is issued *primarily* for purposes other than its legitimate purpose of the process, emphasizing that liability cannot lie if the plaintiff merely alleges an improper motive in connection with the issuance of the process and does not allege further that the party was not using the process for its legitimate purpose. *Id.* at 256. Because the union was funding lawsuits by individual employees seeking redress for wrongful termination and other employment-related causes of action, the majority quite properly found that Food Lion would have to allege that the suits and related process were not pursued for their stated purpose (to secure compensation for wronged employees), but rather were primarily issued for the collateral and illegitimate goal. *Id.*

Accordingly, liability exists not because a party merely seeks to gain a collateral advantage by using some legal process, but because the collateral objective was its sole or paramount reason for acting:

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In addition to the movement in some jurisdictions to reject explicitly the "additional act" requirement, there has also been a more general movement by some courts away from technical requirements limiting the scope of the tort. There has always been an overlap between abuse of process and its "kissing cousin,"[56] malicious prosecution. In fact, abuse of process developed as a means of overcoming the doctrinal limitations of malicious prosecution.[57]

> For the cause of action to exist, there must be a use of the process for an *immediate* purpose other than that for which it was designed. There is no abuse of process, however, when the process is used to accomplish the result for which it was created, regardless of an incidental or *concurrent* motive of spite or ulterior purpose. . . . It therefore follows that . . . the ulterior purpose allegation must be accompanied by an allegation that the process was misused by the undertaking of the alleged act, not for the purpose for which it was intended but for the primary purpose of achieving a collateral aim.

Id. at 256 (citing Scozari v. Barone, 546 So.2d 750, 751 (Fla. Dist. Ct. App. 1989) (emphasis added)). In other words, the fact that the union may have an ulterior motive of causing Food Lion to incur costs and to suffer business disruptions does not transform an appropriate use of legal process in employment litigation into tortious behavior.

This holding does not preclude a finding of liability if a third-party claimant could prove that an insurer filed extensive discovery requests and motions for the primary purpose of wearing down the claimant rather than for the purpose of the process (i.e., obtaining information or evidence relevant to the litigation, or clarifying the pleading). Such an allegation of facts could meet the test of pleading a "willful act," defined by the court as "1) a 'willful' or overt act 2) 'in use of the process' 3) that is improper because it is either (a) unauthorized or (b) aimed at an illegitimate collateral objective." *Id.* at 254. It is a mistake to conflate the court's reasoning to conclude that an additional act is required, beyond the issuance of the process, to establish that the process was abused.

56. *See* Berman v. Karvounis, 518 A.2d 726, 726 n.1 (Md. 1987) (quoting R.P. GILBERT, P.T. GILBERT & R.J. GILBERT, MARYLAND TORT LAW HANDBOOK § 5.0 (1986)).

57. Brownsell v. Klawitter, 306 N.W.2d 41, 44 (Wis. 1981) ("The tort of abuse of process was developed to provide a remedy in situations where malicious prosecution failed."); Clark Equip. Co. v. Wheat, 154 Cal. Rptr. 874, 885 (Cal. Ct. App. 1979) ("The tort evolved as a 'catch-all' category to cover improper uses of the judicial machinery that did not fit within the earlier established *but narrowly circumscribed*, action for malicious prosecution.") (emphasis in original); Italian Star Line v. United States Shipping Bd. Emergency Fleet Corp., 53 F.2d 359, 361 (2d Cir. 1931):

> It has been observed by the courts on several occasions that the elements vital to an action for abuse of process are not clearly defined, either by the cases or by writers on the subject. . . . The reason apparently is that the term has been used as a label for a variety of dissimilar situations which have in common only the fact that actionable injury was inflicted in connection with the use of judicial process and under circumstances such that the narrowly circumscribed action of malicious prosecution was inapplicable.

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Many of the cases dealing with the doctrinal requirements of abuse of process are motivated by an effort to distinguish these two closely related torts.[58] More recently, however, some courts have recognized that this line-drawing is counterproductive because it obscures the principled policy reasons for imposing liability, leading them to do away with the distinction altogether in favor of a single cause of action that returns to the core focus of abuse of process: the use of otherwise properly issued process to cause injury to another.[59] Thus, the New Mexico Supreme Court explained that the new tort of "malicious abuse of process" could be triggered by a litigant misusing "the law primarily for the purpose of harassment or delay,"[60] reaffirming its earlier rejection of the "additional act" requirement under the old tort of abuse of process.[61]

Whether an additional act is a necessary element of abuse of process is likely to be determinative when a claimant is seeking to apply the tort to a liability insurer in the insurance defense setting. In the typical insurance bad faith scenario where a claim of abuse of process might lie, an insurer would

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For a description of how abuse of process evolved out of the tort of malicious prosecution, and its early articulation under New York law, see *Bd. of Educ. of Farmingdale Union Free Sch. Dist. v. Farmingdale Classroom Teach. Ass'n*, 343 N.E.2d 278, 281–82 (N.Y. 1975).

58. *See* Tedards v. Auty, 557 A.2d 1030, 1035 (N.J. Super. Ct. App. Div. 1989):

> To preserve the distinction between the two torts, we have emphasized that process has not been abused unless after its issuance the defendant reveals an ulterior purpose he had in securing it by committing "further acts" whereby he demonstrably uses the process as a means to coerce or oppress the plaintiff.

As to the recognition by courts that the torts need to be more carefully distinguished, *see generally* Simon v. Navon, 71 F.3d 9, 15 (1st Cir. 1995) ("The torts of abuse of process and malicious prosecution frequently are confused because of their close relationship."); *Bd. of Educ. of Farmingdale*, 343 N.E.2d at 280–81 (noting that the two torts are "frequently confused.").

59. *See* Devaney v. Thriftway Mktg. Corp., 953 P.2d 277, 283 (N.M. 1997) ("we conclude that these torts should be restated as a single cause of action, which shall be known as 'malicious abuse of process.'"); Yost v. Torok, 344 S.E.2d 414, 417 (Ga. 1986) (recognizing a single tort of abusive litigation); LAW OF TORTS, *supra* note 48, at 4:107 (arguing that courts should acknowledge that they "themselves facilitate wrongdoing in litigation by the proliferation of unnecessarily detailed 'rules' and 'elements' in their attempt to define [and thereby distinguish] these torts.").

60. *Devaney*, 953 P.2d at 287.

61. *Id.* at 285 (reaffirming the holding of *Richardson v. Rutherford*, 787 P.2d at 421–22 (N.M. 1990) and concluding that the overt act necessary for imposition of liability can be satisfied by the improper or irregular use of process to cause delay or harassment, or as a means of extortion).

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seek to induce a below-market settlement by endlessly delaying the proceedings and forcing the third-party claimant to contend with voluminous discovery requests and motions that are motivated primarily by the collateral goal of wearing down the claimant financially and emotionally. If a jurisdiction continues to adhere to a requirement of some additional act beyond the issuance of process, it might be difficult to allege abuse of process in such typical circumstances because the insurance carrier accomplishes its ulterior objective solely by allowing the legally issued process to play itself out. On the other hand, if courts confront this scenario in which the abuse of process requires no act beyond the issuance of the process itself to obtain the illegitimate result, they might be motivated to acknowledge the overly narrow approach to abuse of process in the traditional formulation.

In addition to the doctrinal uncertainty about the elements of abuse of process, there are independent limitations on the scope of the tort. For example, the First Amendment constitutional guarantee of freedom of speech might require the plaintiff to meet a higher burden of proof to avoid dismissal of an action for abuse of process.[62] Although first amendment considerations might not apply to the standard insurance defense scenario, a related limitation on abuse of process actions might make it more difficult for claimants to recover against insurers. A number of states have adopted a "litigation privilege" that insulates parties from liability for communicative acts during the course of litigation, with the obvious goal of preventing an endless cycle of lawsuits. California's statutory litigation privilege has been read quite broadly by the courts and expressly trumps an otherwise valid claim of abuse of process.[63] In *Doctor's Co. Insurance Services v. Superior Court*,[64] a victim

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62. *See* Protect Our Mountain Env't, Inc. v. Dist. Ct., 677 P.2d 1361, 1369 (Colo. 1984) (en banc) (suit alleging that environmental group brought an administrative appeal to delay and harass a developer must be dismissed unless "the defendant's administrative or judicial claims were devoid of reasonable factual support, or, if so supportable, lacked any cognizable basis in law for their assertion," in addition to other criteria). *See also* Oregon Natural Res. Council v. Mohla, 944 F.2d 531, 533 (9th Cir. 1991) (applying the "sham exception" to the *Noerr-Pennington* constitutional doctrine). Several states have passed statutes designed to prevent strategic lawsuits against public participation (anti-SLAPP statutes) that extend this doctrine. *See generally* Baker v. Parsons, 750 N.E.2d 953, 961–62 n.19 (Mass. 2001) (describing the heightened showing necessary under various state anti-SLAPP statutes to avoid dismissal of tort claims).

63. California law provides that a "privileged publication or broadcast is one made . . . in any . . . judicial proceeding." CAL. CIV. CODE § 47(b) (West 1982 & Supp. 2003). The courts have interpreted this privilege to have a wide scope, in the interest of promoting the effectiveness and finality of judicial proceedings. *See* Silberg v. Anderson, 786 P.2d 365, 372–

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of medical malpractice sued the tortfeasor's liability insurer, alleging that the insurer hid the insured doctor's admitted liability for three years in an effort to browbeat her into settling her claim, going so far as to suborn perjured deposition testimony by the insured and another doctor.[65] Although the Court acknowledged that these allegations stated a viable cause of action,[66] it concluded that the claimant's suit was barred by the absolute litigation privilege because the insurer's role in the litigation effectively made it a "participant" for purposes of the statutory protection.[67] Although the reported law dealing with the insurance defense context under California law is scarce, and the few cases from other jurisdictions are mixed,[68] it is reasonable to

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73 (Cal. 1990). All doubts as to whether the privilege applies are to be resolved in favor of applying it, Morales v. Coop. of Am. Physicians, Inc., 180 F.3d 1060, 1062 (9th Cir. 1999), and the privilege extends even to an act committed fraudulently or with malice, O'Keefe v. Kompa, 100 Cal. Rptr.2d 602, 605 (Ct. App. 2000). Consequently, the absolute privilege extends beyond actions for defamation and precludes suits for abuse of process that relate to "communicative acts" such as filing a lien for an improper purpose. *See, e.g.,* Honea v. Bank of Am. Corp., 2001 WL 1649229 (Cal. Ct. App. Dec. 21, 2001) (filing an abstract of judgment as a lien before the verdict became final may be an abuse of process, but it is protected by the absolute privilege); Brown v. Kennard, 113 Cal. Rptr. 2d 891, 899 (Ct. App. 2002) (wrongful levying on exempt funds is protected by litigation privilege; the court held that "the policy underlying the litigation privilege of encouraging free access to the courts by discouraging derivative litigation simply outweighs the policy of providing [the plaintiff] with a tort remedy for an allegedly wrongful enforcement of a judgment."); Microsoft Corp. v. BEC Computer Co., Inc., 818 F. Supp. 1313, 1319 (C.D. Cal. 1992) (holding that even the filing of improper or meritless pleadings, with an ulterior and wrongful motive, is privileged and does not constitute an abuse of process).

64. 275 Cal. Rptr. 674 (Ct. App. 1990).

65. *Id.* at 676–77.

66. *Id.* at 678. The plaintiff alleged intentional infliction of emotional distress rather than abuse of process because she was seeking to come within the opening provided by *Moradi-Shalal* when, in the course of reversing *Royal Globe*, the court acknowledged that claimants might still have a viable common law cause of action for infliction of emotional distress. *Id.* *See* Moradi-Shalal v. Fireman's Fund Ins. Co., 758 P.2d 58, 69 (Cal. 1998).

67. *See Doctor's Co.*, 275 Cal. Rptr. at 680.

68. *Compare* Gen. Refractories Co. v. Fireman's Fund Ins. Co., 2002 WL 376923, at *4 (E.D. Pa. Feb. 28, 2002) (holding that claim of abuse of process against insurance defense counsel for "abusive discovery tactics and improper motion practice in order to gain a litigation advantage" is overcome by the absolute litigation privilege, requiring dismissal of the abuse of process count) *with* Am. Nat'l. Title & Escrow of Fla. v. Guar. Title & Trust Co., 810 So. 2d 996, 998 (Fla. Dist. Ct. App. 2002) (holding that litigation privilege does not insulate a party from liability for claims of abuse of process and malicious prosecution founded on allegations that it gave false information for the malicious purpose of inducing a wrongful arrest, distinguishing an earlier opinion in the same case (748 So.2d 1054 (Fla. Dist. Ct. App. 1999))

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conclude that if a court reads the litigation privilege broadly, it will likely curtail the effective use of abuse of process against liability insurers acting in bad faith in the settlement and litigation of claims by third parties.

In summary, the "additional act" requirement and the potential applicability of the litigation privilege might pose problems for holding liability insurers responsible for abuse of process when they use the machinery of civil litigation to harass and wear down claimants. However, even where these potential doctrinal problems exist, they need not be disabling. There is some indication that courts might use the context of a lawsuit against a liability insurer to rethink the doctrinal elements and to acknowledge the viability of abuse of process even in face of the litigation privilege, in line with recent decisions. Even so, it will likely be a rather circumscribed set of cases that can successfully be addressed with abuse of process.

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that precluded recovery for abuse of process from defense counsel acting pursuant to a duly issued court order placing certain corporate records into receivership).

A recent New Jersey case exemplifies the complex issues raised when a defendant seeks to overcome an abuse of process claim by relying on the litigation privilege. In Baglini v. Lauletta, 717 A.2d 449 (N.J. Super. 1998), *rev'd and remanded* 768 A.2d 825 (N.J. Super. Ct. App. Div. 2001), the trial court entered judgment on a jury verdict for abuse of process against a defense attorney and his clients. The trial judge reasoned "that at its core, an abuse of process claim is inherently inimical to a litigation privilege and taken to its logical extreme, could emasculate the tort entirely," and therefore concluded "that no reasonable basis exists to immunize attorneys from civil liability where it can be shown that they have abused process which has injured third persons," since the litigation privilege insulates only communications intended to further the *legitimate* purposes of the litigation. *Id.* at 454–56. However, the Appellate Division reversed and vacated this judgement, finding that the defendants' actions were shielded by the litigation privilege. Baglini v. Lauletta, 768 A.2d 825 (N.J. Super. Ct. App. Div. 2001). The Appellate Division did not reject the proposition that attorneys can be held liable for abuse of process; instead, the court found on the facts of the case that the defense attorneys were acting within the scope of the privilege. *Id.* at 834 ("The litigation privilege applies here because the 'communications' were made by the attorney for a litigant authorized to make them, were intended to achieve the objectives of the litigation, and had a logical relation to the [underlying] litigation . . . ."). The clear lesson of this case is that allegations of abuse of process against defendants and their counsel will require a careful, fact-sensitive analysis in light of the litigation privilege.

Although no state appears to have interpreted its litigation privilege as broadly as California, this issue is likely to be a factor in litigation against liability insurers on account of their motion and discovery practice since most states simply have not considered whether such conduct would be protected by a litigation privilege.

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B. The "Problem" of Holding Defendants Accountable for Abuse of Process

It is easy to conceive of situations in which the plaintiff in the underlying litigation might later be held liable in tort for an abuse of process. Although a plaintiff may properly secure a lien or attachment of property, the court might determine that the plaintiff is using this otherwise valid process to pursue collateral and illegitimate goals.[69] But it is less clear how a defendant in civil litigation might be abusing process, since the defendant has been dragged into the litigation and presumably should be afforded a wide berth to contest the claims against it vigorously. In a classic statement, the Illinois Supreme Court reasoned that

> the defendant may present any defense to such action that he may have or that he may deem expedient, and in so doing he will not be subjecting himself to a second suit by the plaintiff based on the wrongful conduct of the defendant . . . in defending the action. The rule is the same even though the wrongful conduct of the defendant is willful, intentional, malicious or fraudulent.[70]

In short, there is a strong presumption that a defendant should not incur potential tort liability for the manner in which it defends itself.

This presumption is manifest in the general refusal by courts to acknowledge a tort of "malicious defense" that would mirror the cause of action for malicious prosecution. The California Supreme Court has emphasized the distinction between defending an action and prosecuting an action, holding that a defendant may be held liable for maliciously prosecuting a cross-complaint or counterclaim, but cannot be held liable for maliciously

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69. One court recently described typical abuse of process scenarios as offering to terminate a proceeding in return for a payment and filing a lien for the purpose of coercing the plaintiff to pay an unrelated debt. Sands v. Living World Fellowship, 34 P.3d 955, 960 (Ala. 2001). Similarly, a treatise describes the paradigm cases as involving the use of process to extort a payment of money. LAW OF TORTS, *supra* note 48, at 4:87–88 (illustrations include issuing a subpoena to cause inconvenience and thereby coerce payment of a debt, and excessive attachment to secure payment of a debt). *See also* Wachter v. Gratech, 608 N.W.2d 279, 287 (N.D. 2000) (stating that the "improper purpose usually takes the form of coercion to obtain a collateral advantage, not properly involved in the proceeding itself, such as the surrender of property or the payment of money, by the use of the process as a threat or a club.").

70. Ritter v. Ritter, 46 N.E.2d 41, 44 (Ill. 1943).

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defending against claims asserted by the plaintiff.[71] The result of this judicial attitude, two commentators note, is that "a defendant who . . . acts in bad faith for his financial gain or to injure a plaintiff for personal reasons, or who simply believes that this is how the litigation game is played, may use the litigation process for malicious and improper purposes without being held accountable."[72] Because this rule provides an important backdrop for any effort to impose liability for abuse of process on insurers who are defending the action, I begin by reviewing the near-unanimous rejection by courts of a general cause of action for "malicious defense."

Courts generally justify their refusal to recognize a tort of malicious defense along two lines of analysis. First, courts are hesitant to impose liability on a party that vigorously defends itself after involuntarily being subjected to legal process, with involuntariness being the key distinguishing feature between a party who defends maliciously and a plaintiff who maliciously prosecutes an action:

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71. Bertero v. Nat'l. Gen. Corp., 118 Cal. Rptr. 184, 190–92 (1975) (In Bank). The court reasoned:

> Defendants invoke a line of cases headed by Eastin v. Bank of Stockton, [4 P. 1106 (Cal. 1884)] in which various courts have refused to recognize a tort of malicious defense. . . . We do not propose to establish such a tort by our holding here. The *Eastin-Ritter* cases protect the right of a defendant, involuntarily haled into court, to conduct a vigorous defense. By seeking affirmative relief, however, defendants in the instant case did more than attempt to repel Bertero's attack; they took the offensive in attempting to prosecute a cause of action of their own. When such action is prompted by malice and is not based on probable cause, it is actionable as in the case of other affirmative, malicious prosecutions.

Id. at 191 (internal citations omitted). The Court later moved in this direction by recognizing a cause of action for tortiously denying the existence of a valid contract in *Seaman's Direct Buying Service, Inc. v. Standard Oil Co.*, 686 P.2d 1158, 1167 (Cal. 1984) (In Bank), but eventually reversed this decision in *Freeman & Mills, Inc. v. Belcher Oil Co.*, 900 P.2d 668, 675–76 (Cal. 1995) (describing the confusion generated in the lower courts by limiting the cause of action to wrongful denial of the existence of a contract). Justice Mosk concurred in the judgment but dissented from the reasoning, arguing that there should be some cases in which tort liability is triggered, but he nevertheless noted that the Court has "consistently refused to recognize a tort of 'malicious defense' that would be equivalent to malicious prosecution. The refusal to recognize such a tort 'protect[s] the right of a defendant, involuntarily haled into court, to conduct a vigorous defense.'" *Freeman & Mills*, 900 P.2d at 688 (Mosk, J. concurring in judgment and dissenting) (quoting *Bertero*, 118 Cal. Rptr. at 191).

72. Jonathan K. Van Patten & Robert E. Willard, *The Limits of Advocacy: A Proposal for the Tort of Malicious Defense in Civil Litigation*, 35 HASTINGS L.J. 891, 899 (1984).

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> The malicious plaintiff in a civil action institutes proceedings without probable cause and with malice. Because the defendant is haled into court, all of the defendant's resulting financial, emotional, and reputational injuries are attributable to the plaintiff's malicious conduct. The malicious defendant, in contrast, raises or continues an ungrounded and malicious defense merely to resist the claim of a plaintiff already before the court. Unlike the defendant targeted by a malicious prosecution, the plaintiff who encounters a malicious defense voluntarily entered the judicial system and must be held to accept, to some degree, the costs and risks of litigation. When this plaintiff ultimately prevails in the action, at best only a portion of the plaintiff's litigation costs and damages can be attributed to the malicious defense.[73]

This reasoning is unpersuasive as a general matter,[74] but particularly so in the insurance defense context. If an injured party with clear evidence of liability and damages is forced to bring suit against a regulated liability insurer that has been paid to provide compensation and is statutorily obligated to do so in good faith, only then to endure ten years of harassing tactics and delay, it is difficult to conclude that the plaintiff should be held to have assumed the "risk" of this behavior merely by being forced to commence the litigation as a result of the insurer's stonewalling tactics. Although courts certainly should not circumscribe the ability of a party to defend against claims vigorously, there is a point where the defense becomes malicious rather than vigorous. "A line must be drawn between the vigorous and good faith assertion of defenses that may turn out to be wrong and the malicious and baseless assertion of defense which are clearly wrong," and the need to draw this line is no

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73. Aranson v. Schroeder, 671 A.2d 1023, 1032 (N.H. 1996) (Thayer, J., dissenting).

74. For example, consider a typical business dispute in which the plaintiff pleads multiple claims and the defendant pleads multiple counterclaims. If the plaintiff defends against the counterclaims by maliciously abusing civil process, should this behavior really be treated differently for the purpose of imposing liability than if the plaintiff maliciously abuses process in the course of prosecuting its original complaint? What if the plaintiff's abuse of process in defense against the counterclaims is motivated by a desire to maximize its ability to prevail on the claims in its complaint? And is there a legitimate distinction, grounded in the concept of "voluntariness," between a plaintiff that maliciously defends against a counterclaim and a defendant that maliciously prosecutes that same counterclaim? Isn't it realistic to concede that defendants "are no more able to resist the temptations of excess advocacy than plaintiffs" and therefore to match the action for malicious prosecution with an action for malicious defense? Van Patten & Willard, *supra* note 72, at 893.

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different than the same need to draw a line in the malicious prosecution context.[75]

A second justification for refusing to recognize a cause of action for malicious defense is the fear of inviting never-ending litigation. For example, a plaintiff who prevails in the litigation but then finds the defendant judgment-proof would be tempted to sue the defendant's lawyers for malicious defense tactics; similarly, a plaintiff who loses the litigation might seek the proverbial "second bite at the apple" by attributing its loss to malicious defense tactics.[76] Moreover, if courts attempt to prevent a flood of secondary litigation with strict doctrinal rules, the result may be to undermine the effectiveness of the tort. For example, if courts limited the tort of malicious defense to those cases in which the aggrieved party prevailed in the underlying litigation, there would be a risk that the worst kind of malicious defense tactics will not be reached.

> Thus, a defendant whose egregious conduct is unsuccessful in obtaining a defendant's verdict may be subject to a malicious defense action, but a defendant whose egregious conduct successfully defeats the plaintiff's suit is not liable. This unlikely result gives the remedies available through a malicious defense action only to those plaintiffs who least need it, i.e., those who prevailed despite the malicious defense.[77]

Although never-ending litigation is a legitimate fear, it is no less a fear in the context of malicious prosecution. And efforts by courts to circumscribe a general tort of malicious defense with additional prerequisites, similar to requiring "additional acts" for an abuse of process, will likely undermine and obscure the ground for liability rather than clarifying it.

The weaknesses in the arguments supporting the traditional rule led the New Hampshire Supreme Court to recognize a new cause of action for malicious defense in a case in which defense counsel manufactured evidence and gave false testimony in previous litigation.[78] The court concluded that the potential for sanctions in the form of attorney's fees was insufficient to compensate the plaintiff for the entire range of emotional and financial losses

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75. *Id.* at 934.

76. *Aranson*, 671 A.2d at 1032 (Thayer, J., dissenting).

77. *Id.* at 1033 (Thayer, J., dissenting).

78. *Id.* at 1027 ("Is a plaintiff less aggrieved when the groundless claim put forth in the courts is done defensively rather than affirmatively in asserting a worthless lawsuit for improper purposes? We think not.").

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caused by the malicious defense.[79] The court's articulation of the elements of this new cause of action clearly would encompass typical forms of bad faith practices by liability insurers. The court imposed liability if a defendant knowingly defended an action without probable cause, and primarily for an improper purpose "such as to harass, annoy or injure, or to cause unnecessary delay or needless increase in the cost of litigation."[80] However reasonable it might be to apply the principles of malicious prosecution to the defense of a civil action, though, it appears likely that the longstanding unwillingness to apply malicious prosecution principles to defendants will continue.[81]

Even if courts have not embraced a general tort of malicious defense, abuse of process clearly encompasses behavior in which both plaintiffs and defendants in the underlying litigation might engage. Perhaps the most significant example is a party's use of discovery procedures to harass, intimidate or cause financial and emotional distress to the other party; activity that bears no relationship to the party's status as plaintiff or defendant. However, it is likely that the justifications offered for refusing to recognize an action for malicious defense may cause courts to be reluctant in holding defendants accountable for abuse of process.

A number of cases recognize that an abuse of discovery and motion practice can result in tort liability. In *Nienstedt v. Wetzel*,[82] the Arizona Supreme Court held that liability for abuse of process is established if the plaintiff in the underlying litigation used pre-trial practice to harass the defendants "by purposely subjecting them to excessive legal fees in defending against [the plaintiff's] claims."[83] The court first made clear that the "process" subject to tortious abuse should be construed broadly:

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79. *Id.* ("In adding malicious defense to our common law, we merely recognize that when a defense is commenced maliciously or is based upon false evidence and perjury or is raised for an improper purpose, the litigant is not made whole if the only remedy is reimbursement of counsel fees.").

80. *Id.* at 1028–29. The court also included an element that the plaintiff prevail in the prior litigation, but this element seems wrongheaded for the reasons advanced by the dissenting judge. *See supra* note 73 and accompanying quoted text.

81. *See* Wilkinson v. Shoney's, Inc., 4 P.3d 1149, 1157 (Kan. 2000) (acknowledging the *Aranson* decision, but holding: "We are not prepared to adopt or recognize a new cause of action for malicious defense. If such is deemed desirable or needed, action by the legislature is required. This is especially true in light of our long-standing recognition of the law to the contrary.").

82. Nienstedt v. Wetzel, 651 P.2d 876 (Ariz. 1982).

83. *Id.* at 880.

> [The process should encompass] the entire range of procedures incident to the litigation process . . . . As applied to this case, we therefore consider as "processes" of the court for abuse of process purposes, the noticing of depositions, the entry of defaults, and the utilization of various motions such as motions to compel production, for protective orders, for change of judge, for sanctions and for continuances.[84]

Noting that the gravamen of the action is that the party did not utilize this pre-trial practice for "its authorized purposes," the court held that attempting to increase an opponent's litigation fees in order to pressure a settlement is an unauthorized purpose for this process:

> [T]here is no liability when the defendant has done nothing more than legitimately utilize the process for its unauthorized purposes, even though with bad intentions[.]
>
> . . .
>
> However, there is evidence from which a trier of fact could have concluded that in many instances the [plaintiff's] ulterior or collateral purpose . . . to subject the [defendants] to excessive litigation expenses was in fact his primary purpose, and that his use of various legal processes was not for legitimate or reasonably justifiable purposes of advancing appellants' interest in the ongoing litigation.[85]

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84. *Id.*

85. *Id.* at 881–82. The *Nienstedt* court cited several New York cases that involved similar abuses of pre-trial process designed to coerce a settlement:

> Although our research has not revealed any cases in which liability for abuse of process has been imposed where the ulterior or collateral purpose involved has been to expose the injured party to excessive attorney's fees and legal expenses, we can perceive no reason why general abuse of process principles should not apply to such circumstances. *Cf.* Ginsberg v. Ginsberg, 84 A.D.2d 573, 443 N.Y.S.2d 439 (1981) (abuse of process liability imposed when party repeatedly used subpoena processes for the purpose of exhausting the opponent's financial resources); Bd. of Educ. of Farmingdale Union Free School Dist. v. Farmingdale Classroom Teachers Ass'n, Inc., 38 N.Y.2d 397, 343 N.E.2d 278, 380 N.Y.S.2d 635(1975) (involving the use of witness subpoena power for 87 teachers so as to impose financial hardship); Dishaw v. Wadleigh, 15 A.D. 205, 44 N.Y.S. 207 (1897) (involving assignment of collection claims to an associate in a distant part of the state, thereby purposely exposing debtors to the inconvenience and expense of attending a distant court).

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The court emphasized that the plaintiff incurred liability only because the primary purpose of the pre-trial process was to cause the defendants additional attorneys fees, noting that there would be no liability if the party had used process primarily for its intended purposes, but then secretly enjoyed the collateral effect of creating a financial burden on the other party.[86]

In a similar vein, the Second Circuit in *Alexander v. Unification Church*,[87] found that plaintiffs had properly stated a claim for abuse of process by alleging that the defendants had instituted process against them solely for the purpose of causing them to incur substantial attorneys fees.[88] The peculiar facts involved several "deprogrammers"—persons hired by parents attempting to dissuade their children from continuing their association with an alleged "cult"—who sued the Unification Church for using legal process as a means to drive them out of business.[89] Because the plaintiffs alleged that the primary purpose of the process was "not the purpose for which they may properly be instituted, namely to obtain damages for the Church members," but rather was "to compel the appellants to cease their deprogramming activities by putting them to the trouble and expense of litigation," the court found that dismissal of the abuse of process claim was improper.[90]

Although it was the plaintiff in the underlying litigation that abused pre-trail process in both *Nienstedt* and *Alexander*, the same reasoning would apply with equal force against a defendant. *Board of Education of Farmingdale Union Free School District v. Farmingdale Classroom Teachers Ass'n Inc.*[91]

Id. at 882. It has long been held that creditors who knowingly file actions or attachments in an improper venue for the purpose of impairing the ability of the other party to defend itself are liable for an abuse of process. *See* Barquis v. Merchants Collection Ass'n., 7 Cal. 3d 94, 103–04 (1972) (In Bank) (Tobriner, J., writing for unanimous court); Yu v. Signet Bank/Virginia, 69 Cal. App. 4th 1377, 1390 (1999). The cases involving abuse of pre-trial process appear to fit well into this traditional example of abuse of process.

86. *Nienstedt,* 651 P.2d at 882.

87. Alexander v. Unification Church of Am., 634 F.2d 673 (2d Cir. 1980), *abrogation on other grounds recognized in* PSI Metals, Inc. v. Firemen's Ins. Co. of Newark, N.J., 839 F.2d 42 (2d Cir. 1988).

88. 634 F.2d 675.

89. *Id.*

90. *Id.* at 678. The case was later abrogated because the tort of abuse of process, unlike the tort of malicious prosecution, cannot be founded on the original issuance of the complaint in the action. The plaintiffs in *Alexander* did not sue for malicious prosecution because they could not satisfy the element that the underlying litigation terminate in their favor. *Id.* at 678 n.7.

91. Bd. of Educ. of Farmingdale Union Free School Dist. v. Farmingdale Classroom Teachers Ass'n, 343 N.E.2d 278 (N.Y. 1975).

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provides a good example of a court finding that a defendant's pre-trial actions constituted an abuse of process.[92] In *Farmingdale*, a school district charged the teacher's union with orchestrating an illegal strike, leading to a hearing instituted by the Public Employees Relations Board.[93] In preparation for defending itself at the hearing, the teacher's union issued eighty-seven subpoenas for individual teachers to appear as witnesses, refusing the school district's request to stagger the times of the appearances as is customary to avoid needless waste of resources.[94] In the end, all eighty-seven teachers attended the full hearing, requiring the school district to hire seventy-seven substitute teachers for that day.[95] The school district, not a party to the hearing, brought an action for abuse of process, alleging that the teacher's union used the subpoenas to achieve the collateral aim of disrupting the district's planning for the day and causing the district to incur substantial costs.[96] The court found that the union's activities as a defendant in the hearing constituted an abuse of process:

> The subpoenas here were regularly issued process, defendants were motivated by an intent to harass and to injure, and the refusal to comply with a reasonable request to stagger the appearances was sufficient to support an inference that the process was being perverted to inflict economic harm on the school district.
>
> While it is true that public policy mandates free access to the courts for redress of wrongs . . . and our adversarial system cannot function without zealous advocacy, it is also true that legal procedure must be utilized in a manner consonant with the purpose for which that procedure was designed. Where process is manipulated to achieve some collateral advantage,

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92. 343 N.E.2d 283 (Wachtler, J., writing for a unanimous court).
93. *Id.* at 280.
94. *Id.*
95. *Id.*
96. *Id.* The court rejected the argument that the school district could not recover for an abuse of process because it was not a party to the underlying hearing:

> While it is true that plaintiff was not a party to that proceeding, it is equally true that they were not disinterested bystanders. More important the deliberate premeditated infliction of economic injury without economic or social excuse or justification is an improper objective which will give rise to a cause of action for abuse of process.

Id. at 283–84.

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> whether it be denominated extortion, blackmail or retribution, the tort of abuse of process will be available to the injured party.[97]

The court concluded that the school district could be entitled to punitive damages, subject to proof at trial that the union acted with malice.[98]

In summary, courts have been hesitant to impose liability on defendants for the manner in which they maintain their defense. This hesitancy is demonstrated most clearly by the refusal of virtually all jurisdictions to accept a cause of action for "malicious defense" that would mirror the traditional cause of action for malicious prosecution. However, the tort of abuse of process applies on its face to conduct by defendants no less than to conduct by plaintiffs. In particular, the typical abuses perpetrated by liability insurers and defense counsel—using pretrial motion practice and discovery to place economic and emotional pressure on third-party claimants rather than for their proper purposes—should give rise to liability for abuse of process.

C. Applying the Tort of Abuse of Process to the Liability Insurance Setting

Third-party claimants generally have not been successful in holding liability insurers accountable with the tort of abuse of process for bad faith claims settlement and litigation practices. This should come as no surprise, in light of the baseline common law rule that insurers owe no tort duties or contract obligations to third-party claimants, the traditional doctrinal rules that narrow the scope of abuse of process, and the general unwillingness to impede the rights of defendants to mount a vigorous defense. After examining several cases that have rejected claims of abuse of process against liability insurers by third-party claimants, I argue that courts should be more receptive to these claims and discuss a few recent cases that point in this direction. My argument is simple: the strong public policy favoring the fair and timely resolution of claims by liability insurers should guide courts to impose tort damages when liability insurers use the instruments of litigation—discovery, motion practice and pleadings—primarily to delay or evade payment of the claim. Although this approach runs counter to some traditional applications of the law of abuse of process, it is well within the articulated principles of the tort.

97. *Id.* at 283.
98. *Id.* at 284.

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The problems facing third-party claimants alleging abuse of process are vividly demonstrated in an older case decided by the Maine Supreme Court. In *Linscott v. State Farm Mutual Automobile Insurance Co.*,[99] a resident of Maine sued a liability insurer after it offered a "less than nominal settlement" for damages arising out of an accident that occurred when a North Carolina driver struck his car while he was driving through Virginia.[100] The claimant alleged that the insurer was attempting to capitalize on the inconvenience caused by geographic distance for the purpose of inducing an unreasonably low settlement.[101] Because the alleged wrongful conduct occurred prior to litigation, the claimant could not allege abuse of process; consequently the claimant was forced to make out a generalized claim of bad faith that ultimately was rejected by the court.[102] This case dramatizes why abuse of process will not be an effective tool for addressing all forms of alleged bad faith by liability insurers. More importantly, the court clearly stated that the liability insurer was permitted to approach the claim and litigation as strategically as if it were the tortfeasor, working from the assumption that liability insurers are properly regarded as the adversary of the claimant:

> In the instant case, defendant was entitled to rest on its right to defend against the claim in Virginia and delay settlement until the threat of suit appeared realistic. The adversary status of the parties precludes creation of a legal obligation to refrain from such a recognized technique of negotiating. The liability insurer of a tortfeasor, as the tortfeasor himself, may legally attempt to minimize the amount of a final settlement with an adversary by exploiting the geographical and economical difficulties which may confront the adverse claimant.[103]

The court's message is unambiguous: liability insurers can defend as vigorously as any other party, even to the extent of taking advantage of the claimant's "economic difficulties."

Similarly, a recent federal district court opinion reaffirmed that insurers are free to act strategically in defense of claims made against their insureds,

99. 368 A.2d 1161 (Me. 1977).

100. *Id.* at 1163.

101. *Id.*

102. *Id.* at 1164. The court concluded that the "pre-trial negotiations, which may be conducted between a tort claimant and a defending insurance company are *adversary* in nature and, hence, will not give rise to a *duty* to bargain in good faith, as claimed by plaintiff." *Id.*

103. *Id.*

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warning specifically against the potential for abuse of process suits to undermine the insurer's right to conduct a vigorous defense.[104] The claimant alleged that the insurer brought a declaratory judgment action challenging coverage, knowing that its insured would fail to appear and be defaulted, and solely for the purpose of exerting undue pressure on the claimant when the insurer suddenly withdrew from the case.[105] The court found that the insurer properly defended against contractual liability to its insured, and that there was no abuse of process even if the public policy embodied in the no-fault law would require the insurer to provide the statutorily mandated coverage notwithstanding valid contract defenses.[106] The court clearly articulated the insurer's right to act strategically in minimizing its exposure:

> Absent a showing that Aetna used the declaratory action to accomplish an end not regularly or legally obtainable, liability will not lie. During the litigation that arose from the accident, all the actions Aetna took were intended to first escape coverage and liability. Once that was accomplished, Aetna paid for a lawyer who tried to defeat Tommy's claim against Jorge on its merits. Escaping coverage and trying to defeat Tommy were perfectly legitimate actions for Aetna, an insurance company, to take. To permit these actions to be the premise of liability expands the tort of abuse of process beyond recognition.
>
> As this case shows, there can be no other rule. If every litigant could use his opponent's activities in litigation as the premise of a second action, litigation would never end because in every lawsuit there would be the seeds of a second lawsuit. Litigation would become like the Russian Doll in which there is a Russian Doll in which there is a Russian Doll *ad infinitum*.[107]

And so, the court concluded that the insurer's actions were not tortious, even while noting that the strategic effort to disclaim coverage under the policy for its insured's liability might be overcome for reasons of public policy.[108]

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104. Athridge v. Aetna Cas. & Sur. Co., 163 F. Supp. 2d 38 (D.D.C. 2001).

105. *Id.* at 54.

106. *Id.*

107. *Id.* at 54–55.

108. The court suggested that the claimant might re-plead the case as a direct action against the insurer for indemnification of the verdict, on the ground that public policy forbids the carrier from using an exclusion to void the statutory minimum policy coverage, although that

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In addition to these cases in which courts have refused to find that liability insurers committed an abuse of process, courts have rejected attempts by claimants to hold liability insurers liable for a generalized tort of "malicious defense." A Delaware trial court flatly rejected an attempt by a third-party to recover tort damages for malicious defense and entered summary judgment for the insurer, despite the insurer's attempt to avoid liability under an exclusion by relying on witness statements that were inaccurate.[109] Noting that the "majority of courts have held that an insurer owes no duty to third parties to negotiate settlements in good faith" because the claimant and insurer are "adversaries," the court concluded "as a matter of law that Hartford had no duty to deal with plaintiff in good faith, to settle her claim promptly or to refrain from 'malicious defense' of her claim, or to use reasonable care in the investigation and handling of plaintiff's claim."[110]

Similarly, the Delaware federal district court applied this reasoning in a case, *Rowlands v. Phico Insurance Company*,[111] in which the victim of medical malpractice sued the malpractice carrier. The claimant alleged that the insurer failed to notify the defendant doctor of the suit for the purposes of setting up a non-cooperation coverage defense when the doctor failed to show for trial, and then to cause the claimant to suffer emotional distress when the insurer announced on the eve of trial that it would be contesting coverage.[112] The court concluded that the well-established policy against recognizing liability for "malicious defense" when "a defendant adopts unfair or unreasonable litigation tactics in an effort to prejudice or harass an opponent"[113] is particularly important in the insurance setting—given the adversarial relationship of the parties until such time as a verdict within

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doctrine might not help the claimant because their own uninsured motorist coverage might fill the gap. *Id.* at 51–52. *See supra* note 30 for an explanation of this public policy argument. It is worth noting that the court found the claimant to be the dishonest and strategic party on these facts, which inevitably shaped its use of broad exculpatory language in describing the insurer's rights. *See Athridge*, 163 F. Supp. 2d at 55 (describing the claimant's factual allegations as being untrue and perhaps even dishonest, in light of privileged documents reviewed by the judge).

109. Hostetter v. Hartford Ins. Co., 1992 WL 179423 (Del. Super. Ct. July 13, 1992).

110. *Id.* at *7–*8.

111. 2000 WL 1092134 (D. Del. July 7, 2000).

112. *Id.* at *1.

113. *Id.* at *2.

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coverage occurs—since "any other result would lead to unending litigation."[114]

These cases might best be explained by the hesitancy of courts to find that parties acted tortiously in defending themselves in civil litigation, and the presupposition that liability insurers can owe no duties to a claimant in light of the insurer's fiduciary responsibility to the insured tortfeasor. However, these attitudes are at odds with the long-recognized and strong public policy favoring compensation for injuries, and the relatively recent move by legislatures to enact provisions requiring insurers to deal with claimants fairly and in good faith. Moreover, as some courts begin to clarify and streamline the elements of abuse of process, it should become clear that this tort encompasses at least some of the bad faith litigation tactics employed by insurers. Recent cases provided some indication that abuse of process might yet prove to be a viable cause of action for third-party claimants.

In *Vallance v. Brewbaker*,[115] the Michigan Court of Appeals rejected the claimant's allegation that the insurer abused the discovery process by securing an ex parte order extending the time for discovery of medical information, holding that the insurer was motivated solely by its legitimate need to obtain this information in order to defend its insured.[116] However, the court acknowledged that abuse of process might lie

> where the defendant has availed himself of a proper legal procedure for a purpose collateral to the intended use of that procedure, e.g., where the defendant utilizes discovery in a manner consistent with the rules of procedure, but for the improper purpose of imposing an added burden and expense on the opposing party in an effort to conclude the litigation on favorable terms.[117]

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114. *Id.* at *4.

115. Vallance v. Brewbaker, 411 N.W.2d 808, 810–11 (Mich. Ct. App. 1987).

116. *Id.* at 810 (finding that there "is no hint of any purpose other than the need for discovery underlying defendants' efforts to obtain the ex parte order in the instant case."). *See also* Blue Goose Growers, Inc. v. Yuma Groves, Inc., 641 F.2d 695, 697 (9th Cir. 1981) (The discovery request of certain business documents "was simply a proper request seeking information relevant to Yuma's claims in the underlying suit. This formal use of the process is not sufficient to support an abuse of process claim.").

117. *Id.* at 810. However, the court reiterated the need for a "corroborating act," which precludes liability in situations in which the defendant achieves its illegitimate ulterior motive by using legal process for its intended purpose. Thus, the court concluded that an attempt to obtain an ex parte discovery order for relevant medical evidence in a personal injury case

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This recognition opens the possibility of applying abuse of process to the insurance defense setting, even if the facts alleged in *Vallance* were insufficient. Similarly, in the analogous setting of first-party uninsured motorist coverage, a Connecticut trial court held that an insurer can be liable for unfair trade practices for refusing to make any payment of benefits in certain types of cases regardless of the individual merits of the claim, since this conduct violates important public policies in a manner that amounts to an abuse of process.[118]

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cannot be an abuse of process, since the process was used for its intended and legitimate purpose even if accompanied by an ulterior motive. *Id.*

In a similar vein, the California Court of Appeal in *Thornton v. Rhoden*, 245 Cal. App. 2d 80 (1966), assumed that the plaintiff stated a claim for abuse of process by alleging that the defendant noticed a deposition for the purpose of eliciting defamatory statements that could then be published by the press without fear of liability due to the litigation privilege, rather than for the purpose of discovering admissible evidence. The court did not decide this issue, however, because it determined that any claim for abuse of process was barred by the applicable one-year statute of limitations. *Id.* (concluding that it "is therefore academic whether the taking of the deposition and the transcribing thereof can be an abuse of process.").

118. In *Smith v. Allstate Indem. Co.*, No. CV 9803541375, 1999 WL 1212440, at *1 (Conn. Super. Ct. Nov. 30, 1999), the plaintiff-insured alleged that Allstate refused to deal fairly with his uninsured motorist claim pursuant to a company policy for dealing with "minimum damage/impact accidents." The court found that the insurer violated the public policy enunciated by the unfair trade practice statutes when it "offhandedly" denied its insured's claim pursuant to a generalized business practice rather than based on the merits of the claim. *Id.* at *3. The court specifically included third-party claimants in its discussion of the public policy issue:

> The defendant's enforcement of a policy of no settlement in minimum impact cases forces insureds, *claimants and accident victims* to file suit to be compensated for any resulting losses sustained in such accidents. Passing this risk is an unconscionable advantage for the insurance company. This is because it received payment to undertake precisely such a risk. Therefore, in the absence of prior notice to its insured, it is contrary to public policy for an insurance company to forego the very nature of its existence and oppressively use its superior bargaining position to hold out on settlement or claims requests and force *the other parties* to absorb the loss or file suit and expend more just to obtain what they bargained for. . . .
>
> Further, Connecticut and all states have a public interest in providing compensation for accident victims and preventing the wholesale liquidation of familial assets which must be sold in the event of an exigency arising from a specified loss or injury. The reasonable expectations of the insureds, and in some instances, *third-party beneficiaries*, should be protected. This is especially true when the rights asserted by the claimant are in accord with the applicable insurance contract, as in the instant case. . . . [I]t is against

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Of greatest significance, a few cases have accepted the possibility that liability insurers can be found liable for abuse of process. A trial court recently held an insurer liable for abuse of process on account of its programmatic unfair settlement and litigation practices. In *Crackel v. Allstate Insurance Co.*,[119] an Arizona jury awarded a third-party claimant $15,000 in compensatory damages for the emotional distress caused by Allstate's hardball tactics in refusing to pay the emergency room charges for a minor-injury claim pursuant to a corporate policy to make no payment in minor injury cases when claimants are represented by counsel.[120] If this verdict is appealed and survives,[121] it will be an important precedent establishing the viability of abuse of process as a means of attacking an express corporate policy to stonewall claimants and pursue a "scorched earth litigation strategy" in certain types of cases, rather than evaluating claims on their individual merits. In a previous suit against Allstate for employing a similar programmatic strategy, the Arizona Court of Appeals had affirmed the dismissal of the allegations that Allstate had breached a general obligation to deal with the claimant in good

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> public policy for an insurance company to allow a claimant, whether they be an insured or other person intended to receive benefits under the policy, to rely to their detriment on the representation that since they paid for coverage they will get coverage when a claim is made, when in fact they may get something less than they bargained for [as a result of a business policy].

Id. at *4–*6 (emphasis added). The court then noted that the insured could have vindicated these same public policy interests with the tort of abuse of process, although the plaintiff had not pleaded the cause of action:

> The legal system was not designed to be used as a tool by insurers to delay or deny payment of all claims involving minimum property damage nor was it designed to help insurance companies avoid assuming liability when they are required by contract to do so. Although the plaintiff has not alleged such a tort violation, the defendant's practices amount to a violation of this policy. Thus such conduct is contrary to public policy and therefore the defendant has provided the plaintiff with alternative grounds for [an unfair trade practices] claim.

Id. at *7.

119. No. C-329946 (Ariz. Super. Ct. 2001).

120. *See* Rebecca Porter, *Jury Punishes Allstate for "Scorched-Earth" Tactics,* TRIAL, Dec. 2001, at 70; David Hechler, *Allstate Found Liable for Abuse of Process*, NAT'L. L. J., Oct. 22, 2001, at A15.

121. Allstate claimed victory after trial, since the claimant had sought $500,000 damages. Hechler, *supra* note 120. The claimant's attorney stated that he might appeal the verdict on the ground that adverse pre-trial rulings had led to an inadequate monetary verdict, indicating his desire to have the unprecedented verdict "in the record books where other attorneys can review it and see that there's a remedy available." *Id.*

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faith, and did not reach the question of whether the insurer could be liable for abuse of process when it refused to pay for soft-tissue injuries in cases involving minor property damage.[122] The recent jury verdict represents the first successful claim of abuse of process against an insurer that bases claims payments on general criteria rather than the merits of the claim. This could prove to be significant, since insurers have begun to turn to such profit-maximizing devices with the belief that they are insulated from liability for the additional injuries that these strategies might inflict on individual third-party claimants.[123]

Perhaps even more significant, in *Givens v. Mullikin*,[124] the Tennessee Supreme Court recently held that a claimant may sue a liability insurer for abuses of process committed by defense counsel "if the attorney's tortious actions were directed, commanded, or knowingly authorized by the insurer."[125] The court found that the claimant had stated a cause of action for abuse of process when she alleged that the counsel retained by Allstate had used extensive discovery procedures "to harass her, to cause her to suffer unnecessary expense, and to 'weaken [her] resolve to pursue the suit to the extent that she [would] abandon it.'"[126] In particular, the claimant alleged that Allstate fired a responsible attorney and retained a new firm that immediately began abusing discovery procedures by filing hundreds of interrogatories seeking information already in its possession, deposing her a second time with intense questioning about her medical history and sexual life, and issuing more than seventy subpoenas to records custodians seeking complete medical files on the claimant.[127] Although Allstate argued that defense counsel is hired

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122. Leal v. Allstate Ins. Co., 17 P.3d 95 (Ariz. Ct. App. 2000), *review denied*, No. CV-01-0023-PR (Ariz. May 23, 2001).

123. These same claim settlement practices were at issue in *Smith*, 1999 WL 1212440, and *Leal* and *Smith* note that the evidence establishes that Allstate had implemented these practices on a nationwide basis.

124. Givens v. Mullikin, 75 S.W.3d 383 (Tenn. 2002).

125. *Id.* at 390.

126. *Id.* at 391.

127. *Id.* at 391–92. For example, the court described the absurdly overbroad production requests submitted to third parties in connection with the claimant's suit for injuries suffered in an automobile accident as follows:

> Further, the Richardson Firm is alleged to have issued more than seventy discovery subpoenas to various records custodians. Despite knowing that many of these records possessed no relevance to the issues in the plaintiff's suit, the Richardson Firm is alleged to have sent subpoenas to (1) "every custodian for every healthcare professional who was suspected . . .

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as an independent contractor that owes fiduciary duties to the insured, the court found that Allstate could be vicariously liable if it exercised control over defense counsel by directing or authorizing the tortious conduct.[128]

> to have rendered treatment to the plaintiff at any time during her life," including her psychologist, her obstetrician/gynecologist, and others; (2) every "hospital in Memphis and Chattanooga (where the plaintiff once lived), even though in many instances[,] the Richardson Firm had no reason to believe that the Plaintiff had received treatment there;" (3) every employer for whom the plaintiff has ever worked; (4) every automobile repair agency to which the plaintiff's automobile has ever been taken; and (5) every insurance company that has written a policy of insurance for the plaintiff.

Id.

128. The court looked to the reality of the underlying relationships rather than accepting the ethical and professional ideal that defense counsel maintain its independence in service to its client:

> Consequently, although an insurer clearly lacks the *right* to control an attorney retained to defend an insured, we simply cannot ignore the practical reality that the insurer may seek to exercise *actual* control over its retained attorneys in this context. . . . To be clear, our recognition of the control exercised by insurers in this context does not condone this practice, especially when it works to favor the interests of the insurer over that of the insured; rather, we acknowledge this aspect of the relationship only because it would be imprudent for this Court to hold that attorneys are independent contractors vis-à-vis insurers, but then to ignore the practical realities of that relationship when it causes injury.

Id. at 395 (emphasis in original). The court emphasized that the plaintiff must plead and prove that the insurer in fact had insinuated itself into the attorney-client relationship by directing, commanding or knowingly authorizing the conduct that constitutes an abuse of process. *Cf.* Food Lion, Inc. v. United Food & Commercial Workers Int'l. Union, 567 S.E.2d 251, 252 n.1 (S.C. Ct. App. 2002) (holding that union may be liable for abuse of process even though it was not a party to the litigation if the plaintiff proves that the union knowingly participated, aided, abetted or ratified the abuse, and finding that plaintiff satisfied this test by alleging that the union directed and funded the underlying litigation). The *Givens* court emphasized the factual basis for its decision, opining that:

> cases in which an insurer may be held liable under an agency theory will be rare indeed. We do not hold today that an insurer may be held vicariously liable for the acts or omissions of its hired attorney based merely upon the existence of the employment relationship alone. Nor do we hold that an insurer may be held liable for any acts or omissions resulting solely from the exercise of that attorney's independent professional judgment, and in all cases, a plaintiff must show that the attorney's tortious actions were taken partly at the insurer's direction or with its knowing authorization.

Givens, 75 S.W.3d at 395–96. Following this same logic, the court held that the insured will be vicariously liable for the actions of defense counsel only if the insured exercised actual control,

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The court carefully explained the basis for liability, working from the sparse precedents involving the abusive use of discovery procedures. First, the court found that using civil process strategically for the primary purpose of harassing and beating down one's opponent is an abuse of process, rejecting the supposition that defendants are free to defend themselves in any manner they choose with the following analysis:

> In its most basic sense, therefore, an action for abuse of process is intended to prevent parties from using litigation to pursue objectives other than those claimed in the suit, such as using a court's process as a weapon "to compel [another party] to pay a different debt or to take some action or refrain from it." It is the use of process to obtain this "collateral goal"—a result that the process itself was not intended to obtain—that is the very heart of this tort. The essential question to be answered concerning the present claim, therefore, is whether the use of process to discourage the other party from continuing the litigation is a sufficiently "collateral goal" to give rise to tort liability.
>
> Ordinarily, the lawful use of a court's process does not give rise to an abuse of process claim, and no claim of abuse will be heard if process is used for its lawful purpose, even though it is accompanied with an incidental spiteful motive or awareness that the use of process will result in increased burdens and expenses to the other party. However, a different case is presented when the *primary* purpose of using the court's process is for spite or other ulterior motive.[129]

The court then discussed the opinions in *Nienstedt*,[130] *Farmingdale*[131] and *Vallance*[132] and developed a principled articulation of the application of abuse

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noting that in the "unique" context of insurance defense litigation the client has little "practical authority to control" the conduct of defense counsel. *Id.* at 396–98.

In a companion case, *Trau-Med of America, Inc. v. Allstate Insurance Co.*, 71 S.W.3d 691 (Tenn. 2002), the court held that an insurer could be held vicariously liable under the same standard of liability when defense counsel tortiously interferes with the prospective business relationships between tort victims and a third-party medical center.

129. *Givens*, 75 S.W.3d at 400–01 (internal citations omitted).

130. Nienstedt v. Wietzel, 651 P.2d 876 (Ariz. 1982), analyzed *supra* notes 82–86 and accompanying text.

131. Bd. of Educ. of Farmingdale Free Union Sch. Dist.v. Farmingdale Classroom Teachers Ass'n. Inc., 343 N.E.2d 278 (N.Y. 1975), analyzed *supra* notes 91–98 and accompanying text.

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of process to situations involving discovery abuse by insurance defense counsel:

> Broadly speaking, the aim of the civil discovery process is "to bring out the facts prior to trial so the parties will be better equipped to decide what is actually at issue," . . . not to wear the mettle of the opposing party to reach a favorable termination of the cause unrelated to its merits. When the civil discovery procedures are used with the specific and malicious intent to weaken the resolve of the other party, then one may rightfully claim that the procedures are being used "to accomplish some end which is without the regular purview of the process." Accordingly, we adopt the test first announced in *Nienstedt* and hold that abuse of process in the civil discovery context may lie when (1) the party who employs the process of a court specifically and *primarily* intends to increase the burden and expense of litigation to the other side; and (2) the use of that process cannot otherwise be said to be for the "legitimate or reasonably justifiable purposes of advancing [the party's] interests in the ongoing litigation."[133]

Under this standard, the court found that the claimant's allegations survived dismissal, and the case was remanded for further proceedings.[134]

Although it is far too soon to predict with any accuracy, the *Givens* case might represent the first successful salvo by third-party claimants seeking to use the tort of abuse of process to police against defensive tactics by liability insurers designed to pressure injured parties to accept inadequate settlements. Courts have too long assumed that liability insurers must be insulated from any manner of liability to third-party claimants if they are to fulfill their fiduciary responsibilities to defend their insureds vigorously. The *Givens* case rejects such misplaced reasoning at the level of tort law doctrine, and does not even draw on the strong public policy arguments that favor holding liability insurers accountable when they seek to strong-arm inadequate settlements with injured parties. As jurisdictions begin to streamline abuse of process doctrine and to acknowledge and enforce the clearly articulated public policy favoring prompt and fair settlement of claims made by injured third parties,

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132. Vallance v. Brewbaker, 411 N.W.2d 808 (Mich. Ct. App. 1987), analyzed *supra* notes 115–17 and accompanying text.

133. *Givens*, 75 S.W.3d at 402.

134. *Id.* at 413.

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there is every reason to believe that the analysis in *Givens* will be accepted as an uncontroversial application of basic tort principles.

CONCLUSION

The tort of abuse of process might prove to be an important means of addressing some forms of bad faith behavior by liability insurers, even if it is not an appropriate vehicle for combating all forms of insurer misconduct toward third-party claimants. A claimant who sues a liability insurer for abuse of process may face several significant obstacles, including the traditional requirement of an "additional act" that corroborates the ulterior motive, the traditional hesitancy by courts to impose liability for the manner in which parties defend themselves, and the "shadow effect" of the general common law rule that liability insurers owe no contract or tort duties to third party claimants since their relationship is adversarial. These issues are made all the more difficult by the fact that the tort of abuse of process is "obscure," "rarely brought to the attention of courts," and "not clearly defined."[135] However, recent cases suggest that these issues can and should be resolved in a manner that does not preclude holding insurers liable in appropriate cases to third-party claimants for abuse of process.

The argument in favor of imposing liability can be made in even stronger terms. In light of the strong public policy that a liability insurer should promptly investigate and reasonably settle claims made by third-parties against its insured, it would follow that the behavior of liability insurers in insurance defense litigation should be subject to close scrutiny. Although a corporate defendant might be given relatively free reign to use the litigation process to postpone and minimize its liability, liability insurers have no basis for claiming that they can use legal process to achieve the same goals. Courts too often assume that it is a permissible for a defendant to use legal process to pursue all relevant motion and discovery practice with the goal of litigating the case aggressively and forcing the other party to marshal its evidence and meet its burden of proof. This assumption is revealed most clearly in the majority of jurisdictions that have refused to recognize a cause of action for "malicious defense." However misguided this assumption may be as a general matter, it plainly is not justified when an insurer is controlling the defense of the action. If liability and damages are reasonably certain, and the factual basis from which these conclusions can be drawn is reasonably clear, courts

135. *Bd. of Educ. of Farmingdale*, 343 N.E.2d at 280 (citations omitted).

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should find that extensive use of motion practice and discovery by insurers simply for the purpose of putting the third-party claimant to her proof would be a tortious use of process. Put differently, courts should conclude that liability insurers cannot use legal process simply for the purpose of mounting a vigorous defense, but instead must show that they are seeking to discover relevant information or are filing motions for the purpose of fairly adjudicating the case. Unlike other defendants, liability insurers controlling litigation should not be permitted to regard litigation as a game in which the strategy is to avoid paying the other party for as long as possible by invoking all the "moves" of civil litigation.[136]

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136. I recognize that distinguishing insurance carriers from other defendants, and particularly self-insured corporate defendants, requires more detailed justification. If a self-insured corporation uses litigation as a weapon to avoid its liabilities to injured parties, this seemingly would implicate the same public policy concerns as an insurance carrier acting in the same manner. I thank John Duffy, Eric Kades and Alan Meese for pressing this point when I presented a related paper at a William and Mary faculty colloquium in November 2002, and forcing me to begin thinking about this question in greater depth. Because this issue is too broad to address properly in an article focusing on the application of abuse of process, in this note I provide only a brief overview of the lines of analysis that might justify the claim that insurance carriers should be held to a higher standard of litigation behavior than other defendants. I expect to return to this more general question in a future article.

I begin by noting that it is not critical to my argument that insurance carriers be held to a higher standard than all other defendants. If my argument for holding insurance carriers to a higher standard makes sense for some self-insured defendants as well, I am not averse to extending the scope of the heightened duty. For present purposes, I believe that I am justified in arguing that liability insurers should be held to a higher standard of behavior than the traditional standard, while remaining agnostic as to whether other, (arguably) similarly-situated, defendants also should be held to this higher standard.

First, it is appropriate to distinguish insurers from other corporate entities because the very nature of the business of insurance implicates the public policy favoring compensation of injured parties: liability insurance is designed to fulfill precisely this function. In contrast, a self-insured corporation engaged in other profit-making ventures regards the payment of liability claims as a cost of pursuing its primary corporate functions. In other words, the term "self-insured" is really another way of saying that a corporation has chosen not to engage a specially regulated business to provide it with insurance, and instead is accepting risks as part of the cost of engaging in its primary business.

Second, insurance is a highly regulated industry because of the nature of its business. Once a covered event has taken place, it is impossible for an insured or third-party claimant to protect themselves by securing a new policy of insurance. Moreover, liability insurance carriers are particularly expert in sophisticated claims assessment and litigation and are constant repeat players in this realm. The purpose of the unfair claims practices act is self-explanatory when considered against this backdrop: liability insurers are in a position where they have the power to pursue their own interests at the expense of both their insured and third-party

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claimants, given their expertise and their ability to spread risks over thousands of cases each year. An injured party may not want to pursue payment from a liability insurer through trial and appeal when the risk of losing the case and receiving no payment could be a devastating event for the claimant. On the other hand, a liability carrier might choose to engage in behavior that occasionally will result in a large tort verdict but that generally will prove to be a profitable business strategy by exacting thousands of below-market settlements. Pooling risks and spreading the exposure is the very nature of the business of insurance, and so states have deemed it appropriate to counteract these potentially adverse effects of the nature of insurance.

Third, beyond the specific articulations of public policy in statutes and regulations, the judiciary has always regarded the business of insurance to be distinct from ordinary commercial activity. Courts read insurance policies differently from other commercial contracts, with the express purpose of furthering public policy. There may be no pristine or logically compelling reason for this practice, but accepting the reality of time-honored practices is a legitimate basis for drawing distinctions. To put the matter differently, in response to critics who challenge whether there is any rational justification for treating insurance carriers differently from other businesses, I would suggest that the burden of proof rests on those who would overturn clear distinctions in legal practice and traditions. Against arguments that exposing insurance carriers to tort damages will result in overpayments and other uneconomic behavior, I would respond that closer analysis might reveal that longstanding practices in this area effectively internalize the cost of strategic behavior by liability insurers. This argument can be articulated more broadly in terms of the unique role of liability insurance in effectuating the compensation function of modern tort law, resting on the idea that permitting liability insurers to spend resources to avoid paying claims on the basis solely of their own economic advantage seriously undermines a more general economic function of tort law. In other words, I would insist that the critic must bear the burden of justifying why the law suddenly should begin to treat insurance carriers as if they are just like any other commercial enterprise despite clear and uniform practices to the contrary.

Finally, and perhaps most important, there are conceptual and historical explanations for the different treatment of insurance carriers by regulators and courts. An attempt to treat liability insurers like any other commercial enterprise moves radically away from the genesis and history of insurance in this country. Insurance is a social and communal undertaking, rooted in the friendly societies and developed through the mutual insurance corporation. The traditional reluctance to permit contracts of insurance was overcome only on the basis of this social understanding of insurance, an understanding that continues to be reflected in regulations and court decisions. My argument for holding liability insurers to a higher standard draws on this continuing legacy, not as a bald normative claim requiring justification about the way things ought to be, but as a descriptive claim about the essential nature of insurance as it in fact has developed. This history supports subsidiary claims about the reasonable expectations of members of society toward insurance carriers, as well as the reasonable expectations of insurance carriers that they will not be permitted to pursue their economic self-interest when they adjust and pay liability claims. These principles have been clouded in the third-party insurance setting not because courts believe that insurance carriers have no social obligations, but because they wrongly conclude that the paramount obligation of insurers to their insureds precludes any obligations to third-party claimants. The genesis and history of the business of insurance would lead to a more pointed challenge to those who would eliminate any distinction

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Even if courts choose not to hold insurers to a higher standard of litigation behavior for reasons of public policy, liability insurers should be held accountable under the generally applicable requirements of the tort of abuse of process. The paradigm case of insurer liability for abuse of process would involve situations in which the insurer: (1) pursues extensive and time-consuming discovery that subjects the claimant to burdensome and invasive requests for information that is only pretextually related to the lawsuit and is actually designed to wear down the claimant, (2) utilizes pleading and motion practice to extend the proceeding for years for the purpose of putting financial and emotional pressure on the claimant to settle for a reduced amount, or (3) refuses to admit facts relating to liability or damages despite having no basis to do so. In these situations, the claimant would allege that the primary purpose for this legal process was not to litigate the case but rather to impose financial and emotional burdens on the claimant. In this regard, the *Givens*[137] case would be an important precedent, and the *Linscott*[138] case would be distinguished as an older case that adopted the discredited view that liability insurers are as free as any defendant to use civil process strategically for the sole purpose of avoiding payment on a legitimate claim.

Holding liability insurers accountable for abuse of process will raise a number of questions. First, some might question whether a non-party should be subjected to tort liability for the manner in which process is used during the course of the litigation. However, it is clear that opposing counsel, also a non-party, may be held directly liable for an abuse of process,[139] and the *Givens* case provides a compelling argument that liability insurers should be held vicariously liable for the actions of the defense counsel that they have retained to represent the insured to the extent that the insurers direct, command or authorize the conduct in question.[140] Liability insurers clearly play the primary role in decisions about defending actions brought against their insureds, and it would be purely a formalist abstraction to insulate them from

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between the business of insurance and ordinary commercial transactions, revealing that by virtue of administrative and judicial regulation, insurance is a quasi-public enterprise that is permitted to be a profit-maximizing entity only in certain respects (e.g., developing a better investment strategy, increasing workforce productivity, and creating superior marketing approaches) and not others (e.g., paying claims and developing policy terms).

137. *See supra* notes 124–29 and accompanying text.

138. *See supra* notes 99–103 and accompanying text.

139. *See* Giles v. Hill Lewis Marce, 988 P.2d 143, 147 (Ariz. 1999) (citing jurisdictions that permit a cause of action for abuse of process against opposing counsel).

140. *See supra* note 128 and accompanying text.

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liability for injuries caused by their exercise of this power. In some cases, it might even be appropriate to find the liability insurer directly liable rather than vicariously liable. For example, if the insurer lies to defense counsel about the results of its investigation and directs counsel to pursue extensive discovery to uncover these "facts," the attorney might use validly issued process for the legitimate purpose of such process, only to find later that he or she has been used unwittingly by the insurer to pursue the collateral goal of increasing the financial and emotional pressures faced by the claimant.[141]

Another important question is whether the claimant must prevail in the underlying litigation as a prerequisite to bringing an action for abuse of process against an insurer. The case law clearly provides that there is no such requirement to state a claim for abuse of process, noting that this is one of the principal differences between malicious prosecution (in which the party must prevail in the underlying litigation in order to establish that it was commenced without probable cause) and abuse of process.[142] This rule makes perfect sense. The gravamen of the action is not that the position adopted by the party in the underlying litigation lacked merit, but rather the harm caused by utilizing process beyond its legitimate purposes. Consequently, a claimant might prevail against a liability insurer for abuse of process, even if the claimant proceeds to verdict in her suit against the insured and loses the case. The fact that a claimant brought a losing case should not free the insurer to abuse civil process and cause that claimant harm during the litigation. It follows that the claimant technically should be permitted to counterclaim for abuse of process by defense counsel and file a third party complaint against the liability insurer, although courts may determine that the abuse of process claims against opposing counsel are better tried in a separate action to avoid

141. I would expect such situations to be rare, since defense counsel would have a duty to ensure that its actions were appropriate and could not delegate this professional obligation to the liability insurer. However, it would appear to be conceptually possible that a liability insurer might be the party directly liable for abuse of process.

142. *See generally* LAW OF TORTS, *supra* note 48, at 4:85 (cases cited in n.3). For more recent cases, see *Greenberg v. Wolfberg*, No. 92-6023, 1995 WL 307582, at *4 (10th Cir. 1995) (The Oklahoma Supreme Court responded to a certified question by stating that a plaintiff "is not required to prove . . . that he/she prevailed in that proceeding. Neither is it necessary that the action, in which the abuse is alleged to have occurred, be concluded."); Berman v. Karvounis, 518 A.2d 726, 727 (Md. 1987); Teefey v. Cleaves, 73 S.W.3d 813, 817–18 (Mo. Ct. App. 2002) (contrasting requirements of malicious prosecution and abuse of process); Read v. City of Fairview Park, 764 N.E.2d 1079, 1081 (Ohio Ct. App. 2001) ("[P]roof of the successful termination of the underlying criminal case is an essential element of malicious prosecution; however, this is not true for presentation of a claim of abuse of process.").

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confusion.[143] Because abuse of process is not tied to the resolution of the underlying litigation, it also would follow that the statute of limitations would begin to run at the time the process is perverted to an illegitimate purpose.[144] Thus, in many cases the claimant might be *required* to bring suit for abuse of process before the underlying litigation concludes, if the illegitimate purpose of prolonging the underlying litigation has succeeded.

Additionally, courts would need to clarify the relationship between sanctions available under rules of civil procedure and the inherent power of the court, and the availability of damages for abuse of process. At first glance it may appear that the claimant should allege that the insurer is abusing discovery or motion practice immediately in the form of a motion to the trial judge for sanctions and a protective order. If the claimant pursues sanctions and obtains a monetary recovery, she certainly will be precluded from receiving a double recovery for the same wrongful behavior. However, sanctions serve a different function than tort law. As one court noted recently in response to a claim that the injured party may only pursue judicial sanctions for abusive litigation tactics: "An abuse of process action is not designed to compel compliance with court procedures or to deter future misconduct. Rather the tort is intended to compensate a party for harm resulting from another's misuse of the legal system."[145] Thus, the availability of judicial sanctions for alleged wrongdoing does not preempt the tort cause of action for

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143. *See, e.g.,* Devaney v. Thriftway Marketing Corp., 953 P.2d 277, 286 (N.M. 1997) (holding that because "we do not recognize favorable termination as an element of a cause of action for malicious abuse of process, we hold that such a claim may be raised by counterclaim," but imposing a "clear and convincing" evidentiary burden on plaintiffs who file claims as counterclaims); Badger Cab Co. v. Soule, 492 N.W.2d 375, 378–79 (Wis. Ct. App. 1992) (holding as a matter of law that a party may not join opposing counsel in a counterclaim alleging abuse of process in the instant litigation).

144. *See Read*, 764 N.E.2d, at 1082 (finding that claim for abuse of process was time-barred by two-year statute of limitations pertaining to actions against political subdivisions when plaintiff brought suit more than two years after the alleged abuse of process).

145. Food Lion, Inc. v. United Food & Commercial Workers Int'l Union, 567 S.E.2d 251, 255 n.5 (S.C. Ct. App. 2002). The dissent agreed with this assessment:

> While sanctions under the FRCP are intended to deter abusive conduct, tort law is intended, at least in large part, to compensate the victims of abuse. . . . The tort is not aimed at procedural control of lawsuits, as the rules are, but at remedying abuses. The goal and focus of each are very different. Thus, I conclude that this abuse of process tort action is not preempted by federal law.

Id. at 259–60 (Stilwell, J., dissenting).

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abuse of process.[146] This rule can be justified on a variety of conceptual and practical grounds that go beyond the different primary purposes of these avenues of relief. To name but a few examples: it is likely that judicial sanctions will be imposed only in egregious cases, a party might choose not to seek sanctions for each instance of abuse for fear of alienating the presiding judge, the ulterior motive and perversion of facially legitimate process might become clear only after a motion for sanctions is no longer timely, and the sanctions awarded by judges are unlikely to compensate the claimant fully for her injuries, particularly with regard to emotional distress and consequential losses.

Finally, there might be reluctance to permit a lawsuit founded on the conduct in a previous lawsuit for fear that the case would never come to conclusion. Critics might ask, "How can insurers settle a case with finality if immediately upon payment of the settlement proceeds the claimant can continue the claim under the guise of a suit for abuse of process?" However, this challenge would be premised on a fundamental misunderstanding of the nature of the action. If the claimant reaches a settlement agreement with an insurer regarding the liability of the insured wrongdoer and an appropriate payment of damages, that settlement will be final as to those parties on those questions. The claimant's allegations of abuse of process target entirely different conduct that causes different injuries. Thus, if a third-party claimant executes a general release in favor of the other party to the litigation, that release will be fully effective and enforceable, but it will not free opposing counsel from liability for his tortious conduct during the litigation.[147] If a claimant alleges that she was compelled by an insurer's abuse of process to settle for an inadequate recovery in the underlying litigation, she may seek as damages the amounts that she otherwise would have been able to obtain in the underlying litigation. But in this case the claimant is not reopening the underlying litigation; instead, she is using the inadequate settlement as a factual referent for the measure of the losses caused by the insurer's independent tortious behavior. This situation parallels the damages measure for legal malpractice, where a client's later claim that his attorney's

146. Fumo v. Gallas, No. CIV.A.00-CV-4774, 2001 WL 115460, at *3 (E.D. Pa. Feb. 6, 2001) (Rule 11 does not create a federal common law tort of wrongful use of civil process that preempts state law claims for abuse of process). *Cf.* McShares, Inc. v. Barry, 970 P.2d 1005, 1013 (Kan. 1998) (discussing the differences between Rule 11 sanctions and tort liability for malicious prosecution).

147. *See* Van Blaricom v. Kronenberg, 50 P.3d 266, 268–69 (Wash. Ct. App. 2002).

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malpractice caused him to lose a case is not regarded as re-opening or prolonging the initial litigation, even though the attorney's liability is measured in part by the damages that the client should have received in the underlying litigation.[148]

To recapitulate the foregoing argument: courts should permit third-party claimants to recover damages for abuse of process from a liability insurer if the claimant can prove that the insurer used civil process not for its intended purpose but rather to inflict financial and emotional costs on her in an effort to coerce her to accept an inadequate settlement. The "proper purpose" of the process in question should be determined with reference to the strong public policy articulated by the legislature and courts regarding the insurer's obligation to act promptly, fairly and reasonably in handling claims. The claimant could bring this action prior to the conclusion of the underlying litigation, and regardless of whether the claimant prevails in that action. A court's refusal to impose sanctions during the course of the underlying litigation for the behavior in question might be relevant evidence, but it would not be determinative as to tort liability. And finally, the claimant's damages would include any difference between the settlement amount and the amount that she would have obtained in the litigation if the insurer had not acted tortiously, and also any consequential losses (financial or emotional) proximately resulting from the tortious behavior. Admittedly, the doctrinal landscape generally remains inhospitable to my argument, but I have attempted to show that I am advocating nothing more than a straightforward application of tort doctrine in a manner that reinforces established public policy. If courts adopted this application of the tort of abuse of process, they would go a long way toward ensuring that when injured persons learn that the wrongdoer has insurance, they can safely assume that this is good news after all.

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148. For the elemental proposition that the proper measure of damages in a legal malpractice case is the amount of damages that would have been collected but for the wrongful act or omission of the attorney, see, e.g., *Two Thirty Nine Joint Venture v. Joe*, 60 S.W.3d 896, 910 (Tex. Ct. App. 2001). For the mirror-image doctrinal rule that a client is entitled to recovery of the entire verdict as damages when she suffers a verdict she would have avoided in the absence of her attorney's malpractice, see *Scognamillo v. Olsen*, 795 P.2d 1357, 1361 (Colo. Ct. App. 1990).

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LIFE INSURANCE RISK CLASSIFICATION: FINDING THE BOUNDARY BETWEEN ANTITRUST AND UNFAIR DISCRIMINATION

*J. Daniel Perkins**

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INTRODUCTION

> And so, this took me directly to the debit system, which as I say, I didn't want to get into problems with the folks from the Department of Justice in the Anti-Trust Division, so I didn't place on my computer here, for this conference, how I would rate this, but it's not hard to figure out.[1]
>
> See, I didn't show you that for the purposes of this meeting, because it's been inbred into me that you've got to watch out for the anti-trust folks.[2]

The Home Office Life Underwriters Association (HOLUA) is one of the two major professional underwriter associations in the United States, which along with the Institute of Home Office Underwriters, has been unified into one organization, the Association of Home Office Underwriters, which held its first meeting in November 2002.[3] HOLUA has a policy statement that strictly forbids any activities on the part of its members that could be construed as violating the antitrust laws.[4]

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1. Anthony Milano, M.D., *The Underwriting Manual: An Evidence-Based Approach, Address Before the Home Office Life Underwriters Association* (May 8, 2001), *in* PROCEEDINGS OF THE HOME OFFICE LIFE UNDERWRITERS ASSOCIATION, Vol. 82, at 274.
2. *Id.* at 280.
3. *Id* at ix, Foreword.
4. *Id.* at viii, Policy Statement of Anti-Trust Compliance:

> The Home Office Life Underwriters Association (HOLUA) is a voluntary association of individual members. The object of the association is to advance the knowledge of sound underwriting of life and disability insurance risks, toward which end it holds meetings, publishes papers and discussions, and promotes educational programs.
>
> Because of the nature of its business—bringing together competitors for the purpose of discussing important facts and issues in life and

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While HOULA itself, its members, as well as any other professional in the life insurance industry should be commended for attempting to play by the "rules of antitrust," two questions come to mind. First, is the antitrust policy used by underwriters/insurers necessary or sufficient? Second, where are the lines to be drawn as to when and what underwriters/insurers can and cannot do as it relates to antitrust and the sharing of life insurance mortality information for risk classification purposes? This Article will attempt to answer these questions, and in doing so, provide a framework by which those interested in life insurance risk classification can determine on which side of the antitrust line their actions or the actions of others fall.

Part I of this Article will provide a historical summary of federal statute and case law as it applies to insurance and antitrust. In addition, pertinent state statutes will be discussed. Part II of this Article will describe the risk classification process in enough detail to provide the reader with a frame of reference as to how the risk classification process is conducted in the life insurance industry. This framework will include the principles by which the risk classification process is governed, and a description of the role played by reinsurers. Part III will describe three activities engaged in by underwriters that have a possible impact on antitrust concerns: underwriting manuals, intercompany mortality studies, and professional papers and presentations. The antitrust implications of these activities will be discussed within the framework of the *Antitrust Guidelines for Collaborations Among Competitors* issued by the Federal Trade Commission and the United States Department of Justice.[5] By discussing the risk classification activities in this manner, this Article will attempt to

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> disability risk appraisal—HOLUA and its members must at all times be sensitive to both the spirit and letter of anti-trust laws, which broadly stated, prohibit any activities that might lessen or tend to lessen the desirable competition of the Association's constituents. It is the policy of HOLUA to avoid all activities which could or might appear to violate any anti-trust competitive law.
>
> The HOLUA will not, through its programs, policies or practices, suggest price fixing. Pricing suggestions which are prohibited include suggested extra ratings or proposed business actions regarding individual applicants for insurance. "Price Fixing" can be broadly interpreted and any semblance of it must be absolutely avoided.

5. ANTITRUST GUIDELINES FOR COLLABORATIONS AMONG COMPETITORS, ISSUED BY THE FEDERAL TRADE COMMISSION AND THE U.S. DEPARTMENT OF JUSTICE (2000), *available at:* http://www.ftc.gov/os/2000/04/ftcdojguidelines.pdf (last visited Mar. 1, 2003) [hereinafter ANTITRUST GUIDELINES].

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provide a determination as to what risk classification practices fall within the ambit of the Guidelines and which do not. The Article will conclude by summarizing the answers to the questions asked by the Article.

I. SUMMARY OF FEDERAL STATUTE, CASE LAW, AND PERTINENT STATE REGULATION

A. Evolution of Federal Regulation of Insurance

The mechanism by which the federal government exerts power over any business entity is found in the "Commerce Clause" of the United States Constitution, which states "[t]he Congress shall have Power . . . [t]o regulate Commerce with foreign Nations, and among the several States, and with the Indian Tribes."[6] Congress' power to regulate commerce was affirmed in *Gibbons v. Ogden*,[7] where the Supreme Court stated that "the power to regulate; that is, to prescribe the rule by which commerce is to be governed. This power, like all others vested in Congress, is complete in itself, may be exercised to its utmost extent, and acknowledges no limitations, other than are prescribed in the constitution."[8] As part of his analysis, Chief Justice Marshall stated that "[c]ommerce, undoubtedly, is traffic, but it is something more: it is intercourse. It describes the commercial intercourse between nations, and parts of nations, in all its branches, and is regulated by prescribing rules for carrying on that intercourse."[9]

It was not until forty-four years post-*Gibbons* that the Court first substantially addressed what power Congress or the several States had over commerce as it related to insurance. In *Paul v. Virginia*,[10] Paul, a resident of Virginia, was appointed an agent for several fire insurance companies incorporated in New York.[11] The insurers proceeded to offer and to issue at least one policy for insurance, without first depositing the bonds required by the State of Virginia to obtain a license to sell insurance.[12]

6. U.S. CONST. art. I, § 8, cl. 3.

7. 22 U.S. 1, 203–04 (1824) (holding that Congress could regulate navigation on New York waterways to the extent that the navigation would be considered interstate commerce, and that when federal law and state law conflict, that federal law preempts state law).

8. *Id.* at 196.

9. *Id.* at 189–90.

10. 75 U.S. 168 (1896).

11. *Id.* at 169.

12. *Id.*

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Consequently, Paul was convicted and fined, whereupon he brought suit against the State of Virginia for claims under both the Commerce Clause of the Constitution, as well as the Privileges and Immunities Clause of Article IV.[13] In ruling against Paul on both claims and upholding the State of Virginia's right to regulate insurance within its borders, the Court held that "[i]ssuing a policy of insurance is not a transaction in commerce. The policies are simple contracts of indemnity against loss by fire."[14] The Court went on to state that insurance contracts were "not articles of commerce,"[15] were "not executed contracts—until delivered by the agent in Virginia,"[16] and the insurance contracts "do not constitute a part of the commerce between the States."[17]

The Sherman Act was signed into law in 1890, and the objectives of the Act were twofold: enhance the welfare of consumers, and give the federal government a mechanism by which to combat and limit the development of supra-large corporations.[18] Section 1 of the Act makes illegal any act that restrains trade.[19] Monopolization or attempts to do so are deemed illegal under Section 2 of the Act.[20] Section 7 defines the term "person" to include corporations and associations existing or authorized by laws of the federal branch, a State, any United States Territory, or the laws of any foreign country.[21] The right of any person to bring a cause of action

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13. *Id.* at 170. Art. IV, § 2, cl. 1 of the U.S. Constitution states: "[t]he Citizens of each State shall be entitled to all Privileges and Immunities of Citizens in the several States." Paul claimed that a corporation was a "citizen" of a State within the meaning of the Constitution and that this citizenship prevented the State of Virginia from imposing its statutory requirements upon the New York insurers. *Paul,* 75 U.S. at 171–72. It is interesting to note that the majority of the Court's opinion concerned this argument, and not the Commerce Clause Claim.

14. *Paul,* 75 U.S. at 183.

15. *Id.*

16. *Id.*

17. *Id.*

18. THOMAS D. MORGAN, MODERN ANTITRUST LAW AND ITS ORIGINS 25–30 (2d ed. 2001) (discussing the history of passage of the Sherman Act).

19. 15 U.S.C. § 1 (2000) "Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is declared to be illegal." *Id.*

20. *Id.* § 2. "Every person who shall monopolize, or attempt to monopolize, or combine or conspire with any other person or persons, to monopolize any part of the trade or commerce among the several States, or with foreign nations, shall be deemed guilty . . . ." *Id.*

21. *Id.* § 7.

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under the Act is stated by Section 8 to be any person injured in his business or property by any other person or corporation.[22]

The insurance industry was brought within the ambit of the Sherman Act by the Court's decision in *United States v. South-Eastern Underwriter Ass'n.*[23] In *South-Eastern*, the 200 private stock fire insurance company members of the South-Eastern Underwriters Association (SEUA) controlled ninety per cent of the fire insurance and "allied" lines sold in six states.[24] The indictment stated that SEUA conspired to "not only fix premium rates and agents' commissions, but employed boycotts together with other types of coercion and intimidation to force non-member insurance companies into the conspiracies, and to compel persons who needed insurance to buy only from SEUA members on SEUA terms."[25] The Court framed the issue as:

> not to uphold another state law, but to strike down an Act of Congress which was intended to regulate certain aspects of the methods by which interstate insurance companies do business; and, in so doing, to narrow the scope of the federal power to regulate the activities of a great business carried on back and forth across state lines.[26]

In finding that the "business of insurance" was subject to the antitrust laws under the Sherman Act, the Court explained its turnabout from its previous decision in *Paul* by stating "[i]t is settled that, for Constitutional purposes, certain activities of a business may be intrastate and therefore subject to state control, while other activities of the same business may be interstate and therefore subject to federal regulation."[27] In addition, the Court found it inconclusive as to whether Congress specifically intended to exempt insurance companies from the all-inclusive scope of the Sherman Act.[28] It held that states could continue to regulate insurance companies, but that a state could not authorize combinations of insurance companies to coerce, intimidate, and boycott competitors and consumers.[29] It is notable that the

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22. *Id.* § 8.
23. 322 U.S. 533 (1944).
24. *Id.* at 534–35.
25. *Id.* at 535.
26. *Id.* at 545.
27. *Id.* at 548 (citations omitted).
28. *Id.* at 560.
29. *Id.* at 562. The court partially based its analysis on this point on a decision it had made one year earlier in *Parker v. Brown*, 317 U.S. 341, 363, 368 (1943). In *Parker*, the

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dissenting opinions by Stone,[30] Frankfurter,[31] and Jackson[32] all agreed with the majority that insurance is interstate commerce, but that insurance had never been treated as such by either Congress or the courts.

Nine months after the *South-Eastern* decision, the McCarran-Ferguson Act was signed into law.[33] Section 1011 of the Act states:

> Congress hereby declares that the continued regulation and taxation by the several States of the business of insurance is in the public interest, and that silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several states.[34]

Section 1012(a) of the Act states that "[t]he business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business."[35] Section 1012(b) states:

> No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance: Provided . . . the Sherman Act, . . . the Clayton Act, and . . . the Federal Trade Commission Act . . . shall be applicable to the business of insurance to the extent that such business is not regulated by State law.[36]

Finally, Section 1013 of the Act states that "[n]othing contained in this chapter shall render the said Sherman Act inapplicable to any agreement to

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Court upheld a law of the State of California that allowed the State to regulate the handling, disposition, and prices of raisins produced in the state. In so doing, the Court also held that "a state does not give immunity to those who violate the Sherman Act by authorizing them to violate it, or by declaring that their action is lawful." *Id.* at 351 (citation omitted).

30. *South-Eastern Underwriter Ass'n*, 322 U.S. at 563.

31. *Id.* at 583.

32. *Id.* at 585–86.

33. 15 U.S.C. §§ 1011–15 (2000) *et seq. South-Eastern* was decided on June 5, 1944 and the McCarran-Ferguson Act signed into law on March 9, 1945.

34. 15 U.S.C. § 1011 (2000).

35. *Id.* § 1012(a).

36. *Id.* § 1012(b).

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boycott, coerce, or intimidate, or act of boycott, coercion, or intimidation."[37]

With almost the same speed exhibited by Congress in passing the McCarran-Ferguson Act following the decision in *South-Eastern*, the Court was asked to interpret and apply the McCarran-Ferguson Act in *Prudential v. Benjamin*.[38] For a number of years, the State of South Carolina had levied only on foreign insurance companies a tax required before that insurer could carry on the business of insurance within the state.[39] Prudential did not argue that commerce was not involved,[40] but instead that the tax was a discriminatory exaction forbidden by the Commerce Clause since it was only levied on foreign insurance corporations.[41] In finding for the State of South Carolina, the Court first remarked that in passing the McCarran-Ferguson Act that "Congress must have had full knowledge of the nation-wide existence of state systems of regulation and taxation; of the fact that they differ greatly in the scope and character of the regulations imposed."[42] The Court then stated that with the McCarran-Ferguson Act "Congress intended to declare, and in effect declared, that uniformity of regulation, and of state taxation, are not required in reference to the business of insurance by the national public interest, except in the specific respects otherwise expressly provided for."[43]

Having affirmed the constitutionality of the McCarran-Ferguson Act in *Benjamin*, the Court was then asked in *Group Life & Health Insurance Co. v. Royal Drug Co.*[44] to define the meaning of the phrase "business of insurance." Group Life & Health, better known as "Blue Shield of Texas" had contracted with pharmacies across Texas to offer prescription drugs to Blue Shield's policyholders at a reduced cost.[45] Owners of several independent pharmacies brought suit accusing Blue Shield of entering agreements to fix the retail prices of drugs and pharmaceuticals.[46] In turn, Blue Shield argued that its actions were exempt from antitrust laws under

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37. *Id.* § 1013(b).
38. 328 U.S. 408 (1946).
39. *Id.* at 410.
40. *Id.* at 427.
41. *Id.* at 428.
42. *Id.* at 430.
43. *Id.* at 431 (internal citations omitted).
44. 440 U.S. 205 (1979).
45. *Id.* at 209.
46. *Id.* at 207.

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section 1012(b) of the McCarran-Ferguson Act because the agreements were within the meaning of the "business of insurance."[47] In finding against Blue Shield, the Court held that the contracted agreements between Blue Shield and the pharmacies were not within the meaning of the term "business of insurance."[48] In so doing, the Court stated that the insurance exemption under McCarran-Ferguson Act "is for the 'business of insurance,' not the business of insurers."[49] The Court also remarked that "[t]he primary elements of an insurance contract are the spreading and underwriting of a policyholder's risk,"[50] and that the McCarran-Ferguson Act was concerned with "[t]he relationship between insurer and insured, the type of policy which could be issued, its reliability, interpretation, and enforcement—these were the core of the 'business of insurance.'"[51] Therefore, the Court held that the pharmacy agreements were not the "business of insurance" because they did not involve any underwriting or spreading of risk.[52]

As part of its *Royal Drug* analysis, the Court also further clarified its interpretation of the McCarran-Ferguson Act. The Court noted that the Act did not overrule its *South-Eastern* decision;[53] instead it "freed the States to continue to regulate and tax the business of insurance companies, in spite of the Commerce Clause . . . [but] [i]t did not, however, exempt the business of insurance companies from the antitrust laws."[54] Finally, the Court suggested that "Congress understood the business of insurance to be the underwriting and spreading of risk,"[55] and that "Congress . . . recognized the necessity for concert of action in the collection of statistical data and rate making."[56]

Shortly thereafter, the Court used its *Royal Drug* analysis to determine what should be considered within the business of insurance. In *Union Labor Life Insurance Co. v. Pireno*,[57] the Plaintiff, a chiropractor, sued the insurer claiming that the insurer's use of peer review by chiropractors to

47. *Id.*
48. *Id.* at 232–33.
49. *Id.* at 211.
50. *Id.*
51. *Id.* at 215–16 (quoting SEC v. Nat'l Sec., Inc., 393 U.S. 453, 460 (1969)).
52. *Id.* at 214.
53. *Id.* at 220.
54. *Id.* at 218–19 n.18.
55. *Id.* at 221.
56. *Id.* at 222.
57. Union Labor Life Ins. Co. v. Pireno, 458 U.S. 119 (1982).

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determine reasonable fees for services was restraint of trade in violation of section 1 of the Sherman Act.[58] Union Life countered by arguing that its actions were exempt under the McCarran-Ferguson Act.[59] Citing *Royal Drug*, the Court identified three criteria relevant in determining whether a particular practice is part of the "business of insurance" exempt from the antitrust laws by section 1012(b):

> [1.] whether the practice has the effect of transferring or spreading a policyholder's risk;
> [2.] whether the practice is an integral part of the policy relationship between the insurer and the insured; and
> [3.] whether the practice is limited to entities within the insurance industry.[60]

Applying these three criteria to the facts of the case, the Court held that insurer's use of the Peer Review Committee did not play a "part in the 'spreading and underwriting of a policyholder's risk,'"[61] "use of . . . [the] Committee is not an integral part of the . . . relationship between insurer and insured,"[62] and "the challenged peer review practices are not limited to entities within the insurance industry."[63] As to the third criteria, the Court did hedge by stating that "practices need not be denied the [section 1012(b)] exemption *solely* because they involved parties outside the insurance industry . . . [b]ut the involvement of such parties, even if not dispositive, constitutes part of the inquiry mandated by the *Royal Drug* analysis."[64]

As it did in *South-Eastern*,[65] the Court once again confronted the extent to which states should regulate insurance in *Federal Trade Commission v. Ticor Title Insurance Co.*[66] In *Ticor Title*, the Federal Trade Commission alleged horizontal price fixing against the six largest title insurance companies in the nation.[67] Two principal defenses raised by the companies were exemption from antitrust under the McCarran-Ferguson Act, and

58. *Id.* at 122–23.
59. *Id.* at 124.
60. *Id.* at 129.
61. *Id.* at 130 (quoting *Royal Drug*, 440 U.S. at 205, 211 (1979)).
62. *Id.* at 131.
63. *Id.* at 132.
64. *Id.* at 133.
65. *See* United States v. South-Eastern Underwriter Ass'n, 322 U.S. 533, 562 (1944).
66. 504 U.S. 621 (1992).
67. *Id.* at 624.

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state-action immunity from antitrust, citing the line of cases beginning with *Parker v. Brown*,[68] which held that anticompetitive conduct has state-action immunity if the activity is authorized and supervised by state officials.[69] The Court brushed aside the McCarran-Ferguson defense since the uniform rates set through rating bureaus and used by the title insurers were not the result of pooling risk information, but instead were based upon profitability studies.[70] In analyzing the state-immunity argument, the Court relied upon the two-part test enunciated in *California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc.*,[71] which states that a state law or regulatory scheme cannot be the basis for antitrust immunity unless:

> 1. the State has articulated a clear and affirmative policy to allow the anticompetitive conduct; and
> 2. the State provides active supervision of anti-competitive conduct undertaken by private actors.[72]

The Court noted from the facts of the case that several of the States used a "negative option" system by which to approve rate filings by the bureaus.[73] Under this system, the rates filed by the bureaus became effective unless the State rejected them within a specified period, and the rate filings were subject to minimal scrutiny by state regulators.[74] The Court found against Ticor Title since there was no evidence of substantial state participation in the rate-setting scheme.[75] In addition, the Court held that "[a]ctual state involvement, not deference to private price-fixing arrangements under the general auspices of state law, is the precondition for immunity from federal law."[76] And as a roadmap for possible future actions on the part of insurers and state regulatory agencies, the Court stated:

> This case involves horizontal price fixing under a vague *imprimatur* in form and agency inaction in fact. No antitrust offense is more pernicious than price fixing . . . . Our decision should be read in light of the gravity of the antitrust

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68. *Id.* at 625; Parker v. Brown, 317 U.S. 341 (1943).

69. *Ticor Title*, 504 U.S. at 627; *Parker*, 317 U.S. at 350–52.

70. *Ticor Title,*, 504 U.S. at 628.

71. Cal. Retail Liqour Dealers Ass'n v. Midcal Aluminum, Inc., 445 U.S. 97, 105 (1980) (invalidating a California statute forbidding licensees in the wine trade to sell below prices set by the producer).

72. *FTC*, 504 U.S. at 631.

73. *Id.* at 638.

74. *Id.*

75. *Id.* at 639.

76. *Id.* at 633.

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> offense, the involvement of private actors throughout, and the clear absence of state supervision. We do not imply that some particular form of state or local regulation is required to achieve ends other than the establishment of uniform prices.[77]

The impact by foreign reinsurers[78] on the United States insurance industry was examined by the Court in *Hartford Fire Insurance Co. v. California*.[79] In *Hartford Fire*, several domestic and foreign insurer and reinsurer defendants were alleged to have violated the Sherman Act by use of a boycott, in order to force other primary insurers to change the terms of their standard commercial general liability (CGL) insurance contracts.[80] The scheme was instigated by four domestic primary insurer defendants who approached domestic reinsurers, as well as several key actors in the London reinsurance market, about using their positions as reinsurers to affect changes in the wording of the standard CGL contract.[81] The leverage in the scheme was that all the reinsurers participating in the activity would withhold reinsurance from the marketplace unless the demanded changes in the standard CGL contract were incorporated into the form.[82] The harm of noncompliance with the demanded changes would be the loss of protection for a primary insurer from catastrophic loss, and decreasing the ability of a primary insurer to sell more insurance than its own financial capacity might otherwise permit.[83] The defendants argued their activities were exempt under the McCarran-Ferguson Act, and the foreign reinsurers also argued that the principle of international comity precluded the Court from exercising jurisdiction over them.[84] The Court stated that its prior cases had "confirm[ed] that the 'business of insurance' should be read to single out one activity from others, not to distinguish one entity from another,"[85] and "that the McCarran-Ferguson Act immunizes activities rather than

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77. *Id.* at 639.

78. Reinsurance defined as "insurance of all or part of one insurer's risk by a second insurer, who accepts the risk in exchange for a percentage of the original premium." BLACK'S LAW DICTIONARY 1290 (7th ed. 1999).

79. 509 U.S. 764 (1993).

80. *Id.* at 769–71.

81. *Id.* at 775.

82. *Id.*

83. *Id.* at 773; *see infra* text accompanying notes 155–57.

84. *Id.* at 769.

85. *Id.* at 781.

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entities."[86] Therefore, the domestic insurers did not lose their McCarran-Ferguson Act exemption simply because their transactions were with foreign reinsurers,[87] but the Court also stated "it is well established by now that the Sherman Act applies to foreign conduct that was meant to produce and did in fact produce some substantial effect in the United States."[88] The Court did, however, state there were sufficient allegations that the defendants engaged in an illegal boycott, which violated the Sherman Act by way of section 1013(b) of the McCarran-Ferguson Act.[89] However, in so finding, the Court distinguished between the term "concerted agreement" to seek particular terms,[90] which is "a way of obtaining and exercising market power by concertedly exacting terms like those which a monopolist might exact,"[91] and a "conditional boycott," which was the "expansion of the refusal to deal beyond the targeted transaction that gives great coercive force to a commercial boycott: unrelated transactions are used as leverage to achieve the terms desired."[92] The Court held that if the reinsurers' activities were determined to be a concerted agreement to seek particular terms, then the reinsurers' activities were not a form of boycott under the Sherman Act, and would therefore be exempt as lawful under the McCarran-Ferguson Act.[93]

The interplay of federal statute and state law laid at the center of the Court's analysis in *Humana Inc. v. Forsyth*.[94] The group health policy at issue stipulated that Humana would pay 80% of the policy beneficiaries' hospital charges at Humana Hospital, while the beneficiaries paid the remaining 20%.[95] However, in a concealed agreement between the insurer and the hospital, the hospital granted large discounts on the insurer's portion of the hospital charges, with the effect that the beneficiaries paid significantly more than the 20% contracted.[96] The plaintiff beneficiaries sued alleging violations of the Racketeer Influenced and Corrupt

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86. *Id.* at 783.
87. *Id.* at 784.
88. *Id.* at 796 (citing Matsushita Elec. Indus. Co. v. Zenith Radio Corp., 475 U.S. 574, 582, n.6 (1986)).
89. *Id.* at 810–11; 15 U.S.C. § 1013(b) (2000).
90. *Hartford Fire*, 509 U.S. at 802.
91. *Id.* (quoting L. SULLIVAN, LAW OF ANTITRUST 257 (1977)).
92. *Id.* at 802–03.
93. *Id.* at 810–11.
94. 525 U.S. 299 (1999).
95. *Id.* at 303.
96. *Id.*

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Organizations Act (RICO) by way of mail, wire, radio, and television fraud, while the defendant insurer and hospital moved for summary judgment citing section 1012(b) of the McCarran-Ferguson Act.[97] The Court noted that:

> [t]he McCarran-Ferguson Act thus precludes application of a federal statute in face of state law "enacted . . . for the purpose of regulating the business of insurance," if the federal measure does not "specifically relate to the business of insurance," and would "invalidate, impair, or supersede the State's law." RICO is not a law that "specifically relates to the business of insurance."[98]

However, the Court then proceeded to formulate the meaning of section 1012(b): "When federal law does not directly conflict with state regulation, and when application of the federal law would not frustrate any declared state policy or interfere with a State's administrative regime, the McCarran-Ferguson Act does not preclude its application."[99] Using this formulation, the Court found against Humana by concluding that the RICO causes of action, and those of the applicable Nevada statute,[100] were not in direct conflict since both statutes advanced the state's interest in combating insurance fraud.[101]

While not involving insurance, some mention must be made as to whom and in what circumstance a party can bring a cause of action for an antitrust violation. In *Associated General Contractors of California v. California State Council of Carpenters*,[102] the court enunciated three factors that should be used to determine if a private party may bring a private antitrust action. These factors are:

> 1. is there a causal connection between the antitrust violation, harm to the plaintiff, and the defendant's act;[103]

97. *Id.* at 304.

98. *Id.* at 307 (internal citations and quotations omitted).

99. *Id.* at 310 (using some of the language from Brief for National Association of Insurance Commissioners (NAIC) as *Amicus Curiae* 6–7 (Sept. 18, 1998)).

100. *Id.* at 311 (citing Nevada Unfair Insurance Practices Act, NEV. REV. STAT. § 686A.010 *et seq.* (1996)).

101. *Id.* at 314.

102. 459 U.S. 519 (1983).

103. *Id.* at 537.

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2. in each case, the "alleged injury must be analyzed to determine whether it is of the type that the antitrust statute was intended to forestall";[104] and

3. "the directness or indirectness of the asserted injury."[105]

B. Pertinent State Regulation

By necessity and design, the review of state regulation will focus only on the state statute versions of insurance antitrust law, including a description of statutes addressing "unfair practices." In addition, only those statutes from the states of California, Texas, New York and Florida will be discussed, since these four states are the largest in the United States both in terms of population and total life insurance premiums written.[106]

As to state versus federal antitrust oversight for the insurance industry, all four states have statutory sections that reflect the language promulgated by the NAIC.[107] This language states that its purpose is:

> to regulate trade practices in the business of insurance in accordance with the intent of Congress as expressed [in the McCarran-Ferguson Act] by defining, or providing for the determination of, all such practices in this State which constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined.[108]

Incorporating the language of section 1013 of the Sherman Act, California, Florida and Texas include NAIC language in their definitions of unfair trade practices by insurers by prohibiting the "[e]ntering into any agreement to commit, or by any concerted action committing any act of boycott, coercion or intimidation resulting in or tending to result in unreasonable restraint of, or monopoly in, the business of insurance."[109]

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104. *Id.* at 540.

105. *Id.*

106. LIMRA International, LIMRA'S MARKET TRENDS: 2002 TRENDS IN THE UNITED STATES 25 (2001).

107. NAT'L ASSOC. OF INS. COMM'RS, UNFAIR TRADE PRACTICES, NAIC MODEL LAWS, REGULATIONS AND GUIDELINES 880-1 § 1.

108. CAL. INS. CODE § 790 (2001); *See* FLA. STAT. ch. 626.951(1) (2001); NY INS. § 2401 (2002); *and* TEX. INS. CODE art. 21.21 § 1(a) (2002).

109. NAT'L ASSOC OF INS. COMM'RS, UNFAIR TRADE PRACTICES, NAIC MODEL LAWS, REGULATIONS AND GUIDELINES 880-1 § 3, D; *see* CAL. INS. CODE § 790.03(c) (2001); FLA. STAT. ch. 626.9541(1)(d) (2001); *and* TEX. INS. CODE art. 21.21 § 4(4) (2002).

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On the other hand, New York simply applies its general business code to declare illegal and void any attempt to establish or maintain a monopoly, or conduct activity that restrains trade or commerce,[110] but provides an exception as to those activities regulated by its insurance code.[111]

All four states also have statutes that prohibit unfair discriminatory practices relating to the setting of premium rates among individuals of the same risk classification, except where the discrimination is based on "sound actuarial principles" or is related to "actual and reasonably anticipated experience."[112] Each of these statutes provides a private cause of action for unfair discrimination involving the risk classification process. None of the statutes nor the NAIC give a direct definition of either term, but by examining the definition of the individual words that constitute each term, "sound actuarial principles" can be described as "basic assumptions as to the computing of insurance risks and premiums, based upon valid reasoning,"[113] and "actual and reasonably anticipated experience" can be defined as "knowledge gained in accordance with sound thinking as to existing facts and those facts expected in the future."[114] These conjoined definitions imply that in order for a life insurer to discriminate in its risk classification process, the discrimination must be based upon current, statistically valid mortality information.

C. Summary of Regulatory Guidelines for Antitrust Violations

At this point, it is perhaps helpful to summarize the federal case law and state regulations reviewed into "rules" that can be used when making a determination as to whether an insurer is engaged in an activity that violates antitrust laws. These "rules" would require an assessment as to:

> 1. Does the activity engaged in by the insurer fall within the "business of insurance?" An activity would meet this criteria if:

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110. NY GEN. BUS. § 340, 1 (2002).

111. *Id.* § 340, 2 (2002).

112. *See* CAL. INS. CODE § 10144 (2002); FLA. STAT. ch. 626.9541(1)(g) 1, (1)(g) 2 (2001); NY INS § 4224(a)(1), (a)(2) (2002); *and* TEX. INS. CODE art. 21.21-6 §§ 1, 4(a) (2002). *See also* NAT'L ASSOC OF INS. COMM'RS, UNFAIR TRADE PRACTICES, NAIC MODEL LAWS, REGULATIONS AND GUIDELINES 887-1 § 3.

113. AMERICAN HERITAGE DICTIONARY (4th ed.) at 18 (actuary), 1395 (principle), and 1660–62 (sound).

114. *Id.* at 18 (actual), 77 (anticipate), 625 (experience), and 1457 (reasonable).

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a. it involved the transfer or spreading of the policyholder's risk, or statistical data and rate-making; and

b. the activity or practice is an integral part of the policy relationship between the insurer and the insured.[115]

2. Does the insurer's activity involve a third party? If yes, and the third party is within the insurance industry, the activity probably falls within the ambit of the business of insurance. If the third party is outside the insurance industry, this does not automatically disqualify the activity as not being within the business of insurance, but it requires a more in-depth analysis on the part of the court.[116]

3. Activities conducted by an insurer or insurers that cause boycott, coercion, or intimidation are not exempt under McCarran-Ferguson; therefore, these activities are subject to action under the full range of antitrust laws.[117]

4. The antitrust laws apply to insurers and reinsurers, and includes both United States domestic insurers and foreign insurers, whose insurance activities affect the United States market.[118]

5. Activities that are considered the business of insurance are exempt from federal antitrust laws only if the activity is regulated by the state and that state:

a. has articulated a clear and affirmative policy to allow the anticompetitive conduct; and

b. provides active supervision of anticompetitive conduct undertaken by insurers. There must be active state supervision and not deference to private agreements to maintain immunity from federal law.[119]

6. If an activity is subject to both federal and state law, and application of the federal law does not interfere with a state's supervision of the activity, then the activity is subject to both federal and state causes of action.[120]

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115. *See supra* text accompanying note 62.
116. *See supra* text accompanying notes 60–64.
117. *See supra* text accompanying notes 27–29.
118. *See supra* text accompanying notes 78–93.
119. *See supra* text accompanying notes 71–76.
120. *See supra* text accompanying notes 98–101.

> 7. State regulation of insurers does not allow a state to sanction activities of private insurers that would coerce, intimidate, and boycott competitors and consumers.[121]
>
> 8. State laws require insurers to use statistically valid information when insurers classify risks for coverage.[122]
>
> 9. An individual applying for insurance coverage cannot bring a private cause of action for alleged antitrust violations by an insurer because the antitrust laws only apply to injuries to competition among competitors.[123]
>
> 10. An individual applying for coverage can bring a private cause of action under state law for unfair discrimination involving the risk classification process.[124]

II. METHODOLOGY OF THE RISK CLASSIFICATION PROCESS

> Risk classification is a discriminatory process in which individuals are included in different risk classes according to the mortality expected. The persons in each class are expected to experience similar mortality; the expected mortality for each class is different. In this way each person pays his fair share and equity is achieved.[125]

This part of the Article will begin by describing the "risk classification process" as it applies to life insurance risk classification and selection. Subsequent discussions will focus on how the risk classification process is conducted at the primary insurer level, and then, the effect reinsurance companies have upon the same process.

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121. *See supra* text accompanying notes 28–29.

122. *See supra* text accompanying notes 56.

123. *See supra* text accompanying notes 103–05.

124. *See supra* text accompanying notes 112–14.

125. Harry A. Woodman, *Principles of Risk Selection and Classification*, MEDICAL SELECTION OF LIFE RISKS 25, 35 (R.D.C. Brackenridge & W. John Elder eds., 4th ed. 1998) [hereinafter Breckenridge & Elder]. Author's Note: The fourth edition will be used to describe the risk classification process. This text is used not because it provides the only or most definitive description of the process, but, instead, because its availability to the general public allows for a discussion of the process without infringing upon any insurer or reinsurer's proprietary methods for classifying insurance risks.

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A. Description of the Risk Classification Process

As an introduction to the risk classification process and why insurers deem it necessary, it is perhaps best to analogize the methodology with something more familiar to most individuals. A prime example is the determination of how large a payment an individual wants to make on his house mortgage. A mortgage payment has four components—the amount of the mortgage, the interest rate, the payment cycle (generally monthly), and the duration or number of payments—that results in a monthly payment amount of X. If the number of payments is lowered from 360 months to 180 months, leaving the amount of the mortgage, the interest rate, and the payment cycle the same, the amount of the monthly payment increases to compensate for the shorter payment period. Equating this to a life insurance policy, if the face amount of the policy remains constant, at a given interest rate, with payments on a monthly basis, a monthly payment of X amount is required to pay for the policy. However, if the insurer determines that the proposed insured's medical history is such that there is a strong likelihood that he will not survive to his normal life expectancy (shorter duration of payment), then the monthly payment must be increased greater than X to pay for the policy.

The determination of individual risks acceptable to the company is called risk selection; the separation of groups of insurance risks into categories of standard, and the degrees of substandard, is called risk classification.[126] The object of risk classification is to protect the insurance company and control mortality experience by declining the severest risks and charging an extra premium commensurate with the expected extra mortality for insurable but substandard risks.[127] Each person must pay a premium in proportion to the risk in order to maintain equity among all policy owners.[128]

When insurers engage in risk classification and risk selection, they are primarily attempting to differentiate standard mortality risks from excess risks, and stratify the insurability of the latter.[129] Risk classification creates risk classes of comparable mortality.[130] Risk selection (*i.e.*, underwriting)

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126. *Id.* at 25.

127. *Id.* at 29.

128. *Id.*

129. Michael W. Kita, *The Rating of Substandard Lives, in* Breckenridge & Elder, *supra* note 125, at 67.

130. *Id.*

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then involves looking at a proposed risk (an applicant at risk of dying and the death benefit at stake), sizing up the nature and severity of the mortality risk involved, and assessing the proper risk class and premium.[131]

"In insurance parlance, 'standard' connotes an applicant with an acceptably normal or average profile of mortality risks: health history, risk factors, family history, avocations and the like."[132] Substandard lives have mortality risk profiles that predispose an individual to premature mortality.[133]

> [T]he key variable affecting each life insurance decision is mortality risk, and the extra ratings applied to substandard business chiefly reflect the mortality costs associated with specific impairments. Quantifying excess mortality and the factors governing it, and anticipating the pattern[s] of mortality over time (loss distribution), are what the rating of substandard lives addresses.[134]

The "numerical rating system" used by life insurance underwriters is a methodology that quantifies the risk classification and selection process. "[T]he standard risk is assigned a value of 100 percent (*i.e.*, one unit of risk),"[135] and an individual is charged the "standard premium." "Unfavorable risk factors, conditions, or impairments expected to produce excess mortality risk are added to that baseline . . . ."[136] If an unfavorable risk factor is expected to produce excess mortality that can be quantified as +50 (read as "plus fifty"), this +50 is added to the 100 percent standard premium to produce a substandard premium of +150.[137] This excess mortality of +50 is also referred to as a "debit" since it results in an extra premium being charged.[138] By the same token, if an applicant has some characteristic associated with unusual longevity, then a "credit" might be considered (*e.g.*, -25 or "minus twenty-five").[139]

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131. *Id.*
132. *Id.* at 64.
133. *Id.*
134. *Id.* at 64–65.
135. *Id.* at 62.
136. *Id.*
137. *Id.*
138. *Id.*
139. *Id.*

For most insurers, the standard premium takes into consideration the risk factors of age, gender, and smoking or tobacco habits.[140] While:

> standard risk is the basic unit risk, or 100 percent, it should be understood that this is the implicit central risk for the standard class—a class that is a mixture of some risks whose mortality is less than 100 percent (80 percent or 90 percent of standard) and some whose mortality is more than 100 percent (110 percent or 120 percent of standard). "Just how broad the standard class can be and still meet standard actuarial pricing assumptions is a matter each company decides. . . . The vast majority (93–94 percent) of applications for life insurance in the [United States] are accepted as standard risks[,]" while 4–5 percent are offered coverage on a substandard basis, and the remaining 2–3 percent are not offered coverage on any basis (referred to as "declined").[141]

"The primary factor in classifying risks that are not standard is state of health."[142] "Medical impairments account for the substantial majority of substandard and declined risks, particularly at the older ages."[143] "The appropriate ratings for impairments may be developed from the results of previous intercompany mortality studies, from studies of a company's own experience, from studies published in medical literature, and from current clinical opinion on prognosis in the light of developments in medical treatment and surgical procedures."[144] Most substandard ratings are calculated either upon a "table rating" basis (mortality ratio) or a "flat extra' basis (excess death rate).[145]

In its simplest terms, table ratings are derived from the ratio of the observed or actual deaths for those members of a study population cohort with the studied impairment (e.g., heart disease), as compared to the expected deaths for those members of the study population cohort without the studied impairment.[146] For example, if the observed number of deaths in a study population cohort was 175 lives, and if the expected number of

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140. Breckenridge & Elder, *supra* note 125, at 26.
141. Kita, *supra* note 129, at 63–64.
142. Breckenridge & Elder, *supra* note 125, at 27.
143. *Id.*
144. *Id.*
145. Kita, *supra* note 129, at 66–67.
146. *Id.*

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deaths was 100 lives, the mortality ratio would be 175% (the standard risk of 100 and +75).[147] A common scheme is to organize risk classes or table ratings in increments of +25%.[148] Table ratings are traditionally considered permanent increases in premium, and are most useful for impairments with a level or slowly increasing percentage of standard mortality.[149] However, the substandard applicant may be charged an extra premium lower than 1.75 times the standard premium, depending upon the type of insurance product, as well as the insurer's costs for substandard acquisition, maintenance, reconsideration, lapse, and reinsurance arrangements.[150]

Whereas table ratings represent a ratio of the observed mortality to the expected mortality, a flat extra represents the excess number of deaths for a study population cohort, and it is calculated by subtracting the expected deaths from the observed deaths.[151] For example, if 20 deaths were observed in a group of 1,000 individuals, and only 10 deaths were expected, the excess death rate would be 10 deaths. Since it is not known in advance which of the 1,000 individuals would produce the 10 excess deaths, every member of the group of 1,000 would be charged the flat extra premium to compensate for the excess deaths. Flat extras are most useful for impairments with a level number of extra deaths or rapidly decreasing percentage extra mortality.[152] Flat extras may be temporary, as in the case of initially high risk decreasing with time (such as treated cancer or attempted suicide), or permanent if the risk is constant or ongoing, as in the case of accidents related to a chosen occupation or avocation.[153]

Now armed with insight into the risk classification process, it is time to return to the mortgage example that started this section and convert it into a risk classification example. Two males, both age thirty years, apply for life insurance company. One is considered a standard risk, which projects to a probable remaining life expectancy of forty-seven years to age seventy-seven.[154] The second individual is a well-controlled Type I diabetic, with

147. *Id.*
148. *Id.* at 62.
149. Breckenridge & Elder, *supra* note 125, at 70 & 71, Table 5.5.
150. *Id.* at 71.
151. *Id.*
152. *Id.* at 71, Table 5.5.
153. *Id.*
154. *Id.* at 75, Table 5.6.

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no complications, which requires a substandard rating of +250.[155] The probable remaining life expectancy for the diabetic is reduced from the forty-seven years of the standard risk, to only thirty-eight years to age sixty-eight.[156] Equity is achieved if each of the two individuals pays the premium that properly reflects his expected mortality or life expectancy.

B. Risk Classification at the Primary Insurer Level

Upon receipt of a completed application for life insurance, the insurer's underwriter is responsible for the determination as to whether the proposed insured will be selected for coverage and on what basis. Life underwriting can be defined as:

> the process of assessing an individual's anticipated mortality—that is, the relative incidence of death among a given group of people . . . in order to determine (1) whether to approve that person for insurance coverage and, if so, (2) the risk classification to which the proposed insured should be assigned.[157]

The primary resource used by underwriters to classify risks is the "underwriting manual," which provides background on the impairment in question, and gives the underwriter guidance as to how to assess the appropriate rating for the risk or risks involved.[158]

For an underwriting manual to accurately and statistically reflect expected mortalities for impairments, the producing entity must have access to an extensive database of mortality information for a large number of impairments; therefore, the production of these manuals is generally limited to reinsurers and some of the larger primary or direct insurers.[159] With the extensive amount of statistical data necessary to appropriately classify risks, as well as the required professionals to interpret and analyze the data, sometimes the rapid pace of medical advances causes the underwriting manual guidelines to lag behind in its statistical accuracy as to expected mortality.[160]

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155. Robert L. Goldstone, *Diabetes Mellitus, in* Breckenridge & Elder, *supra* note 125, at 298, Table 20.8.

156. Breckenridge & Elder, *supra* note 125, at 75, Table 5.6.

157. LIFE OFFICE MGMT. ASS'N, UNDERWRITING IN LIFE AND HEALTH INS. COS. 1 (Richard Bailey ed. 1985).

158. *Id.* at 10.

159. *Id.*

160. *Id.* at 14.

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If it can be shown that an insurer cannot make a risk classification decision based upon statistically valid and current mortality information, that insurer may be found to violate state unfair discriminatory practices laws.[161] Of the two unfair discriminatory practices prongs that could be violated, the prong that requires the insurer to discriminate based upon actual and reasonably anticipated experience can be violated in one of two ways: where the insurer either has not utilized the most recent mortality data available from the results of medical studies, or where the insurer has not incorporated into its insurance policy data processing system the capability to store, accumulate, and analyze its own policy records as it pertains to specific medical impairments. As to analyzing its own data, it is not enough that the insurer is able to calculate mortality information for the entire block of insurance policies that are either active or have resulted in death claims, but instead, the level of detailed analysis should at a minimum be at the level for each impairment that is insured, and where possible for each impairment, subcategorization and analysis based upon the degree of severity of the impairment. Of course, it must be recognized that some impairments occur so infrequently that it may be impossible for one insurer to gather enough statistical data to make valid mortality assumptions for all impairments. The prong requiring that sound actuarial principles be used to discriminate insurance risks would be violated if the insurer failed to use reasonable assumptions and methodology in its risk classification process.

C. Reinsurer's Effect on the Risk Classification Process

"The fundamental principle of reinsurance is that a transfer of risk occurs."[162] "Reinsurance refers to insurance purchase[s] by an insurance company to cover all or part of certain risks on insurance policies issued by that company."[163]

> Reinsurance is the process whereby one insurance company, referred to as the reinsurer, for a consideration, agrees to indemnify another insurance company, referred to as the ceding company or the reinsured, against all or part of a loss which the ceding

161. *See supra* text accompanying notes 112.
162. JOHN E. TILLER & DENISE FAGERBERG, LIFE, HEALTH & ANNUITY REINS. 3 (1990).
163. *Id.*

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> company may incur under certain policies of insurance which it has issued.[164]

There are three uses of reinsurance directly pertinent to the underwriting process. An insurer's "retention" is the maximum amount of risk that the insurer wants to be responsible for paying in the event of a claim.[165] Reinsurance allows an insurer to issue a policy on a single life for an amount in excess of its own retention, with the reinsurer assuming the risk on the excess amount above the insurer's retention.[166] This activity allows smaller insurers to compete for applicants against larger insurers that have larger retentions without the danger that the smaller insurer will suffer a claim that exceeds its financial ability to pay the claim. An insurer may also seek reinsurance for underwriting needs.[167] Not only do most reinsurers provide underwriting manuals to client insurers, but also it provides the underwriting expertise of a reinsurance underwriter for those applications involving complex medical and financial risks.[168] Finally, reinsurance is often used to finance the acquisition costs and statutory reserve requirements associated with the writing of new business.[169]

One frequent method of transferring insurance risk from the insurer to the reinsurer is through the use of "automatic" reinsurance. "Automatic reinsurance is a contractual arrangement whereby an insurance company is allowed to cede insurance issued in amounts over its retention limit, subject to certain criteria, to a specific reinsurer at a predetermined cost without submitting underwriting papers [to the reinsurer]."[170] "This process saves the ceding company much time and administrative expense, and allows it to issue the majority of its policies on a timely basis."[171] In return, "the reinsurer anticipates receiving quality business because the ceding company is retaining its full retention," and the reinsurer "does not have to compete on underwriting decisions with other reinsurers, which saves each reinsurer time as well as the expense of underwriting."[172]

164. *Id.*
165. *Id.* at 4.
166. *Id.*
167. *Id.* at 5.
168. *Id.*
169. *Id.*
170. *Id.* at 21.
171. *Id.* at 36.
172. *Id.*

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"Facultative reinsurance is an arrangement whereby the ceding company submits its underwriting file on an [applicant] to the reinsurer for the reinsurer's decision."[173] This method of reinsurance "is utilized when a cession does not meet the requirements for automatic reinsurance, or when the ceding company voluntarily requests that the reinsurer underwrite an application" involving a questionable risk or impairment.[174] The offering of facultative insurance by a reinsurer to a client insurer allows the client insurer the opportunity to offer insurance coverage to applicants where the insurance risk is either too large in size or too questionable a mortality risk for it to accept itself.[175] The reinsurer gains from the transaction as well. First, insurers wishing to use the reinsurer's facultative service must agree to cede a portion of its new business to the reinsurer on the more profitable automatic basis.[176] Second, the reinsurer uses this service as a quality control device to allow it the opportunity to gauge the degree of skill and knowledge on the part of the client insurer, which affects the terms of the agreement between the reinsurer and the insurer.[177] Finally, the review of questionable risks by the reinsurer allows it to gather data from several insurers on the same type of questionable risk, with the objective of determining how these risks should be underwritten in the future so that both the reinsurer and insurer can do so profitably.[178]

III. UNDERWRITING ACTIVITIES AND ANTITRUST IMPLICATIONS

A. Purpose and Overview of Collaborative Guidelines

As previously discussed, the purpose of the Sherman Act of 1890 and its progeny, both statutory and case law, is to enhance the welfare of consumers, and give the federal government a mechanism by which to combat and limit the development of supra-large corporations. However, it is recognized by both the Federal Trade Commission and U.S. Department of Justice (the "Agencies") that competition in modern markets sometimes requires collaboration among competitors to achieve goals such as expanding into foreign markets, funding expensive innovation efforts, and

173. *Id.* at 37.
174. *Id.* at 37–38.
175. *Id.* at 43.
176. *Id.* at 45.
177. *Id.*
178. *Id.* at 45–46.

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lowering production and other costs.[179] Therefore, the Agencies issued the *Antitrust Guidelines for Collaborations Among Competitors* (the "Guidelines") as an analytical framework to be used by competitors to evaluate proposed collaborative transactions with one another.[180] The Agencies believe the Guidelines "enable businesses to evaluate [these] proposed transactions with greater understanding of possible antitrust implications, thus encouraging procompetitive collaborations, deterring collaborations likely to harm competition and consumers, and facilitating the Agencies' investigations of collaborations."[181] The analytical framework of the Guidelines is structured along the "[t]wo types of analysis . . . used by the Supreme Court to determine the lawfulness of an agreement among competitors: *per se* and *rule of reason*."[182]

Agreements that are considered per se illegal include "agreements among competitors to fix prices or output, rig bids, or share or divide markets by allocating customers, suppliers, territories, or lines of commerce."[183] "The courts conclusively presume such agreements, once identified, to be illegal, without inquiring into their claimed business purposes, anticompetitive harms, procompetitive benefits, or overall competitive effects."[184]

Analysis under rule of reason is a flexible inquiry that focuses on the state of competition with, as compared to without, the relevant agreement among collaborating competitors.[185] "The central question is whether the relevant agreement likely harms competition by increasing the ability or incentive profitably to raise price above or reduce output, quality, service, or innovation below what likely would prevail in the absence of the relevant agreement."[186] "If the nature of the agreement and the absence of market power together demonstrate the absence of anticompetitive harm, the Agencies do not challenge the agreement."[187] "Alternatively, where the likelihood of anticompetitive harm is evident from the nature of the

179. ANTITRUST GUIDELINES, *supra* note 5, at Preamble.

180. *Id.*

181. *Id.*

182. *Id.* § 1.2 (citing Nat'l Soc'y of Prof'l Eng'rs v. United States, 435 U.S. 679, 692 (1978) (emphasis added)).

183. *Id.* § 3.2 (citing Palmer v. BRG of Georgia, Inc., 498 U.S. 46 (1990); United States v. Trenton Potteries Co., 273 U.S. 392 (1927)).

184. *Id.* § 3.2.

185. *Id.* § 3.3.

186. *Id.*

187. *Id.* (internal citations omitted).

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agreement, or anticompetitive harm has resulted from an agreement already in operation, then, absent overriding benefits that could offset the anticompetitive harm, the Agencies challenge such agreements without a detailed market analysis."[188]

"If the initial examination of the nature of the agreement [under rule of reason analysis] indicates possible competitive concerns, but the agreement is not one that would be challenged without a detailed market analysis, the Agencies analyze the agreement in greater depth."[189] "The Agencies typically define relevant markets and calculate market shares and concentration as an initial step in assessing whether the agreement may create or increase market power or facilitate its exercise and thus poses risks to competition."[190] Additional factors examined by the Agencies include whether the collaborating competitors still have the ability to compete independently, what effects the agreement has on the ability of other firms to enter the market, and any other market circumstances that may foster or impede anticompetitive harms.[191] "If the examination of these factors indicates no potential for anticompetitive harm, the Agencies end the investigation without considering procompetitive benefits."[192] "If investigation indicates anticompetitive harm, the Agencies examine whether the relevant agreement is reasonably necessary to achieve procompetitive benefits that likely would offset anticompetitive harms."[193]

B. *Underwriting Manuals*

1. Anticompetitive Harm

As previously discussed, underwriting manuals are the primary tool by which life insurance risks are classified, and the majority of underwriting manuals are developed by reinsurers and large primary or direct insurers.[194]

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188. *Id.* (citing Cal. Dental Ass'n v. FTC, 526 U.S. 756, 768–72, 778–80 (1999); FTC v. Ind. Fed'n of Dentist, 476 U.S. 447, 459–61 (1986); Nat'l Coll. Athletic Ass'n v. Bd. of Regents of the Univ. of Okla., 468 U.S. 85, 104–08, 106–10 n.42 (1984)). This type of shortened rule of reason analysis is often referred to as "quick look" rule of reason.

189. *Id.* § 3.3.

190. *Id.* (citing Eastman Kodak Co. v. Image Tech. Serv., Inc., 504 U.S. 451, 464 (1992)).

191. *Id.* § 3.3.

192. *Id.*

193. *Id.* (citing NCAA, 468 U.S. at 113–15; Prof'l Eng'rs, 435 U.S. at 696; Bd. of Trade of Chicago v. United States, 246 U.S. 231, 238 (1918)).

194. *See supra* text accompanying notes 161–63.

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A reinsurer uses its own underwriting manual not only to classify which risks it wants to insure, but more importantly, the reinsurer provides its client, direct insurers, with the manual as well. In addition, the mortality results experienced by the reinsurer, and on which the reinsurer bases its ratings for various impairments, come from the policies it reinsurers from its clients. The underwriting manual facilitates the transfer of life insurance on an automatic basis by providing the reinsurer's client the criteria by which the reinsurer will accept a given impairment risk, and the rating or price that the reinsurer expects the direct insurer to charge the applicant. On its face, this transaction would appear to violate antitrust laws as a vertical price fixing scheme.[195] If it is assumed that insurers would deny that this arrangement is price fixing, but instead, has procompetitive benefits, the Agencies inquiry will probably be on a rule of reason basis.

Initially, one has to determine the relevant markets for both direct insurer competitors and reinsurance competitors. The Guidelines define a relevant market as:

> a product or group of products and a geographic area in which it is produced or sold such that a hypothetical profit-maximizing firm, not subject to price regulation, that was the only present and future producer or seller of those products in that area likely would impose at least a "small but significant and nontransitory" increase in price, assuming the terms of sale of all other products are held constant. A relevant market is a group of products and a geographic area that is no bigger than necessary to satisfy this test.[196]

The Guidelines then require that market shares be assigned both to firms currently in the relevant market and to firms that are able to make "uncommitted" supply responses.[197]

As of 2001, there were 1,663 life and health insurance companies licensed in the United States.[198] Focusing once again on the four states previously identified, 579 (34.8%) insurers are licensed or domiciled in

195. *See* Dr. Miles Med. Co. v. John D. Park & Sons Co., 220 U.S. 373 (1911); United States v. Parke, Davis & Co., 362 U.S. 29 (1960).

196. ANTITRUST GUIDELINES, *supra* note 5, § 3.32(a) (referencing Horizontal Merger Guidelines § 1.0).

197. *Id.* § 3.32(a) (referencing Horizontal Merger Guidelines §§ 1.31, 1.32).

198. BEST'S INS. REP., LIFE-HEALTH UNITED STATES A53–A74 (2001). This figure includes both direct insurers and reinsurers.

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California, 628 (37.8%) in Florida, 217 (13.0%) in New York, and 770 (46.3%) in Texas.[199] State rankings in terms of an insurer's market share for each state was not available, but with the number of insurers involved, it is instructive to look at rankings for the entire United States life insurance industry. Based upon the amount of "admitted assets," the top ten insurance companies in the industry owned 33.4% of all admitted assets, with 1,642 insurers having admitted assets shares of less than one percent each.[200] Based upon life insurance inforce (active policies), the top ten insurance companies in the industry owned 31.1% of all life insurance inforce, with 1,635 insurers having life insurance inforce shares of less than one percent each.[201] It should also be noted that only four insurance companies made both top ten lists, therefore, signifying even greater dispersion of market share.

The relevant market for firms specializing only in reinsurance entails a much smaller number of companies than does the direct market. Only sixteen companies in the United States provide primarily only reinsurance.[202] More importantly, the amount of reinsurance assumed by these sixteen reinsurers was $933.101 billion, which represented 58.4% of all United States ordinary individual life insurance sales for the year 2001.[203] In addition, it should be noted that of the twelve reinsurers with market share of at least two percent, only four are owned by United States interests, while the remaining reinsurers are owned by Swiss, Dutch, German, Italian, and Bermudan interests.[204]

199. *Id.*

200. *Id.* at A75–A84. The actual shares for the top ten companies were (%): 6.1, 6.0, 3.7, 2.8, 2.8, 2.6, 2.6, 2.4, 2.3, and 2.1. The total amount of admitted assets for the industry was $3.2 trillion. *Id.* Admitted assets are defined as "cash and investments that meet criteria for liquidity and safety set by the NAIC and by the individual state commissioners. Only admitted assets are used in measuring the capacity and soundness of an insurer. Non-admitted assets, such as overdue receivables, are excluded from statutory assets and surplus." LIFE, HEALTH & ANNUITY REINS. 485 (1990).

201. *Id.* at A65, A85–A90. The actual shares for the top ten companies were (%): 7.4, 5.0, 2.8, 2.7, 2.6, 2.6, 2.4, 2.1, 1.8, and 1.7. *Id.* The total amount of life insurance in force for the industry was $23.4 trillion. *Id.*

202. Market shares for amounts of reinsurance assumed in 2001 of (%): 26.4, 12.1, 11.1, 10.0, 9.2, 6.0, 4.7, 4.2, 4.0, 3.0, 2.8, 2.3, 2.0, 1.7, 0.3, and 0.1. James L. Sweeney & David M. Briggeman, *Life Reins From The Munich Am. Survey*, REINS. NEWS, at 29, June 2002.

203. *Id.* at 31.

204. *Id.* at 12.

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With the stage now set, let us re-state the above information, as it could be perceived from an antitrust perspective. We have a flat, two-tiered industry, with the bottom tier (direct insurers) extremely wide, and the top tier (reinsurers) extremely narrow in relation to the bottom tier. As a natural by-product of transferring insurance risks to the reinsurers, the direct insurers are providing the reinsurers with competitive mortality information. In turn, the reinsurers are analyzing this mortality data, and sending back to its clients the ratings the reinsurers expect these clients to use when they assess an applicant for insurance. This scheme could be considered a restraint of trade, analogous to vertical price fixing, which violates Section 1 of the Sherman Act.[205] If it can be shown that this activity caused boycott, coercion, or intimidation, the activity would not be exempt under McCarran-Ferguson.[206] In addition, the reinsurers owned by foreign interests would be subject to United States antitrust laws since their activities would affect the United States market, primarily at the reinsurance level.[207]

A direct insurer's cause of action for an antitrust violation would entail proving that this scheme directly injured its ability to compete vis-à-vis other direct insurers. The direct insurer's best argument would be that in order to compete in the market, its retention required it to use the facilities of a reinsurer. As part of the agreement between the direct insurer and reinsurer, the direct insurer had to share mortality information with the reinsurer. In turn, the reinsurer combined this information with that from other direct insurers, and used this aggregation of statistical information to develop the underwriting manual that all of the reinsurer's clients must use to retain their automatic agreement with the reinsurer. The direct insurer would argue that, in order to compete, it was coerced or intimidated into giving the reinsurer the mortality information, and that the direct insurer faced a possible boycott by the other reinsurers if it did not comply with the reinsurer's demands. As will be shown, the ability of an insurer to prove a claim of injury such as this is very remote.

205. 15 U.S.C. § 1 (2000).
206. 15 U.S.C. § 1013(b).
207. Hartford Fire Ins. Co. v. Cal., 509 U.S. 764, 796 (1993).

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2. Procompetitive Benefits

By using the rule of reason criteria listed in the Guidelines as well as requirements specific to the Guidelines, it can be shown that the procompetitive benefits of this activity far outweigh the possible anticompetitive harm. The primary argument upon which an insurer/reinsurer can substantiate procompetitive benefits is whether the collaboration benefits the insurance-buying consumer. If the exchange and analysis of the combined mortality information enables the insurer/reinsurer to price impaired insurance risks more accurately, the individuals whose medical disease or disorder has experienced an improvement in mortality will be able to buy coverage at less expensive premiums rates, while those with medical impairments where mortality has not improved will continue to pay an equitable premium for the life insurance protection.

The relevant market for life insurance is a reasonable starting point for the insurer/reinsurer to argue the procompetitive benefits of sharing mortality information via underwriting manuals. With the relatively low market share of the majority of insurers and some of the reinsurers,[208] some insurer/reinsurer combinations can argue that the sharing of statistical information regarding mortality information falls within one of the Guidelines' safety zones.[209] As long as the competitor collaboration agreement was neither per se illegal nor subject to challenge without a detailed market analysis, the Agencies would not challenge the agreement when the market shares of the collaboration participants collectively accounted for no more than twenty percent of each relevant market in which competition may be affected.[210]

For those insurer/reinsurer combinations where the collective market share exceeds twenty percent, the Agencies would not automatically deem these agreements anticompetitive, but instead, use the factors involved in rule of reason analysis to assess the circumstances at play.

The insurer/reinsurer needs to argue that the competitive collaboration enables all of the participants to more quickly or efficiently research and develop or improve the insurance product.[211] This occurs if the insurer/reinsurer can show that the aggregate mortality data from all of the

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208. *See supra* text accompanying notes 201–05.
209. ANTITRUST GUIDELINES, *supra* note 5, § 4.2.
210. *Id.*
211. *Id.* § 3.31(a).

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direct insurer competitors provides statistical validity that mortality for given medical disorders has improved, lessening the need for substandard premiums.

One of the concerns for the Agencies when competitors collaborate is whether the collaboration reduces the independent decision making of the collaborators involved.[212] Insurers can confront this possible concern in at least two ways. First, as previously noted, the overwhelming majority of United States applications for life insurance are approved at standard premium rates.[213] This implies that either direct insurers are making risk classification decisions without the use of the reinsurance underwriting manual, or that the manual is pricing the majority of the insurance applicants at standard rates. Either way, the actual decision is being left to the discretion of the direct insurer and not the reinsurer for the majority of automatic reinsured business. Second, for some impaired risks, the direct insurer will use more than one reinsurer for those risks requiring facultative review by reinsurers—referred to as "reinsurance shopping."[214] Reinsurance shopping can be described as auction bidding to find the lowest price. The direct insurer "shops" the proposed risk to several reinsurers to see which one is willing to offer the lowest price, more correctly stated, which reinsurer will offer insurance on a standard basis or on a substandard basis as close to standard as possible. This competitive bidding reduces the probability that reinsurers are colluding to set a certain price for a certain medical disorder.

This competitive bidding process also operates at the direct insurer level. Often, an applicant for life insurance is shopped to more than one direct insurer to obtain the lowest possible substandard rating. If you use the simple example of three direct insurers, each with the help of three different reinsurers, the competitive bidding for the insurance coverage would be conducted among nine insurance companies. This process should alleviate the Agencies concerns as to exclusivity.[215] The Guidelines indicate that competitive concern likely is reduced to the extent that participants actually continue to compete, either through separate,

212. *Id.*

213. *See supra* text accompanying notes 141–44.

214. LIFE OFFICE MGMT. ASSOC., UNDERWRITING IN LIFE AND HEALTH INS. COS. 103 (Richard Bailey ed. 1985).

215. ANTITRUST GUIDELINES, *supra* note 5, § 3.34(a).

independent business operations or through membership in other collaborations.[216]

The Agencies also have concern if a collaborative competitor agreement occurs in an industry where the introduction of new competitors is mitigated by high entry requirements.[217] With over 1,600 life and health insurers in the United States market,[218] it is hard to comprehend that any increase in the price of the life insurance product can occur without competitors rushing in to "grab" the market of the insurer that raises its price above that in the marketplace.

Finally, the Agencies look at the duration of the collaboration under the theory that the shorter the duration of the collaboration, the more likely participants are to compete against each other and their collaboration.[219] Although direct insurers and reinsurers often maintain business ties with each other that stretch into decades, the relationship is not a static one. Periodically, whether every year or two, or when a new product is to be introduced into the life insurance market, direct insurers usually conduct a bidding process among its potential reinsurers to see which of these reinsurers will reinsure the product automatically and review cases facultatively. As with any business negotiation, each party is looking for terms that are most advantageous to itself. Insurers and reinsurers who are able to show that the continued relationship between each other is based upon criteria such as competitive product price, service, and customer support will be able to justify long duration relationships.

C. Intercompany Mortality Studies

Whereas the prior discussion about underwriting manuals focused on the established business relationship between reinsurers and their respective direct insurer clients, this section focuses on what could be considered pure research and analysis by insurers. An "intercompany mortality study" involves multiple insurers that pool their mortality data together for a specific impairment or impairments. Through the larger combined database of several insurers, it is hoped that the mortality results of the aggregate study is statistically more accurate than a study done by any one insurer, and that this increased accuracy of mortality data will

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216. *Id.*
217. *Id.* § 3.35.
218. *See supra* text accompanying note 201.
219. *Id.* § 3.34(f).

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result in more accurate and equitable pricing of life insurance risk. Intercompany studies have been done by the life insurance industry since at least 1909.[220]

1. Anticompetitive Harm

On its face, intercompany mortality studies could be seen as an attempt to fix prices among competitors by establishing uniform rates to be charged potential applicants for life insurance, similar to the arguments raised with underwriting manuals. An insurer would have to prove that it was competitively harmed by this activity, either by boycott, coercion, or intimidation, as conducted by other competitor insurers, or that that insurer could bring a cause of action for the supposed injury. This argument, however, would appear to be "dead-on-arrival" unless the insurer could prove that insurers collaborating together to conduct mortality studies, actually intended to harm that insurer specifically.

2. Procompetitive Benefit

In keeping with the use of the Guidelines, the Agencies state "[i]nformation sharing . . . may take place through competitor collaborations."[221] The only caveat is the requirement that the information sharing does not facilitate collusion involving competitively sensitive variables.[222] Insurers should be able to meet this requirement as long as the information sharing only involves the aggregation of data records on insured lives, without any means of identify a particular individual, and more importantly and practical, no discussions concerning a particular insurer's costs, methods of doing business, marketing plan, etc.

The more fundamental argument to information sharing by insurers is the Supreme Court's interpretation of the McCarran-Ferguson Act through its various decisions. First, the Court has recognized that information sharing among insurers was necessary for determining appropriate premiums.[223] Then, when the Court established the criteria to determine whether a practice was part of the business of insurance, it included the transferring or spreading of a policyholder's risk, and whether the practice is an integral part of the policy relationship between the insurer and the

220. R.D.C. Brackenridge & Arthur E. Brown, *A Historical Survey of the Development of Life Assurance, in* Breckenridge & Elder, *supra* note 125, at 8.

221. ANTITRUST GUIDELINES, *supra* note 5, § 1.1.

222. *Id.* § 3.34(e).

223. *See supra* text accompanying notes 55–56.

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insured.[224] The determination of the appropriate premium to be charged to an applicant based upon his or her expected mortality goes to the essence of spreading the policyholder's risk, and since the insured will be charged a premium based upon his or her expected mortality, it is certainly integral to the policy relationship between the insurer and insured.

A recent example of an intercompany mortality study involved forty-seven insurers and analyzed insureds with histories of either alcohol abuse or elevated liver enzymes.[225] One primary finding of the study was that those individuals issued standard coverage (100% mortality), actually had a mortality of 147%.[226] Those individuals issued coverage on a substandard basis had actual mortality consistent with the substandard rating assessed.[227] Insurers should encourage these types of studies in order to show the insurance-buying public that active efforts are being made to classify life insurance risks as equitably as possible, and to establish an industry baseline for each impairment. In addition, each insurer should conduct its own mortality studies in connection with those on an intercompany basis, so that risk classification decisions that deviate from the industry baseline can be substantiated actuarially.

Possibly the most important argument to be raised by an insurer for intercompany mortality studies is to guard against lawsuits being brought by private individuals on a state action basis under unfair discrimination laws. A recent example of this is *Chabner v. United of Omaha Life Insurance Co.*,[228] where the court held that the insurer's decision as to the insurability of Mr. Chabner was based neither upon sound actuarial principles nor related to actual or reasonably anticipated experience.[229] Mr. Chabner's impairment was a rare nervous system disorder called facioscapulohumeral muscular dystrophy.[230] The incidence of this impairment is so low that any one insurer probably would not underwrite enough of these type cases to have confidence that it mortality results were

224. *See supra* text accompanying notes 57–63.

225. Clifton Titcomb, M.D. et al., *Alcohol Abuse and Liver Enzymes (AALE): Results of an Intercompany Study of Mortality*, 33 J. INSUR. MED. 277 (2001).

226. *Id.* at 282, Tables 2, 3 & 4.

227. *Id.* at 282, Table 4.

228. 225 F.3d 1042, 1051–52 (9th Cir. 2000).

229. *Id.* at 1052.

230. HARRISON'S PRINCIPLES OF INTERNAL MEDICINE 2533 (Eugene Braunwald et al. 15th ed. 2001) (stating that the incidence of this disease is approximately 1 in 20,000 (0.005%) persons).

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statistically accurate. Pooling the resources of many insurers to produce data for mortality studies may provide the necessary number of insured lives to help make the statistical data more valid. This in turn, allows the insurer to charge a premium that is more equitable to the insurance applicant, and helps the insurer avoid any charge of unfair discrimination.

D. Professional Papers and Presentations

Most of the arguments as to whether individual insurance professionals either violate or adhere to antitrust concerns has been elaborated upon in the discussions on underwriting manuals and intercompany mortality studies. Therefore, this part of the Article will not bifurcate the arguments into anticompetitive harm or procompetitive benefits. Instead, some general comments will be made.

First, price fixing either through a professional paper or presentation does not occur when the discussion centers on information sharing of mortality information. Based upon the analysis presented in this Article, stating that an individual with moderate hypertension should be rated at 200% mortality (100 standard mortality with +100 extra mortality) simply reflects the mortality experienced by the insurer or reinsurer, and it should not be considered price fixing.

Second, price fixing would occur if several reinsurers combined together in a paper or presentation and informed their respective client insurers that all applicants with histories of hypertension must be rated at a minimum 200% mortality rating. And that failure to comply with this instruction would result in the loss of reinsurance capacity for any client insurer. This type of activity would violate federal antitrust laws as coercion or intimidation, as well as state antitrust and unfair discrimination laws.

Third, federal antitrust laws would be violated if an insurance professional from a United States insurer traveled to an insurance meeting outside the United States and discussed price fixing with other similar professionals. At the same time, an insurance professional affiliated with a foreign insurer, for example one domiciled in Canada, would violate United States federal antitrust laws if that individual—whether in the United States, Canada, or elsewhere—advocated price fixing.

Finally, to avoid violations of state unfair discrimination practices, insurance professionals in both papers and presentations, as well as in any other appropriate medium, should advocate that their own employer have in place the necessary resources to conduct detailed substandard mortality studies. In addition, there should also be advocacy by these same professionals for greater participation in intercompany mortality studies.

CONCLUSION

The first question asked in the Introduction was, "whether the antitrust policy used by underwriters/insurers was necessary or sufficient?" As to its necessity, the answer is absolutely "yes." Insurance companies are liable for violations of federal antitrust laws. However, as demonstrated in this Article, insurers have a carved-out exemption to these type laws as it pertains to activities that come within the "business of insurance." But, this policy is not sufficient because it only tells an insurance professional what he or she cannot do, and gives no direction as to what activities are permitted.

The lack of direction brings us to the second question which asks, "where are the lines to be drawn as to when and what underwriters/insurers can and cannot do as it relates to antitrust and the sharing of life insurance mortality information for risk classification purposes?" The boundary line for risk classification appears to substantially extend outward. Absent attempts by one insurer or reinsurer to coerce, intimidate, or boycott another on this issue, insurers appear to have almost an unfettered ability to share information on risk classification. In addition, there is legal motivation to force insurers toward this boundary. The unfair discrimination laws of the states as they relate to insurance require insurers to statistically substantiate risk classification decisions with valid, current information. Information that is best obtained through the combined efforts of many insurers.

Although social policy for or against life insurance risk classification was not explored in this Article, it is perhaps best to conclude by quoting from the insurance perspective:

> It is important that risk classification is based on *real* differences in mortality experience. That is, that unfair discrimination due to classification based on impressions that cannot be substantiated does not occur. Many states also prohibit (1) refusal, (2) limitation of coverage or (3) rate differentials based solely on physical or mental impairment unless such action is based on sound actuarial principles or actual or reasonably anticipated experience. Even when not required by law, it makes sound business sense to apply only fair discrimination practice to risk classification. Failure to exercise fairness and equity will cause the public, agents and

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underwriters to lose respect for the risk classification process in particular, and for the institution of life insurance in general.[231]

231. Breckenridge & Elder, *supra* note 125, at 35.

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IN BETWEEN THE TRENCHES: THE JURISDICTIONAL CONFLICT BETWEEN A BANKRUPTCY COURT AND A STATE INSURANCE RECEIVERSHIP COURT

William Goddard[*]

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INTRODUCTION

A judicial no man's land lies between the jurisdiction of a state receivership court administering an insurance insolvency and the jurisdiction of a federal bankruptcy court administering the bankruptcy of an insurance holding company. The bankruptcy and insolvency systems have evolved separately, each serving the function for which it was designed. However, now that financial products and services are converging as never before, the two spheres of influence could be on a collision course. This Comment will explore two of the most likely areas of conflict between these two court systems and suggest some decision rules to use in evaluating those conflicts. Before beginning the legal discussion however, it may be best to construct a series of events which would set this conflict in motion.

BACKGROUND

Imagine a modern financial corporate family in the wake of financial convergence. It is a holding company with five subsidiaries: (1) a property-casualty insurance company, (2) a third-party administrator of insurance claims, (3) an insurance agency, (4) a depository institution such

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as a bank[1] or thrift and (5) a third party processor of banking transactions (loan payments, checks, etc.). Imagine that severe losses suddenly strike the property-casualty insurer. It has provided corporate general liability policies, workers compensation insurance and a significant auto insurance program to a large corporation. A bomb explodes in the corporation's parking garage just as the day shift is leaving work. Many employees are injured or killed. Debris from the explosion scatters widely, injuring thousands of bystanders. Chemicals stored in the basement of the garage catch fire and explode, spreading toxins for miles. The insurer is called upon to defend thousands of lawsuits. Claims mount logarithmically. The insurer's reinsurance has been rendered dubious in a string of reinsurer insolvencies. The principal financial officers of the holding company are overwhelmed by the conflicting demands of creditors, shareholders, regulators and the mounting liquidity crisis. In a panic, trying to meet rising waves of obligations, underlings transfer millions around the various entities without respect for corporate dividing lines.

The Department of Insurance quickly arrives on the scene and begins an in-depth evaluation of the insurer's finances. The holding company, dependent on dividends from the insurer, is unable to make an interest payment on its public bonds. The holding company files for Chapter 11 protection in the federal bankruptcy court in its state of incorporation, far distant from the insurance company's domicile. The insurance processing subsidiaries, dependent on fees from the insurance company quickly follow the holding company into bankruptcy. The Department of Insurance places the insurer into rehabilitation proceedings in a state court in the domiciliary state and a liquidation petition appears forthcoming.

This hypothetical may seem a bit farfetched, but in today's world sudden events can strike an insurer and take it from financial soundness to threatened insolvency very quickly. Natural disasters such as hurricanes or earthquakes can be more devastating than man-made calamities and strike almost as quickly. Dubious acquisitions or failed investment strategies can also have crippling effects. In contrast, financial companies have become more and more complex collections of specialized subsidiaries, custom tailored to meet regulatory, tax or financing objectives. The dividing lines between these subsidiaries are only as good as the financial controls and accounting systems that keep them distinct. Financial controls,

1. This is now possible under the Gramm-Leach-Bliley Financial Modernization Act, PL 106-102 (S900), 106th Congress, passed Nov. 12, 1999, the pertinent provisions of which are now found at 15 U.S.C. §§ 6701–6781 (2000).

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implemented in calm times with all the best intentions, break down in crises. These breakdowns can blur vital distinctions between separately regulated businesses. Our judicial system reflects an age-old patchwork of state regulation of insurance companies in an era when financial distress routinely crosses state lines. Federal processes and federal law govern corporate bankruptcy and bank insolvency, while state law and state courts govern insurer insolvency. As financial institutions diversify, conflicts will arise between these two systems for control of assets in financial distress. This Comment will explore two of those conflicts.

This Comment intends an attempt to answer two related questions:

Part I will ask if the insurance company is in possession of assets belonging to the holding company at the time of the filing of the petition for rehabilitation, (for example tangible cash premiums collected by the agency for other carriers but swept, by mistake or otherwise, into insurance company accounts just prior to the rehabilitation order) which court would have jurisdiction over the disposition of those assets, the bankruptcy court administering the holding company's proceeding or the state court overseeing the insurance company's insolvency?

Part II will discuss a second scenario. If the holding company, insurance agency or the third-party claims processor is holding assets of the insurance company (for example a tax refund held by the holding company or premiums collected by the agency), which court will hear the insurance company's claim on those assets: the state court administering the insolvency or the federal court supervising the Chapter 11 proceeding?

PART I: THE INSURANCE COMPANY HOLDS THE ASSET

Introduction

If the insurance company is in possession of assets belonging to the holding company at the time of the filing of the petition for rehabilitation (or conservation or liquidation), which court would hold jurisdiction over the disposition of those assets, the bankruptcy court administering the holding company's proceeding or the state court overseeing the insurance company's insolvency?

As discussed below, in most cases, the state insolvency court will be granted the power to determine the fate of assets in the hands of the insurer at the time it was placed under court control. The generous breadth of authority and deference granted to state insurance regulators and state insolvency courts by the McCarran-Ferguson Act leads to this conclusion. There is a possible exception to this rule in the case of in rem jurisdiction,

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but that exception has never truly been tested. Deference to the state court can have some undesirable effects; however, it appears to enjoy widespread acceptance.

Discussion

If holding company assets are in the possession of the insolvent insurer, the bankruptcy court has several paths it could follow to arrive at a determination that the assets are property of the bankruptcy estate. First, assets could have been transferred shortly before the bankruptcy petition, in which case they could be a preferential transfer. Second, they could have been fraudulently conveyed to the insurer for less than adequate consideration or while the holding company was insolvent. Third, they could simply be assets of the holding company wrongfully in the possession of the insurer, such as post-petition transfers by insurance company personnel. Any one of these could, potentially, lead to an order from the bankruptcy court to turn over property.

A. The Bankruptcy Court's Jurisdiction

All three transactions mentioned above are "core" matters under the Bankruptcy Code (the "Code").[2] Even with the changes in bankruptcy court jurisdiction in the wake of the United States Supreme Court decision in *Northern Pipeline Construction Co. v. Marathon Pipe Line Co.*,[3] these "core" matters remain unquestionably conferred upon the bankruptcy court by 28 U.S.C. §§ 157(b)(2)(E), (F), and (H). The Bankruptcy Code places the property of the estate squarely in the hands of the bankruptcy court in a very broad grant of authority:

> The automatic stay protects "property of the estate." This estate is created by the filing of a petition and comprises property of the debtor "wherever located and by whomever held," including (among other things) "all legal or equitable interests of the debtor in property as of the commencement of the case."[4]

Even in context of conflicts with federal banking laws, the bankruptcy court's authority has been given the upper hand.[5] According to these rules, if the assets belong to the bankruptcy estate, the Code, on its face, seems to

2. 28 U.S.C. § 157(b) (2000).

3. Northern Pipeline Constr. Co. v. Marathon Pipe Line Co., 458 U.S. 50 (1982).

4. United States v. Inslaw, Inc., 932 F.2d 1467, 1471 (DC Cir. 1991), *cert. denied*, 502 U.S. 1048 (1992) (citing 11 U.S.C. § 541(a)(1) (1988)).

5. *See, e.g.*, In re Colonial Realty Co., 980 F.2d 125 (2d Cir. 1992).

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grant jurisdiction to the bankruptcy court.

B. The Supremacy Clause

The Supremacy Clause of the United States Constitution grants priority to federal statutes when they come in conflict with other laws. "[T]he Laws of the United States . . . shall be the supreme Law of the Land . . . any thing in the Constitution or Laws of any State to the Contrary notwithstanding."[6] As laws enacted by Congress, the Bankruptcy Code can be construed to be the supreme law of the land, not having to yield to state law unless the Code specifically provides. In *Barnett Bank of Marion County N.A. v. Nelson*,[7] the United States Supreme Court set out the normal criteria for preemption of a state statute by a federal one. "Did Congress, in enacting the Federal Statute, intend to exercise its constitutionally delegated authority to set aside the laws of a State? If so, the Supremacy Clause requires courts to follow federal, not state, law."[8] If there is no explicit preemption language, courts should examine the federal statute for indicia of preemption to determine if

> the federal statute's structure and purpose, or nonspecific statutory language, nonetheless reveal a clear, but implicit, pre-emptive intent. . . . [The] federal statute, for example, may create a scheme of federal regulation so pervasive as to make reasonable the inference that Congress left no room for the States to supplement it. . . . [F]ederal law may be in irreconcilable conflict with state law. . . . Compliance with both statutes, for example, may be a physical impossibility. . . . [T]he state law may stand as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress.[9]

In such cases, the federal statute would generally pre-empt a conflicting state law.

The Bankruptcy Code would appear to be a pervasive scheme of federal regulation leaving no room for the states. Under the normal rules of preemption outlined above, if a state law were to contradict the Code by granting jurisdiction over property of the estate to a state court, that law would normally be pre-empted.

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6. U.S. CONST. art. VI, cl. 2.
7. 517 U.S. 25 (1996).
8. *Id.* at 30.
9. *Id.* at 31 (internal quotation marks and citations omitted).

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Enactment of the Bankruptcy Code is not the only source of possible preemption. The Commerce Clause also makes a grant of authority to Congress which the Supremacy Clause enforces on the states.[10] If a single state were to dominate a large multistate process, such as a major insurance collapse, by imposing its own rules and priorities on the case, that would appear to be a burden on interstate commerce, forbidden by the Commerce Clause. However, as discussed in the next section, Congress has provided an exception to the usual rules of preemption in the case of insurance.

C. The McCarran-Ferguson Act

The critical difference between insurance regulation and other areas of federal influence is that the regulation of insurance has been left to the states. This is primarily a result of the McCarran-Ferguson Act which turns the usual rules of preemption upside-down.[11] A few courts have looked at insurance insolvency in terms of McCarran-Ferguson and found that its reverse preemption of federal laws applies in the insolvency context.[12] To determine how the bankruptcy process interacts with state insurance receiverships, it is vital to define the breadth of the McCarran-Ferguson Act's influence.

Up until 1944, insurance was viewed to be beyond the reach of Congress' Commerce powers. The United States Supreme Court reached this conclusion during post-Civil War Reconstruction in *Paul v. Virginia.*[13] The Court declared that, "[i]ssuing a policy of insurance is not a transaction of commerce. The policies are simple contracts of indemnity against loss by fire, entered into between the corporations and the assured, for a consideration paid by the latter."[14] The subsequent one-hundred years of industrial expansion and acceleration of communications found this determination increasingly bordering on absurd. In 1944, the Court re-examined its view of insurance in *United States v. South-Eastern Underwriters Ass'n,*[15] finding that

> a heavy burden is on him who asserts that the plenary power which the Commerce Clause grants to Congress to regulate "Commerce among the several States" does not include the

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10. U.S. CONST. art. I, § 8, cl. 3.

11. 15 U.S.C. §§ 1011–1015 (2000).

12. *See e.g.* United States Dep't of the Treasury v. Fabe, 508 U.S. 491 (1993) *and* United States v. Ruthardt, 303 F.3d 375 (1st Cir. 2002).

13. 75 U.S. 168 (1868).

14. *Id.* at 183.

15. 322 U.S. 533 (1944).

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> power to regulate trading in insurance to the same extent that it includes power to regulate other trades or businesses conducted across state lines.[16]

The Court went on to find that this "heavy burden" could not be supported.[17] Overnight the entire insurance industry and its collective rate-making apparatus were subject to federal anti-trust enforcement. Other federal laws governing interstate commerce were now also applicable to insurance.

Congress reacted quickly to the Court's decision by enacting the McCarran-Ferguson Act.[18] Although the Act devotes most of its attention to exemption from anti-trust laws, it is generally agreed that it removes Dormant Commerce Clause challenges to insurance regulation by nullifying the preemptive effect of all Congressional legislation (and therefore federal regulation) not specifically targeted toward insurance.[19] In fact, its language (see below) creates an exception to every federal act not specifically directed to insurance.

It is rarely asked if the McCarran-Ferguson Act also sweeps aside laws enacted pursuant to Congress' Constitutional mandate to "[t]o establish . . . uniform Laws on the subject of Bankruptcies throughout the United States."[20] The imposition of insolvency courts on bankruptcy matters would appear anything but "uniform." Given the exception to the Bankruptcy Code for insurance companies,[21] this Comment will assume that Congress and the courts do not believe the Bankruptcy Clause reaches the administration of the internal affairs of an insolvent insurer and

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16. *Id.* at 539.

17. *Id.* at 550.

18. The policy goals of the Act are set out in 15 U.S.C. § 1011:

> Congress hereby declares that the continued regulation and taxation by the several States of the business of insurance is in the public interest, and that silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States.

15 U.S.C. § 1022 (2000). *See also* Barnett Bank of Marion County N.A. v. Nelson, 517 U.S. 25, 39 (1996).

19. "The McCarran-Ferguson Act operates to assure that the States are free to regulate insurance companies without fear of Commerce Clause attack." Group Life and Health Ins. Co. v. Royal Drug Co., 440 U.S. 205, 218 n.18 (1979).

20. U.S. CONST. art. I, § 8, cl. 4.

21. 11 U.S.C. §§ 109(b)(2), 109(d) (2000).

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therefore there is no Constitutional bar (on uniformity grounds) to an insolvency court determining the fate of an asset already in its hands.[22]

The United States Supreme Court has never directly examined the conflict between bankruptcy and state insurance receiverships. In fact, it has only rarely examined the jurisdictional conflict between a federal court and an insolvency court. In *Penn General Casualty Co. v. Pennsylvania*,[23] the Court ruled that a federal court took precedence over a state insolvency court because the federal court had acquired jurisdiction first.[24] However, this, like all decisions prior to 1944, is of limited precedential value in light of the subsequent passage of the McCarran-Ferguson Act. The Court took up the question of conflicting jurisdiction with a receivership court again, in a very limited way in *Quackenbush v. Allstate Insurance Co.*,[25] some fifty years later, but there has been very little guidance from the Court on where an insolvency court stops and where a bankruptcy court begins jurisdiction. In order to begin analysis of this question, it is important to look at the reverse preemption in the McCarran-Ferguson Act and understand the impact of each of its conditions on the rehabilitation of an insolvent insurer.

The McCarran-Ferguson Act provides: "[N]o Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance . . . ."[26] These are three separate and distinct tests, making up three distinct questions:

> 1. Does the Bankruptcy Code specifically relate to the business of insurance?
> 2. Are state insolvency statutes giving state courts jurisdiction over insolvency matters, laws enacted for the purpose of regulating the business of insurance? and
> 3. Does the Bankruptcy Code's grant of jurisdiction invalidate, impair or supercede the state court's grant of jurisdiction?

22. This paper explicitly reserves the right to take the opposite position when the asset is in the possession of the bankruptcy estate and therefore subject to the Code. *See* Part II *infra*.

23. 294 U.S. 189 (1935).

24. *Id.* at 198–99.

25. 517 U.S. 706 (1996).

26. 15 U.S.C. § 1012(b) (2000).

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1. Unless Such Act Specifically Relates to the Business of Insurance

It is generally agreed that the Bankruptcy Code[27] does not specifically relate to the business of insurance. The Bankruptcy Code's own exclusion of insurance companies seems to reinforce this.[28] In fact, when searching for an example of laws which do not specifically relate to insurance, the United States Supreme Court reached for the bankruptcy statutes:

> Many federal statutes with potentially pre-emptive effect, *such as the bankruptcy statutes*, use general language that does not appear to "specifically relate" to insurance; and where those statutes conflict with state law that was enacted "for the purpose of regulating the business of insurance," the McCarran-Ferguson Act's anti-preemption rule will apply.[29]

In the face of the clear reference in *Barnett Bank*, even if it is only used as an example, it appears reasonable to conclude that most courts will assume that the bankruptcy statutes do not specifically relate to the business of insurance.

Even when things appear so clear, it is important to tread with caution. Courts may find a connection to insurance where none is clearly stated. In *Lander v. Hartford Life and Annuity Insurance Co.*,[30] the Second Circuit noted that Congress could preempt state regulation without stating a specific intent toward insurance, if it legislated in an area of national concern and intended to have a preemptive effect.[31] Recently, the Eleventh Circuit appeared to stretch the meaning of a federal statute to imply that it was designed to regulate insurance by the presence of the word "underwrite" in the statute and the mention of enforcement by a state insurance commissioner,[32] even though the casual observer would have difficulty finding an insurance context. It is possible that a federal court, reading some pressing agenda into a specific provision, could determine that part of the Bankruptcy Code was actually intended to relate to insurance. However, it appears reasonable to make the assumption that

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27. U.S. Code Title 11 and related provisions in Title 28.

28. 11 U.S.C. § 109 (b)(2) (2000).

29. Barnett Bank of Marion County, N.A. v. Nelson, 517 U.S. 25, 42 (1996) (emphasis added). *See also* United States Dep't of the Treasury v. Fabe, 508 U.S. 491, 519 (1993) (Kennedy, J. dissenting).

30. 251 F.3d 101 (2d Cir. 2001).

31. *Id.* at 117.

32. Patton v. Triad Guar. Ins. Corp., 277 F.3d 1294, 1298–99 (11th Cir. 2002).

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cases like these will be the exception rather than the rule. If the Bankruptcy Code is assumed not to relate to insurance, courts will be left to contend with the two remaining McCarran-Ferguson tests.

2. Enacted for the Purpose of Regulating the Business of Insurance

Are state insolvency statutes, from which state receivership courts draw their jurisdiction, laws "enacted for the purpose of regulating the business of insurance?" The states would appear to have a pressing interest to answer this question in the affirmative. In the only state supreme court case to have examined the jurisdictional conflict between bankruptcy and insolvency, the Supreme Court of Arkansas determined that their state insolvency statutes regulated the business of insurance and barred a bankrupt debtor from proceeding in bankruptcy court because "[t]he over 300,000 policyholders affected by the rehabilitation and the appellants' bankruptcy proceedings are at a distinct economic disadvantage in the protection of their interests."[33] The decision is rarely cited and may be a straightforward assertion of state sovereignty in the face of a pressing state interest.

The federal courts have been less definitive. The United States Supreme Court delineated the test for determining if a given activity was the business of insurance in *Union Labor Life v. Pireno*:[34]

> In sum, *Royal Drug*[35] identified three criteria relevant in determining whether a particular practice is part of the "business of insurance" exempted from the antitrust laws by § 2(b): *first*, whether the practice has the effect of transferring or spreading a policyholder's risk; *second*, whether the practice is an integral part of the policy relationship between the insurer and the insured; and *third*, whether the practice is limited to entities within the insurance industry. None of these criteria is necessarily determinative in itself . . . .[36]

Pireno examined the meaning of the words "the business of insurance" in the proviso of 15 U.S.C. § 1012(b) dealing with the antitrust laws[37] as

33. Baldwin-United Corp. v. Garner, 678 S.W.2d 754, 758 (Ark. 1984).
34. 458 U.S. 119 (1982).
35. Referring to *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979).
36. *Pireno*, 458 U.S. at 129.
37. 15 U.S.C. § 1012(b) states in relevant part that:

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opposed to the phrase "for the purpose of regulating the business of insurance" found in the main section of 15 U.S.C. § 1012(b).[38] Even though many federal courts have now embraced the *Pireno* criteria in evaluating "the business of insurance" in both places,[39] it was not for another eleven years after *Pireno* that the Supreme Court finally examined the meaning of "for the purpose of regulating the business of insurance" in the context of an insurance insolvency. However, before the Supreme Court acted, two circuit courts of appeal viewed the "business of insurance" narrowly, throwing out state liquidation priority statutes by finding they were outside the boundaries of the phrase.[40]

In 1993, the Supreme Court considered the meaning of "for the purpose of regulating the business of insurance" in *United States Department of the Treasury v. Fabe.*[41] The Court began with the phrase itself and defined it as centered on the policyholder:

> This Court has had occasion to construe this phrase only once. On that occasion, it observed: "statutes aimed at protecting or regulating this relationship [between insurer and insured], directly or indirectly, are laws regulating the 'business of insurance,' within the meaning of the phrase. . . . [T]he focus of McCarran-Ferguson is upon the relationship between the insurance company and its policyholders." [42]

The Court went on to interpret the clause "for the purpose of regulating" very broadly, concluding that it encompassed "laws that possess the 'end, intention, or aim' of adjusting, managing, or controlling the business of insurance."[43] The Court found this to include much more than just the

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> *Provided,* That after June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, as amended, shall be applicable to the business of insurance to the extent that such business is not regulated by State law.

15 U.S.C. § 1012(b) (2000).

38. *Pireno*, 458 U.S. at 122.

39. "However, we do not interpret this language [from United States Dep't of Treasury v. Fabe, 508 U.S. 491 (1993)] to mean that it is inappropriate to utilize the criteria announced in *Royal Drug* and *Pireno* in cases involving the first clause of Section 1012(b)." Am. Deposit Corp. v. Schacht, 84 F.3d. 834, 840 (7th Cir. 1996).

40. Gordon v. United States Dept. of Treasury, 846 F.2d 272 (4th Cir. 1988), and Idaho ex rel. Soward v. United States, 858 F.2d 445 (9th Cir. 1989).

41. 508 U.S. 491 (1993).

42. *Id.* at 501 (citing SEC v. Nat'l Sec., Inc., 393 U.S. 453, 460 (1969)).

43. *Id.* at 505.

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business of insurance.[44] Yet when the Court applied the three tests for the business of insurance used in its *Pireno* decision, it determined that insolvency statutes regulate the business of insurance only so far as they protect policyholders:

> We hold that the Ohio priority statute, to the extent that it regulates policyholders is a law enacted for the purpose of regulating the business of insurance. To the extent that it is designed to further the interests of other creditors, however, it is not a law enacted for the purpose of regulating the business of insurance.[45]

This distinction was to prove challenging. The *Fabe* decision has left in its wake a decade of conflicting court decisions attempting decide what did and did not protect policyholders.

Shortly after the *Fabe* decision, the First Circuit Court of Appeals decided *Garcia v. Island Program Designer, Inc.*,[46] in which then-Chief Judge (now United States Supreme Court Justice) Breyer took a very narrow view of what protected policyholders. Similar to the controversy in *Fabe*, *Garcia* considered the interaction between the Federal Priority Statute[47] and a Puerto Rico statute governing the priority of claims in an insurance insolvency.[48] Using a very exacting standard, the First Circuit found that a provision setting the date for the filing of claims (and the resulting subordination of late filers, including the IRS) did not protect policyholders.[49] In doing so, the court directed that the late filing statute must be pre-empted by federal law.[50] By holding that the IRS was not subject to the filing deadline, one can argue that the First Circuit pre-empted the entire insolvency priority scheme because the IRS could so delay filing its claim as to hold the receivership court hostage.

The bright line painted in *Garcia* has dimmed over the succeeding years. As the 1990s unfolded, the narrow view of *Garcia* began to stand in opposition to a number of decisions that took a much broader view of *Fabe* and what did and did not protect policyholders. A trio of Circuit Court opinions from the mid-1990s interpreted *Fabe* much more broadly in the

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44. *Id.*

45. *Id.* at 508.

46. 4 F.3d 57 (1st Cir. 1993).

47. 31 U.S.C. § 3713 (2000) which requires that the United States government be paid first in bankruptcy or insolvency.

48. *See* P.R. Laws Ann., tit. 26, § 4019(2).

49. *Garcia*, 4 F.3d at 62.

50. *Id.*

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context of the interaction between state insurance insolvency laws and the Federal Arbitration Act.[51] In addition, courts in two other cases, one federal[52] and one state,[53] chose to directly contradict the holding in *Garcia.*

The Federal Arbitration Act[54] requires that contractual provisions mandating arbitration must be enforced. Yet in three significant cases, this has been found to be pre-empted by state insolvency statutes. In contrast to *Garcia,* these cases appear to view broad segments of state insolvency statutes to be regulating the business of insurance. In *Stephens v. American International Insurance Co.,*[55] the Second Circuit concluded that Kentucky's anti-setoff provisions[56] and its single-forum provisions[57] were enacted for the purpose of regulating the business of insurance. Yet the court went well beyond that in dicta stating "The Liquidation Act 'protects' policyholders . . . by assuring that an insolvent insurer will be liquidated in an orderly and predictable manner and the anti-arbitration provision is simply one piece of that mechanism."[58]

In *Munich American Reinsurance Co. v. Crawford,*[59] the Fifth Circuit wholeheartedly endorsed the holding in *Stephens*, stating that the Oklahoma liquidation statute's single forum clause was for the purpose of regulating the business of insurance.[60] "The same logic applies to the provisions of OUILA[61] requiring consolidation of all claims related to the delinquency in Oklahoma State court. For the many reasons we have just identified, these laws are reasonably necessary to further the goal of protecting policyholders, even though they may benefit other creditors."[62] The court appeared to have believed the entire Oklahoma insolvency statute was enacted for the purpose of regulating insurance, finding it passed two of the three *Pireno* tests.[63] The court calls *Fabe* "unclear" on

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51. Munich Am. Reins. Co. v. Crawford, 141 F.3d 585 (5th Cir. 1998); Davister Corp. v. United Republic Life Ins. Co., 152 F.3d 1277 (10th Cir. 1998); Stephens v. Am. Int'l Ins. Co., 66 F.3d 41 (2d Cir. 1995).
52. Boozell v. United States, 979 F. Supp. 670 (N.D. Ill. 1997).
53. Clark v. Blue Cross Blue Shield of W. Va., 510 S.E.2d 764 (W. Va. 1998).
54. 9 U.S.C. § 1 et seq. (2000).
55. 66 F.3d 41 (2d Cir. 1995).
56. KY. REV. STAT. ANN. § 304.33–330(2)(d) (Michie 2001).
57. *Id.* § 304.33–010(6).
58. *Stephens*, 66 F.3d at 45.
59. 141 F.3d 585.
60. *Id.* at 591.
61. The Oklahoma Uniform Insurance Liquidation Act, 36 Ok. St. Section 1921.
62. *Munich Am. Re*, 141 F.3d at 594.
63. *Id.* at 592.

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the question of whether a liquidation statute must be parsed or taken whole.[64] The court then swept this broad logic into dicta by deciding the case on the single forum clause.[65] "[V]esting exclusive original jurisdiction of delinquency proceedings in the Oklahoma state court and authorizing the court to enjoin any action interfering with the delinquency proceedings—are laws enacted clearly for the purpose of regulating the business of insurance."[66]

Finally, in the most recent of the FAA trio, *Davister v. United Republic Life Insurance Co.*,[67] the Tenth Circuit found that the insolvency court, not the federal court may decide if arbitration should be enforced in a dispute between an insolvent insurer and another party in the unwinding of a corporate transaction.[68]

In 1997, a Federal District Court in Illinois took a very broad view of the *Fabe* decision, specifically contradicting the holding in *Garcia* in *Boozell v. United States*.[69] The District Court found that state insurance guaranty associations were designed to protect policyholders and therefore ranking their claims ahead of federal non-policy claims was protected by the holding in *Fabe*.[70] The court went on to take a very expansive interpretation of *Fabe*. It determined that Illinois's entire priority scheme was protected from preemption by the McCarran-Ferguson Act.[71] It made such a broad reading of the Act's reverse preemption based upon the broad language found in *Stephens* and *American Deposit Corp. v. Schacht*.[72] The precedential value of *Boozell* may be limited by the total amount of federal claims at issue—only $580.00.[73] It is perhaps possible that the failure to seek appellate review of this case was based upon the tiny amount in controversy.

Before concluding the *Bozell* opinion, the district court took the opportunity to speculate that the *Fabe* holding itself might be in jeopardy because of the changed composition of the Supreme Court (implying that

64. *Id.*

65. A single forum clause mandates that all claims against an insolvent insurer be resolved in the court with jurisdiction over the insolvency. *See* discussion of NAIC Model Act, *infra*.

66. *Munich Am. Re.*, 141 F.3d at 592–93.

67. 152 F.3d 1277 (10th Cir. 1998).

68. *Id.* at 1282.

69. 979 F. Supp. 670, 675 n.3 (N.D. Ill. 1997).

70. *Id.* at 677.

71. *See id.*

72. *Id.* at 677–78.

73. *Id.* at 675.

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the addition of Breyer who took the narrow view in *Garcia* and the remaining dissenters on *Fabe* would form a new majority).[74] Nevertheless, the following year one state supreme court also declined to follow the narrow view of *Fabe* taken in *Garcia*.[75]

The currents and eddies of this stream of interpretation flow in many directions at the same time making it difficult to forecast the future of the reverse preemption. On the one hand, in dicta in a recent case, the Supreme Court commented that it would "reject any suggestion that Congress intended to cede the field of insurance regulation to the States, saving only instances in which Congress expressly orders otherwise."[76] On the other hand, the Supreme Court may be providing a hint on its future direction on McCarran-Ferguson through its interpretation of ERISA.[77] In the landmark case *Rush Prudential HMO, Inc. v. Moran*,[78] the Court took a very broad view of the "business of insurance."[79] The Court found a law which required HMOs to submit to an Illinois independent review statute to be regulating the business of insurance using the tests from *Pireno*.[80] The Court made it clear that satisfaction of all three Pireno tests was not required, "[b]ecause the factors are guideposts, a state law is not required to satisfy all three McCarran-Ferguson criteria to survive preemption."[81] The Court leapt through a conflict that has bedeviled bankruptcy courts for years and declared HMO contracts to be contracts of insurance for purposes of McCarran-Ferguson,[82] and further that independent review in the claims

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74. *See id.* at 679.

75. Clark v. Blue Cross Blue Shield of W. Va., Inc., 510 S.E.2d 764 (W. Va. 1998).

76. Humana, Inc. v. Forsyth, 525 U.S. 299, 308 (1999).

77. Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001–1461 (2000).

78. 122 S. Ct. 2151, 536 U.S. 355 (2002) (United States Reports publication pending).

79. *Id.* at 2159. In general terms, ERISA supercedes state regulation of benefit plans 29 U.S.C. § 1144(a) (2000). However, state laws regulating the business of insurance are excepted. 29 U.S.C. § 1144(b)(2)(a). Employer funded plans are specifically placed outside the business of insurance. 29 U.S.C. § 1144(b)(2)(b) (2000). Courts have borrowed the McCarran Ferguson Act jurisprudence to define the business of insurance. *See* Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41 (1987). Courts have used the three part test from *Pireno* in making this evaluation, in addition to a "common sense" view. *Moran*, 122 S. Ct. at 2159, 2163. While there is no absolute assurance that the Supreme Court would paint with as broad a brush when applying McCarran-Ferguson to insolvency as it does when interpreting ERISA, Moran could be seen as providing insight into the Court's thinking on the breadth of the business of insurance.

80. *Moran*, 112 S. Ct. at 2163–64.

81. *Id.* at 2163.

82. *See id.* at 2164.

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process was integral to the policyholder relationship, satisfying that prong of the *Pireno* test.[83] If it is necessary to fulfill only two of the three *Pireno* tests, this may lead to the conclusion that state insurance receiverships will always be within the business of insurance as long as they impact policyholders (as defined in *Fabe*). If insolvency proceedings are limited to the insurance industry, there would be no need to meet the remaining *Pireno* test for the definitional requirement to be satisfied.

The Supreme Court may soon encounter another important test of the relationship between state insolvency statutes and the McCarran-Ferguson Act, if they choose to take the case. The First Circuit's recent decision in *Ruthardt v. United States*[84] may give the Court much to think about. The First Circuit upheld a Massachusetts liquidation priority statute giving precedence to the reimbursement of state insurance guaranty funds ahead of the United States in contravention to the Federal Priority Statute.[85] The First Circuit found that the protection of the guaranty funds was within the business of insurance.[86] At the same time, the First Circuit reaffirmed its prior holding in *Garcia* that the claims bar date for filing claims did not regulate the business of insurance and was therefore invalid.[87] The court asked the rhetorical question: if the United States must rank lower in priority, but need never file its claims in a timely fashion, is it really a lower priority after all or can it extract whatever it wants from the insolvency in exchange for a release?[88] The First Circuit concluded that decisions seeking to contradict their conclusions in *Garcia*

> implicitly reflect the pressure created where the conduct of an already complicated state proceeding is further complicated by a seemingly unlimited in time (and therefore irrational) veto possessed by the United States. If the Department of Justice cannot find time to draft a proper amendment, it will simply encourage judicial self-help, however misguided that may be.[89]

The court invited Congress to enter the fray and decide the question once and for all.[90] The First Circuit then dramatically invited an en banc review

83. *See id.*
84. 303 F.3d 375 (1st Cir. 2002).
85. *Id.* at 382–83.
86. *Id.* at 384.
87. *See id.* at 385.
88. *Id.*
89. *Id.* at 385–86.
90. *Id.* at 385.

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(possibly to overturn *Garcia*) or a Supreme Court review of its *Ruthardt* holding by allowing the state guaranty funds to intervene in the case after its decision.[91] The First Circuit seemed to be throwing up its hands in frustration at the lack of guidance in resolving the seemingly irreconcilable tension created by running a complex financial process through definition of an abstract phrase such as "the business of insurance."

The courts have given us a mixed conclusion on whether the jurisdiction provisions of state insolvency statutes are laws enacted for the purpose of regulating the business of insurance. To the extent laws which mandate a single forum for matters related to an insolvent insurer are construed to allow for an orderly liquidation of the insurance company and the paying of policyholders, then such laws would most likely be held to meet this test. But if an insolvent insurance company were to have sufficient assets to easily meet the needs of policyholder claimants,[92] one wonders if the continued rehabilitation of the company would still be the business of insurance or if the bankruptcy court could exercise authority in that case. In addition, one can speculate if a bankruptcy court, like the IRS in *Garcia*, might be immune to the claims bar date, thus placing a substantial wrench in the state's works. Under this scenario, the bankruptcy court could refuse to submit its claim until the state court cedes jurisdiction. Such tactical turf battles would be unusually nasty and therefore are extremely rare in judicial history. In the end, it may be best to conclude that a bankruptcy court would leave such weapons holstered and abstain from exercising jurisdiction if it must rely on contesting a state insolvency law as not being enacted for the purpose of regulating the business of insurance. With two questions resolved, more or less, it is time to take on the final McCarran-Ferguson criteria.

3. Invalidate, Impair, Supercede

Next, we turn to the final, and perhaps most controversial, test of the McCarran-Ferguson reverse preemption. Do the Bankruptcy Code's jurisdiction provisions[93] and powers over assets of the estate[94] "invalidate, impair, or supersede" state law?

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91. *See id.* at 386.

92. Admittedly a rare case, but possible for a company with large non-policyholder creditors such as reinsurance cedents.

93. 28 U.S.C. § 157 (2000).

94. 11 U.S.C. § 541(a) (2000).

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The Supreme Court has defined these terms recently in *Humana, Inc. v. Forsyth.*[95] "The term 'invalidate' ordinarily means 'to render ineffective, generally without providing a replacement rule or law.' . . . [a]nd the term 'supersede' ordinarily means 'to displace (and thus render ineffective) while providing a substitute rule.'"[96] The Court describes a standard for the term "impair," which means to "'directly conflict with state regulation,' . . . 'frustrate any declared state policy,' [or] 'interfere with a State's administrative regime.'"[97]

Many federal statutes which impact upon state insurance regulation have been held to not "impair, invalidate or supercede" state law; specifically, federal securities regulation,[98] RICO,[99] the Age Discrimination in Employment Act (ADEA)[100] and the Miller Act,[101] have all been held to neither impair, invalidate nor supercede state law. Of the cases, *Murff v. Professional Medical Insurance Co.*[102] which interprets the ADEA, is significant in that it was a claim against an insolvent carrier; however, the *Murff* court hints strongly that it would have stayed the federal action if it had not already been dismissed.[103]

Whether the bankruptcy court's jurisdiction runs headlong into the state court's jurisdiction may be dependent on the specific grant of authority found in the state statute. In one of the rare cases looking at the conflicting jurisdiction, a bankruptcy court in Puerto Rico examined this question. In *In re Advanced Cellular Systems*,[104] the bankruptcy court dismissed an action by a bankruptcy trustee to compel turnover of a certificate of deposit pledged by the bankrupt company as security for a surety bond.[105] The carrier holding the bond was in insolvency in Puerto

95. 525 U.S. 299, 307–11 (1999).

96. *Id.* at 307 (internal citations omitted).

97. *Id.* at 311.

98. SEC v. Variable Annuity Life Ins. Co., 359 U.S. 65 (1959).

99. The Racketeer Influenced and Corrupt Organizations Act, 18 U.S.C. §§ 1961 et. seq., (2000) interpreted in *Humana, Inc. v. Forsyth*, 525 U.S. 299, 308 (1999).

100. Age Discrimination in Employment Act (ADEA), 29 U.S.C. §§ 621 et. seq., (2000) interpreted in *Murff v. Pro. Med. Ins. Co.*, 97 F.3d 289 (8th Cir. 1996).

101. 40 U.S.C. §§ 270a–270f (2000), interpreted in *United States v. Pi Construction Corp.*, 2002 WL 818075 (E.D. La., Apr. 26, 2002).

102. 97 F.3d 289 (8th Cir. 1996).

103. *Id.* at 293. In *Pi Construction*, the abstention was rejected and the action was partially stayed. United States v. Pi Constr. Corp., No. Civ.A. 02-0117, 2002 WL 818075, at *1–*2 (E.D. La. Apr. 26, 2002).

104. 235 B.R. 713 (Bnkr. D. PR 1999).

105. *Id.* at 716, 724.

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Rico.[106] The court based its findings on the expansive grant of authority given to the Puerto Rico insolvency court. The Puerto Rico statute states:

> Upon issuance of an order appointing a liquidator of a domestic insurer or of an alien insurer domiciled in Puerto Rico, no action at law shall be brought against the insurer or the liquidator, whether in Puerto Rico or elsewhere, nor shall an action of that nature be maintained or entered after issuance of such order.[107]

The court construed this statute to apply to actions in equity as well.[108] Yet the court went to great pains to say it would find a way to prevent the action from going forward in any case, offering abstention if the reverse-preemption did not apply.[109] There is no reported appeal of the decision, possibly because a claim had been filed on the surety bond and the security was required.

If armed with a less clear grant of jurisdictional authority under state statute, would other courts reach a different result from the enthusiastic one in *Advanced Cellular*? Other state laws may not be as clear. For example, in *Suter v. Munich Reinsurance Co.*,[110] the court concluded that the New Jersey Liquidation Act did not provide for exclusive jurisdiction when compared with the Oklahoma law examined in *Munich American*.[111] In *Costle v. Fremont Indemnity Co.*,[112] the court pointed out that the Vermont statute did not give the state insolvency court exclusive jurisdiction.[113] In these cases, the courts found the McCarran-Ferguson Act did not reverse preempt federal laws or treaties requiring arbitration because the relevant state insolvency law did not conflict with the federal law.

Many states have enacted statutes based upon the Uniform Insurers Liquidation Act (the "Uniform Act"). The jurisdictional provisions enacted under the Uniform Act may not clearly give the insolvency court jurisdiction over all matters concerning the liquidation of insurers.[114] A

106. *Id.* at 716.
107. P. R. LAWS ANN. tit. 26 § 4021 (2002).
108. *Advanced Cellular*, 235 B.R. at 721.
109. *Id.* at 726.
110. 223 F.3d 150 (3d Cir. 2000).
111. *Id.* at 162.
112. 839 F.Supp. 265 (D.Vt. 1993).
113. *Id.* at 274–75.
114. For example, the Alaska statute states:

> (a) The court is vested with exclusive original jurisdiction of delinquency proceedings under this chapter, and is authorized to make all necessary and proper orders to carry out the purposes of this chapter. (b)

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grant of authority under a version of the Uniform Act may give the court jurisdiction over the conduct of an insolvency, but stop short of requiring the state court to hear all claims related to an insolvent insurer. If a statute lacked such a comprehensive provision, perhaps a bankruptcy court would have more authority in conflicts with an insolvent insurer.

Today, many state insolvency laws are based upon the National Association of Insurance Commissioners' Insurers Rehabilitation and Liquidation Model Act. Section 5(A) of the Model Act contains a very aggressive single forum clause:

> §5(A): The conservation, rehabilitation and liquidation of insurance companies and other persons subject to the provisions of this Act are a matter of vital public interest affecting the relationships between those insured and their insurers. The efficient administration of such activities requires that a single court have jurisdiction over these persons, their assets, and all claims against these persons. The domiciliary court acquiring jurisdiction over persons subject to the provisions of this Act may exercise its jurisdiction to the exclusion of all other courts, except as limited by the provisions of this Act. Upon the issuance of an order under Section 10, 11, 17 or 20 of this Act, the court shall have exclusive jurisdiction with respect to assets or any claims against these persons. Except as otherwise provided in this section, the court may issue orders which bar the institution or prosecution of any actions, counterclaims, cross-complaints, proceedings, arbitration proceedings, writs or other dispute resolution proceedings.[115]

Although all states certainly do not enact the Model Act verbatim, an order of the bankruptcy court directing turnover of property in the possession of the insolvent estate would appear to "invalidate, impair or supercede" the provisions of the Model Act.

> Delinquency proceedings under this chapter constitute the sole and exclusive method of liquidating, rehabilitating, reorganizing, or conserving an insurer, and a court may not entertain a petition for the commencement of the proceedings unless it has been filed in the name of the state on the relation of the director.

ALASKA STAT. § 21.78.010 Jurisdiction of Delinquency Proceedings.

115. The Model Act can be found at the NAIC web site: http://www.naic.org/receivership/documents/rma.doc (last visited Mar. 1, 2003).

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In the final analysis, whether the bankruptcy court's jurisdiction impairs, invalidates or supercedes the insolvency court really depends on the statute in question, how broadly it grants authority and how strictly the federal court is willing to construe it. The NAIC Model Act would seem to give much less wiggle room to the bankruptcy court than the older Uniform Act. Yet, given the public policy pressures granted to the business of insurance and the broad grants of authority given to state regulators, it is unlikely that a bankruptcy court would conclude that a direct order to an insolvency court to turnover property in the possession of an insolvent estate would be construed to be anything less than an attempt to "interfere with a State's administrative regime" as "impair" is defined in *Humana.*[116]

Having now run through all three tests, we can see that McCarran-Ferguson provides extremely good cover for a state insolvency court to reject or ignore a bankruptcy court order seeking assets for a bankruptcy estate. The three McCarran-Ferguson tests appear to be met: the Bankruptcy Code does not specifically relate to insurance, courts view the "business of insurance" broadly to include the affairs of an insolvent insurer, and, depending on state law, actions reaching into an insolvent estate impair the impact of the state's insolvency system.

Is there another way for the bankruptcy court to exercise jurisdiction over a specific asset without confronting the insolvency court?

D. The Possible in rem Exception

The Fifth Circuit in *Munich American Reinsurance Co. v. Crawford*[117] motions to a legal path which may circumvent the McCarran-Ferguson reverse preemption, but it has yet to be tested in the case of an insolvent insurer. If the bankruptcy petition were filed prior to the insolvency petition and the action for the asset were in rem, then the McCarran-Ferguson Act reverse preemption would appear to fall away. No longer would the action be against an insolvent insurer, but an action against a specific piece of property. That appears to be allowed unless specifically prohibited by state statute. The *Munich American* court said:

> [t]o the extent Munich and NAC . . . claim a vested property interest in identifiable proceeds and seek an adjudication of ownership in those proceeds, the nature of their action is *quasi in rem*. . . . Likewise, the delinquency proceedings in Oklahoma state court are *in rem* or *quasi in rem*

116. Humana, Inc. v. Forsyth, 525 U.S. 299, 311 (1999).
117. 141 F.3d 585 (5th Cir. 1998).

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> proceedings. . . . Because the Oklahoma state court first obtained jurisdiction over the proceeds in question, it alone has the power to determine ownership of those funds.[118]

The court in *Munich American* appears to be making an invitation to apply the reverse of this rule: if the federal court gains jurisdiction first, it should be able to hold jurisdiction.

The rule that the party to file first gains jurisdiction in an in rem action stems from the United States Supreme Court's decision in *Princess Lida of Thurn and Taxis v. Thompson*:[119]

> [I]f the two suits are in rem, or quasi in rem, so that the court, or its officer, has possession or must have control of the property which is the subject of the litigation in order to proceed with the cause and grant the relief sought the jurisdiction of the one court must yield to that of the other. We have said that the principle applicable to both federal and state courts that the court first assuming jurisdiction over property may maintain and exercise that jurisdiction to the exclusion of the other, is not restricted to cases where property has been actually seized under judicial process before a second suit is instituted, but applies as well where suits are brought to marshal assets, administer trusts, or liquidate estates, and in suits of a similar nature where, to give effect to its jurisdiction, the court must control the property.[120]

Since one of the bankruptcy court's tasks is to marshal assets, if the rehabilitation order was filed after the bankruptcy petition, this case appears to give the bankruptcy court jurisdiction.

The Supreme Court reiterated its position in *Donovan v. Dallas*:[121]

> Early in the history of our country a general rule was established that state and federal courts would not interfere with or try to restrain each other's proceedings. . . . An exception has been made in cases where a court has custody of property, that is, proceedings in rem or quasi in rem. In such cases this Court has said that the state or federal court

118. *Id.* at 594–95 n.6.
119. 305 U.S. 456 (1939).
120. *Id.* at 466.
121. 377 U.S. 408 (1964).

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> having custody of such property has exclusive jurisdiction to proceed.[122]

The Court went on to say that

> [w]hile Congress has seen fit to authorize courts of the United States to restrain state-court proceedings in some special circumstances, it has in no way relaxed the old and well-established judicially declared rule that state courts are completely without power to restrain federal-court proceedings in in personam actions like the one here.[123]

Presumably McCarran-Ferguson's grant of reverse preemption to the states allows them to restrain the power of in personam jurisdiction in insurance settings, but the Court appears to suggest that there is no such restraint in an in rem action.

In *Gross v. Weingarten*,[124] the Fourth Circuit reviewed the holding in *Donovan* in an insurance insolvency context.[125] In that case, the court re-iterated the *Donovan* court's prohibition on state courts enjoining federal proceedings and reviewed the in rem rules. The *Gross* court found that a counterclaim in a federal action against the officers and directors of an insolvent insurer was not pre-empted by McCarran-Ferguson.[126] The court went on to speculate that McCarran-Ferguson Act has limits. "We are skeptical that Congress intended, through the McCarran-Ferguson Act, to remove federal jurisdiction over every claim that might be asserted against an insurer in state insolvency proceedings."[127]

It must be remembered, however, that for an in rem action to work, the asset must be within the reach of the district court within whose jurisdiction the bankruptcy court is operating. It must also not face a state insurance insolvency statute that specifically prohibits in rem actions outside an insolvency court.

Does the in rem "exception" apply? Technically it would seem so, provided that the bankruptcy is filed first, and the asset is within the reach of the district court's in rem jurisdiction. After all, the *Princess Lida* doctrine is a federal *common* law, not an "Act of Congress" subject to reverse preemption under McCarran-Ferguson. In addition, an insolvent insurer cannot have rights in property beyond those the actual insurer had

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122. *Id.* at 412.
123. *Id.* at 412–13.
124. 217 F.3d 208 (4th Cir. 2000).
125. *Id.* at 221.
126. *Id.* at 222.
127. *Id.*

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prior to insolvency. If a bankruptcy proceeding was already underway, there may be restrictions on those rights the receiver cannot supercede. On the other hand bankruptcy courts, cognizant of the important state purpose in insurance insolvency may choose to use an abstention mechanism rather than render a technically correct decision, subject to considerable scrutiny on appeal.

E. Abstention

Federal courts may abstain in certain defined grounds to rule on questions which are under consideration in other courts. The Supreme Court has cautioned the courts on the use of abstention: "[W]e have often acknowledged that federal courts have a strict duty to exercise the jurisdiction that is conferred upon them by Congress."[128] Even so, many federal courts have relied upon abstention to resolve conflicts with insurance insolvency courts.[129] There are a few types of abstention that should concern this conflict. The first are the mandatory and permissive abstentions found in the Bankruptcy Code itself at 28 U.S.C. § 1334(c), and the second is the *Burford* abstention.[130] There are a number of other types of abstentions, which will not be discussed in this paper.[131]

Mandatory abstention under the Bankruptcy Code would seem inappropriate. Mandatory abstention is allowed for proceedings based upon a state law claim or a cause of action in matters "related to . . . but not arising under title 11 . . . ."[132] The three bankruptcy court actions described

128. Quackenbush v. Allstate Ins. Co., 517 U.S. 706, 716 (1996).

129. *See, e.g.,* In re Reliance Group Holdings, 273 B.R. 374 (Bankr. E.D. Pa. 2002); In re Advanced Cellular Sys., 235 B.R. 713 (Bankr. D. P.R. 1999).

130. First pronounced in *Burford v. Sun Oil Co.*, 319 U.S. 315 (1943).

131. Abstention criteria are outlined in a number of cases. *See, e.g.,* Colo. River Water Conservation Dist. v. United States, 424 U.S. 800 (1976) (respecting the need for judicial economy); Younger v. Harris, 401 U.S. 37 (1971) (keeping federal courts out of state criminal proceedings); R.R. Comm'n v. Pullman Co. 312 U.S. 496 (1941) (declining to address constitutional issues that might be mooted by a state court decision on state law issues). *See also* La. Power & Light Co. v. City of Thibodaux, 360 U.S. 25 (1959), which involved cases "'intimately involved with . . . sovereign prerogative' . . . which might be impaired by unsettled questions of state law." *Quackenbush*, 517 U.S. at 716 (quoting *La. Power & Light Co.*, 360 U.S. at 28). The choices are reviewed in *Quackenbush*, 517 U.S. at 716–17. Sometimes multiple abstentions are used in insurance insolvency related matters. In *Sabato v. Fla. Dept. of Ins.*, 768 F.Supp. 1562 (S.D. Fla. 1991), the court used *Burford, Younger*, and *Colorado River* to reach its conclusion to dismiss in favor of the state insolvency proceeding.

132. 28 U.S.C. § 1334(c)(2) (2000).

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in the beginning of this article[133] are "core" proceedings arising under Title 11, not actions "related to" Title 11, therefore the mandatory abstention provisions of 28 U.S.C. § 1334(c)(2) do not seem to apply to these three actions.

Permissive abstention, on the other hand, is permitted for matters arising under Title 11 as provided by 28 U.S.C. § 1334(c)(1).[134] While there are examples of a bankruptcy court considering a permissive abstention when it is in possession of the contested asset, there appear to be no cases using the abstention when the asset is in the possession of the insurance insolvency court. The Tenth Circuit appears to have held that simple abstention is not enough to allow another court to proceed with an action affecting estate property, but that a lifting of the automatic stay is also in order.[135] This would make abstention much simpler when the bankruptcy court does not have possession of the asset.

In addition to the bankruptcy abstention, courts have used the abstention outlined in *Burford v. Sun Oil Co.*[136] to abstain from proceedings involving state courts.

> *Burford* which allows a federal court to dismiss a case only if it presents "difficult questions of state law bearing on policy problems of substantial public import whose importance transcends the result in the case then at bar" or if its adjudication in a federal forum would be disruptive of state efforts to establish a coherent policy with respect to a matter of substantial public concern.[137]

> Upon timely motion of a party in a proceeding based upon a State law claim or State law cause of action, related to a case under title 11 but not arising under title 11 or arising in a case under title 11, with respect to which an action could not have been commenced in a court of the United States absent jurisdiction under this section, the district court shall abstain from hearing such proceeding if an action is commenced, and can be timely adjudicated, in a State forum of appropriate jurisdiction.

Id.

133. Preferential transfer, fraudulent conveyance and turnover.

134. "Nothing in this section prevents a district court in the interest of justice, or in the interest of comity with State courts or respect for State law, from abstaining from hearing a particular proceeding arising under title 11 or arising in or related to a case under title 11." 28 U.S.C. § 1334(c)(1).

135. *See* Persifull v. Eakin, 814 F.2d 1501 (10th Cir. 1987).

136. 319 U.S. 315 (1943).

137. Quackenbush v. Allstate Ins. Co. 517 U.S. 706, 730 (1996) (quoting New Orleans Pub. Serv., Inc. v. Council of New Orleans, 491 U.S. 350, 361 (1989)).

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A classic *Burford* case is *Caudill v. Eubanks Farm, Inc.,*[138] where a federal court abstained in deciding an action for the dissolution of a corporation.[139] Identifying "important state interests implicated in a shareholder dissolution," the court chose to abstain rather than tread in this important state area. The Sixth Circuit affirmed the district court's abstention.[140]

It is not at all clear why a bankruptcy court would use a *Burford* abstention when the bankruptcy abstention is available to it, but a bankruptcy court did so in *In re Philips Offset Co., Inc.*[141] The court cited as precedent *Hartford Casualty Insurance Co. v. Borg Warner Corp.*[142] and *Mondrus v. Mutual Benefit Life Insurance. Co.*[143] However, in neither case was the plaintiff bankrupt, so it is unclear why this court chose the *Burford* option. Outside of the bankruptcy context, one federal court found that none of the traditional abstentions applied when the McCarran-Ferguson reverse pre-emption precluded jurisdiction, therefore a securities law action required dismissal.[144]

F. Other Potential Concerns

There are a number of other statutory and common law devices which may have an impact on the relationship between the two court systems. Although worth discussion, two of these devices—equitable remedies and sovereign immunity—do not appear to be viable tools in this jurisdictional dispute.

1. Equitable Remedies

If there is no deference granted to the bankruptcy court, can a trustee resort to an equitable remedy to gain a special status in the insolvency proceeding? A constructive trust imposed over the contested asset would be the most likely way to accomplish this. There is little to no law on this subject. In a conflict between two insurance insolvency proceedings, the Arizona Court of Appeals found that state's insurers' liquidation act to be "broad enough to encompass a constructive trust."[145] On the other hand,

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138. 301 F.3d 658 (6th Cir. 2002).
139. *Id.* at 665.
140. *Id.* at 664.
141. 152 B.R. 836 (Bankr. S.D.N.Y. 1992).
142. 913 F.2d 419 (7th Cir. 1990).
143. 775 F. Supp. 1155 (N.D. Ill. 1991).
144. United States Fin. Corp. v. Warfield, 839 F. Supp. 684 (D. Ariz. 1993).
145. Pioneer Annuity Life Ins. Co. v. Nat'l Equity Life Ins., 765 P.2d 550, 555 (Ariz. App. 1988).

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the Illinois Supreme Court determined that constructive trusts were precluded in an insolvency because the "liquidation provisions of the [Illinois] Insurance Code provide the exclusive scheme for determining priorities in distribution."[146] The reason this remedy may be so seldom seen in insurance insolvencies is that receivership courts may consider themselves creatures of a statutory priority scheme, therefore immune from traditional common law equitable remedies which might allow a party to gain an exception to its statutory priority.

2. Sovereign Immunity

The doctrine of sovereign immunity under the Eleventh Amendment to the Constitution might also provide a barrier to suits by a bankruptcy trustee against a liquidator in the person of the state insurance commissioner. There are endless debates, most of them unresolved, about whether the bankruptcy courts have the power to adjudicate claims against sovereign entities. Following along from the United States Supreme Court's decision in *Seminole Tribe of Florida v. Florida*,[147] the Fourth Circuit found 11 U.S.C. § 106(a) to be unconstitutional; it held that the bankruptcy power was an Article I power and the Eleventh Amendment bars actions against states under Article I.[148] A bankruptcy court in Georgia subsequently determined that 11 U.S.C. § 106 was constitutional as enacted under the Fourteenth Amendment.[149] Shortly thereafter, a bankruptcy court in Illinois replied that section 106 was enacted under Article I and was therefore unconstitutional.[150] Given the state of flux of the law in this area and a New York holding that a state insurance commissioner acting as receiver for an insolvent insurer is not being sued as regulator,[151] it appears fair to assume that sovereign immunity does not supply a bar to an action against an insolvent insurer.

146. In re Liquidation of Sec. Cas., 127 N.E.2d 775, 782 (Ill. 1989).

147. 517 U.S. 44 (1996).

148. In re Creative Goldsmiths of Wash. D.C., 119 F.3d 1140, 1147 (4th Cir. 1997).

149. In re Wilson, 258 B.R. 303 (Bankr. S.D. Ga. 2001).

150. In re Claxton, 273 B.R. 174 (Bankr. N.D. Ill 2002).

151. Corcoran v. Nat'l Union Fire Ins. Co. of Pittsburg, PA., 532 N.Y.S.2d 376 (1988). Of course, the United States Supreme Court's opinion in *Ex Parte Young*, 209 U.S. 123 (1908), allows for suits to obtain injunctions against state officials trying to enforce an unconstitutional law, so this may also provide room to challenge state jurisdiction. The contours of *Young* in a bankruptcy context are explored in *Claxton*. Claxton v. United States, 273 B.R. 174, 184-87 (Bankr. NB Ill. 2002).

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G. Implications of Deference to the Insolvency Court

At this point in the discussion, it would seem a justifiable conclusion that unless certain specific exceptions apply, a bankruptcy court will either abstain from an action to retrieve property held within an insolvency proceeding or dismiss it in light of McCarran-Ferguson. This may be a legitimate extension of state and federal policy to keep insurance under the direction of the states. In addition, holding company ownership may still be operating the holding company as debtors in possession during a bankruptcy proceeding. The reverse preemption may provide state regulators with a way of mitigating the former owners' influence over an insolvent insurance subsidiary, especially if state regulators believe the parent was responsible for the insurance company's failure. Even if it were to serve these ends, the reverse preemption may have some harsh effects on a bankruptcy estate's ability to recover assets which were inappropriately swept into an insurance company now in liquidation under the direction of a state court. It could subject the bankruptcy trustee to a far distant proceeding with potentially unfamiliar rules in order to recover a badly needed asset. In addition, the Gramm, Leach, Bliley Act[152] provides a new and troubling scenario. Gramm, Leach, Bliley specifically mandates that McCarran-Ferguson is still the law,[153] yet allows insurance companies to acquire depository institutions.[154] The new legislation allows federal regulators only expedited relief to a Circuit Court of Appeals in the event of a conflict with state regulators.[155] This is a poor substitute for Congressional guidance in how to work out jurisdictional squabbles and provides no guidance as to whether the Circuit Court would feel compelled to abstain or give up jurisdiction to an insolvency court on the grounds of McCarran-Ferguson. If we were to imagine that a bank and an insurer existed under the same holding company and that the bank and the insurer had become insolvent while the holding company had entered bankruptcy, the reverse pre-emption could make things very difficult for a banking regulator. It is possible to envision accidental transfer of the depository institution's funds into the insurance company just prior to the insolvency petition. If the depositary institution were to subsequently become insolvent, federal regulators would come looking for any funds shortchanged to their regulated entity.

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152. 15 U.S.C. §§ 6701–81 (2000).
153. *Id.* § 6701.
154. *Id.* § 6715.
155. *Id.* § 6714.

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Courts have taken the position that federal banking regulators are subject to the automatic stay under 11 U.S.C § 362(a) and therefore cannot proceed without a waiver of the automatic stay by the bankruptcy court.[156] If federal regulators are subject to the jurisdiction of the bankruptcy court and the bankruptcy court must defer to the state insolvency court, a bank regulator may have to go to the state insolvency court to obtain relief, a concept that may prove an unpalatable concept to federal regulators of depository institutions. Federal regulators would be left with "expedited relief" to a federal Circuit Court of Appeals which may feel that under McCarran-Ferguson, it would have no jurisdiction in any event. Could Gramm, Leach, Bliley require the receiver of a failed bank to seek relief in a state insolvency court? That would appear to be an unexpected, but predictable result of the applicable case law.

Conclusion: Part I

It is fair to conclude from the case law that a bankruptcy trustee will have a steep uphill climb to get a bankruptcy court to conclude that it has jurisdiction over an asset in the possession of the estate of an insolvent insurance company. The McCarran-Ferguson arguments are simply too strong when combined with deference to an ongoing state proceeding as part of a complex regulatory structure. If the bankruptcy petition was filed prior to the rehabilitation or liquidation petition, there remains the possibility of an in rem action, however courts may still be reluctant to exercise jurisdiction. In the end, if the asset is in the possession of the insolvency estate, it appears the role of the insolvency court is to decide its fate.

PART II: THE BANKRUPTCY ESTATE HOLDS THE ASSET

Introduction

If in the opening hypothetical the holding company, insurance agency or the third-party claims processor are holding assets of the insurance company (for example a tax refund held by the holding company or premiums collected by the agency) at the time of their bankruptcy, which court will hear the insurance company's claim on those assets: the state

156. *See, e.g.,* In re Colonial Realty Co., 980 F.2d 125 (2d Cir. 1992); In re Parker N. Am. Corp., 24 F.3d 1145 (9th Cir. 1994) *and* Sunshine Dev. Inc. v. FDIC, 33 F.3d 106 (1st Cir. 1994).

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court administering the insolvency or the federal court supervising the bankruptcy proceeding?

The arguments for applying bankruptcy court jurisdiction are much stronger when the asset is in the hands of the bankruptcy court. Longstanding rules against interference by state courts in federal proceedings and reasonable interpretations of the Constitution's bankruptcy provisions imply this result. Even so, there are two recent federal court decisions which advocate granting much larger authority to state courts and these may represent a harbinger of the future.

Discussion

If the asset is in the hands of the bankruptcy court, the Bankruptcy Code gives the court very wide powers over estate assets[157] and actions regarding the estate.[158] These are considered "core" matters.[159] There are many bases for the primacy of that authority over other venues.

A. The Constitution, Again

Once again, we look at the United States Constitution, but this time the bankruptcy court has physical possession of the asset and the Constitutional implications may be very different. Certainly the interplay between the Supremacy Clause and the McCarran-Ferguson Act remains the same. Congress has passed a law that denies certain inferences from its other laws, therefore exempting certain state laws regulating the business of insurance from being superceded by most federal laws. The Supremacy Clause may keep state laws from pre-empting acts of Congress, but in the case of McCarran-Ferguson, one act of Congress pre-empts another and therefore there is no Supremacy Clause argument. Still, no act of Congress, even McCarran-Ferguson, may supercede the Constitution. The Constitutional analysis may have considerably more influence when examining the inner workings of a bankruptcy itself.

1. The Bankruptcy Clause

Remembering that the Constitution vests in Congress the power to enact "uniform" bankruptcy laws,[160] and that Congress has clearly assumed this power and enacted bankruptcy legislation, the wording of the

157. 28 U.S.C. § 1334(e) (2000).
158. *Id.* § 157.
159. *Id.* § 157(b)(2).
160. U.S. CONST. art. I § 8 cl. 4.

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Constitution appears to require that, once enacted, the laws actually be uniform. When an asset is in the hands of the bankruptcy estate, the liquidation court must reach directly into the bankruptcy process. It would seem strange for Congress to be able to permit non-uniform state laws to grant jurisdiction to non-bankruptcy courts to impact activities inside the bankruptcy process.

The Constitution does not require Congress to take up the bankruptcy power and Congress has refrained from doing so for most of United States history prior to 1898. Even if one assumes that Congress has the power to refrain from exercising that power over specific segments of industry, such as insurance, does the Constitution give Congress the power to make the system itself be non-uniform with regard to circumstances inside the bankruptcy process? If "the constitution is superior to any ordinary act of the legislature,"[161] and the Constitution mandates a "uniform" system, then can Congress ignore this condition on the exercise of the power given to it? The framers took the uniformity requirement seriously and judged it to be a selling point of the new Constitution.[162] Although bankruptcy cases are rarely grounded in the Constitution (except on questions of sovereign immunity) it would seem incumbent upon the bankruptcy courts to enforce uniformity and decide the fate of assets already in their hands.

The Supreme Court has rarely examined the meaning of "uniformity" in the bankruptcy context. The most expansive review was in 1902 in the context of the various state exemptions to bankruptcy:

> We . . . hold that the system is, in the constitutional sense, uniform throughout the United States, when the trustee takes in each state whatever would have been available to the creditor if the bankrupt law had not been passed. The general operation of the law is uniform although it may result in certain particulars differently in different states.[163]

State-by-state distinctions in the way a debtor entered into commercial transactions do not appear to violate the uniformity requirement. It is now

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161. Marbury v. Madison, 5 U.S. 137, 178 (1803).

162. The power of establishing uniform laws of bankruptcy is so intimately connected with the regulation of commerce, and will prevent so many frauds where the parties or their property may lie or be removed into different States, that the expediency of it seems not likely to be drawn into question.

The Federalist No. 42 (James Madison).

163. Hanover Nat'l Bank of the City of N.Y. v. Moyses, 186 U.S. 181, 190 (1902).

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generally accepted that state determinations of basic property law, if permitted by Congress, are not in violation of the uniformity requirement. This is often discussed in terms of state-by-state exemptions from bankruptcy.[164]

Eighty years later however, the Court set a boundary line for the uniformity requirement. The Court determined that laws that apply to only a single debtor are not uniform in the Constitutional sense:

> To survive scrutiny under the Bankruptcy Clause, a law must at least apply uniformly to a defined class of debtors. A bankruptcy law, such as RITA, confined as it is to the affairs of one named debtor can hardly be considered uniform. To hold otherwise would allow Congress to repeal the uniformity requirement from Art. I, § 8, cl. 4, of the Constitution.[165]

The jurisdictional conflict in insolvency appears to be in between these two extremes. Insurance insolvency laws are state laws regulating commercial transactions and therefore may be like the state determination of exemptions. Yet it is hard to envision a "class" of debtors as consisting of those bankrupt companies unfortunate enough to have done business with an insolvent insurance company and in this aspect, might bear some similarity to the prohibited single-debtor class legislation. If McCarran-Ferguson were interpreted to give state courts powers over a bankruptcy proceeding, would it be a law creating non-uniform bankruptcies? It can be argued that granting jurisdiction over an asset belonging to a bankrupt company to a state insolvency court would go beyond state regulation of creditor's rights into the realm of non-uniformity.

2. The Taxation Clause

In contrast, the Supreme Court long ago swept aside concerns about the word uniform as found in the Constitution's taxation clause[166] saying, "the constitutional requirement of uniformity is not intrinsic, but geographic. And differences of state law, which may bring a person within or without the category designated by Congress as taxable, may not be read into the

164. *See* In re Sullivan, 680 F.2d 1131 (7th Cir. 1982).

165. Ry. Labor Executives Ass'n v. Gibbons, 455 U.S. 457, 473 (1982).

166. The Congress shall have Power To lay and collect Taxes, Duties, Imposts and Excises, to pay the Debts and provide for the common Defence and general Welfare of the United States; but all Duties, Imposts and Excises shall be uniform throughout the United States.

U. S. CONST. art. I § 8 cl. 1.

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Revenue Act to spell out a lack of uniformity."[167]

> Thus it is apparent that the expression "uniform throughout the United States" was at that time considered as purely geographical, as being synonymous with the expression "general operation throughout the United States," and that no thought of restricting Congress to intrinsic uniformity obtained, since the powers recommended were absolutely in conflict with such theory.[168]

If this interpretation were to be followed when evaluating the impact of a state insolvency court on the bankruptcy process, there would appear to be considerable room for "geographic uniformity." Yet the two bankruptcy cases mentioned above seem to indicate that the Court interprets the uniformity requirement found in taxation clause differently from that in the bankruptcy clause. This would appear to suggest that the Constitution is meant to be more restrictive in the case of bankruptcy.

The primary distinction between the scenario in Part II and the scenario addressed in Part I is that the insolvency receiver is no longer within his own dominion, but is reaching out into another estate to get an asset. Long ago, courts recognized a bankruptcy court's jurisdiction over claims operating outside of the unique environment of the liquidation of an insurance subsidiary. "Congress determined that interference with state insurance regulations would not occur as long as bankruptcy courts did not reorganize insurance companies or adjudge them to be bankrupts."[169] Once outside the state receivership courts, federal courts appear to be exercising legitimate powers granted them by Congress in exercising control over assets in their estates. Those powers flow from a grant of authority given to Congress by the Bankruptcy Clause. As a result, there would appear to be serious questions if a grant of authority to a receivership court violated the terms of the Constitution's uniformity requirement by giving the state court powers over the contents of a bankruptcy estate.

B. The McCarran-Ferguson Act, Again

When the asset is in the possession of the bankruptcy court, the McCarran-Ferguson analysis starts out the same as it did in Part I, but then takes a different turn toward bankruptcy court jurisdiction. It remains true

167. Poe v. Seaborn, 282 U.S. 101, 117–18 (1930).

168. Knowlton v. Moore, 178 U.S. 41, 98 (1900).

169. In the Matter of Equity Funding Corp. of Am., 396 F. Supp. 1266, 1275 (C.D. Cal. 1975).

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that the Bankruptcy Code does not relate specifically to the business of insurance, and therefore this McCarran-Ferguson test comes out the same. Yet the other two tests have changed with the shift in perspective. When a receiver of an insolvent insurance company reaches out of the insolvent estate into a bankrupt debtor's estate, are those actions a result of a statute enacted for the purpose of regulating the business of insurance? Do actions of the bankruptcy court taken within the bankruptcy estate impair, invalidate or supercede state law? The case law is mixed, but the majority seem to answer these questions in the negative.

1. Enacted for the Purpose of Regulating the Business of Insurance

In the abstract, the *Pireno*[170] tests do not appear to be met when acting outside the insolvent estate. The tests are: "*first*, whether the practice has the effect of transferring or spreading a policyholder's risk; *second*, whether the practice is an integral part of the policy relationship between the insurer and the insured; and *third*, whether the practice is limited to entities within the insurance industry."[171] Taking an asset from another entity would not seem to be in furtherance of spreading policyholder risk. There may not be a policyholder relationship involved in an asset held by a bankrupt holding company, and the bankruptcy process is clearly not limited to the insurance industry.

As discussed above, when examining state-federal conflicts in the context of ERISA, the Supreme Court also applies a "common sense" test to determine the boundaries of the business of insurance.[172] Determining the fate of property within a bankruptcy estate would not seem to be a common sense extension of the business of insurance unless the asset sought had a direct tie to policyholders.

As discussed in Part I, the McCarran-Ferguson Act pre-empts the Federal Arbitration Act's requirement to compel arbitration when a third party is seeking to recover assets held by the insurer because the FAA has been found to impair state laws enacted for the purpose of regulating the business of insurance. However, the McCarran-Ferguson analysis in the Federal Arbitration Act cases generally changes when the receiver of an insolvent insurer is trying to compel arbitration on an outside party and state law does not prohibit it. In Part I, three FAA cases were reviewed

170. Union Labor Life v. Pireno, 458 U.S. 119 (1982).
171. *Id.* at 129.
172. *See supra* note 79 (discussion of *Moran v. Rush Prudential*, 536 U.S. 355 (2002)).

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which granted jurisdiction to the insolvency court, but they can all be distinguished from the fact pattern in Part II. In *Munich American*, funds were in the hands of an insolvent estate and reinsurers were trying to compel arbitration.[173] In *Stephens*, the asset was outside the estate, but Kentucky law specifically did not allow the desired set-off or arbitration.[174] In *Davister*, the action was to compel the estate to release contract rights and stay the liquidation itself.[175] These cases do not appear to control when a receiver or liquidator is exercising authority beyond the bounds of the insolvent insurer's estate. In *Fremont Indemnity v. Costle*,[176] the court concluded that:

> Certainly, the Liquidator's collection of reinsurance proceeds increases the pool of Ambassador's assets, but the record reflects that those assets are to be distributed to nonpolicyholder creditors. Under *Fabe,* the Liquidator's powers to collect these particular proceeds do not have as their purpose the regulation of the business of insurance as that term is construed under the McCarran-Ferguson Act.[177]

This could have been attributed to the unusual facts in *Fremont*, where the parties agreed that there were enough funds in the estate to pay policyholders.[178] However, a federal court in Pennsylvania recently came to the same position saying, "this case, as a suit by the Liquidator to collect from a third party, does not involve the business of insurance."[179]

A possible conclusion from these cases is that when a liquidator goes outside of the insolvent estate seeking the determination of ownership or assets, he is like any other creditor. Unless specific insurance law applies to the liquidator's claim, he has subjected himself to whatever process is applicable to determine ownership of the asset and that process is far from the business of insurance.

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173. Munich Am. Re. Co. v. Crawford, 141 F.3d 585, 587 (5th Cir. 1998).

174. Stephens v. Am. Int'l Ins. Co., 66 F.3d 41, 42–43 (2d Cir. 1995).

175. Davister Corp. v. United Republic Life Ins. Co., 152 F.3d 1277, 1278 (10th Cir. 1998).

176. 839 F. Supp 265 (D. Vt. 1993).

177. *Id.* at 274.

178. *Id.*

179. Koken v. Cologne Reinsurance (Barbados) Ltd., 34 F. Supp. 2d 240, 256 (M.D. Pa. 1999).

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2. Invalidate, Impair, Supercede

When the asset is outside the insolvent insurer's estate, the Bankruptcy Code may not impair, invalidate or supercede the state insolvency laws. In *Suter v. Munich Reinsurance Co.*,[180] the court found that the United Nations Convention on the Recognition and Enforcement of Foreign Arbital Awards (the "NY Convention") and the Federal Arbitration Act did not impair the New Jersey Liquidation Act in requiring the liquidator to submit to arbitration in order to recover on reinsurance treaties.[181]

Although it resulted in no published decisions and very little published commentary, one recent conflict between an insolvent insurer and a bankrupt holding company may offer some guidance. In the case of the Superior National Insurance Companies, the insurance subsidiaries were taken into conservation and later liquidation while the holding company and non-insurance subsidiaries were in bankruptcy. The bankruptcy court was asked to determine ownership of pre-petition assets in the possession of the holding company. Robert B. Millner, a participant at a recent conference stated that, "the bankruptcy court observed that it has core jurisdiction under Bankruptcy Code § 541 to determine what constitutes tangible and intangible property of the Debtors' bankruptcy estates, at least in respect of property which is in the possession of (or held in the name of) the Debtors."[182] Mr. Milner (who represented a party adverse to the insurance insolvency receiver) went on to argue that this was because the bankruptcy proceedings did not invalidate, impair or supercede the state receivership statute or proceedings. He further noted that the California Insurance Commissioner disagreed with this assertion using *Advanced Cellular* as precedent[183] and that the dispute was generally resolved by a private settlement between the parties.[184]

3. The Changing Tides

The distinction between an asset inside and outside the estate may be in danger of becoming a passing trend. A recent decision in a California bankruptcy court found that McCarran-Ferguson preempted a bankruptcy

180. 223 F.3d 150 (3d Cir. 2000).

181. *Id.* at 161–62.

182. Robert B. Milner, Jurisdiction over Property Claimed by a Debtor and a Receiver for an Insolvent Insurer, 3–4 (Feb. 6, 2003) (written materials distributed with a presentation to the International Association of Insurance Receivers Insolvency Workshop).

183. *Id.* at 10.

184. *Id.* at 3.

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court from exercising jurisdiction.[185] In examining a tax allocation agreement when a tax refund was being sought from the bankruptcy estate, the court concluded two findings in the alternative: first that McCarran-Ferguson reverse preempted its authority in examining the agreement because it would cause a conflict with the liquidation court, and in the alternative, if the action was not reverse preempted, then voluntary abstention was warranted to allow the liquidation court to examine the agreement.[186] In the case, *In re Amwest Insurance Group, Inc.*, the court weighed the McCarran-Ferguson tests and found them conclusive in favor of reverse-preemption.[187] This is a departure from an unpublished prior California federal court decision that found that the liquidation statutes of California insurance law did not regulate the business of insurance.[188] This ruling has much of the reasoning of *In re Advanced Cellular*, but with a key difference: the tax refund is in the possession of the bankrupt estate. As a result, the *Amwest* court appears to leave behind the provisions of the bankruptcy code that give the federal court exclusive jurisdiction over the assets of the estate.[189] The court also gives no deference to Constitutional questions about what its actions do to uniformity of the bankruptcy process. It is most interesting to note that Judge Mund, who decided this case, presided over the Superior National proceeding discussed in the last section. We must wait to see if other bankruptcy courts share this expansive view of McCarran-Ferguson reverse preemption.

4. In Search of Conclusions on the Reverse Preemption

When the roles are reversed, the McCarran-Ferguson analysis does not lead to clear answers. While the Bankruptcy Code is not specifically related to insurance, it is not clear that actions outside the insolvent estate are actions pursuant to state laws enacted for the purpose of regulating the business of insurance, nor is it clear that the provisions of the Bankruptcy Code impair the orderly execution of an insurer insolvency. This would especially be true if the insurance receiver filed a claim in the bankruptcy court, in which case, the receiver runs the danger of having waived

185. In re Amwest Ins. Group, 285 B.R. 447, 451 (Bnkr C.D. Cal. 2002).

186. *Id.* at 451–52, 455–56.

187. *Id.* at 451.

188. Garamendi v. Caldwell, 1992 WL 203827 (C.D. Cal. May 4, 1992). This decision was rendered one month prior to *Fabe* and was based upon *Idaho ex rel. Soward*, 858 F.2d 445 (9th Cir. 1988) that *Fabe* had overruled. As a result, it may have had limited value as precedent before *Amwest* swept it aside.

189. 28 U.S.C. § 1334(e) (2000).

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McCarran-Ferguson arguments and voluntarily subjected the claim to the bankruptcy court's jurisdiction.

C. Abstentions, Again

If the McCarran-Ferguson Act's reverse preemption does not protect receivers straying outside the boundaries of the insolvent estate, do the abstention doctrines give them deference? The courts are very mixed on this topic, but many have refused abstention and exercised jurisdiction. In *Quackenbush v. Allstate Insurance Co.*, the Supreme Court cautioned that federal courts should use abstention only with caution.[190] But since *Quackenbush* involves neither McCarran-Ferguson nor a bankruptcy process, it may be of limited guidance.

Some courts have refused either to abstain or grant relief from the automatic stay for insurance receivers. One court found that an insurance receiver reaching into a personal bankruptcy to attach a homestead asset had reached too far.[191] Another bankruptcy court refused to abstain when examining an action by an insurance department to revoke the licenses of a bankrupt individual.[192] A district court refused to stay an adversary proceeding in which an insurer in liquidation was compelled to provide a defense.[193] It seems doubtful that a court would grant relief from the automatic stay unless confronted with novel concepts of law or a compelling state law situation. On the other hand, there is considerable precedent for bankruptcy courts to defer to state courts in delicate state-administered matters such as divorce.[194] It is possible that a bankruptcy court would view an insurance insolvency in this same light and defer to the state court for direction.

In a recent case, the Pennsylvania Insurance Commissioner petitioned the bankruptcy court in the Reliance Holdings bankruptcy to establish a constructive trust over tax proceeds in a dispute between Reliance and its insolvent insurance subsidiary and sought to keep the bankrupt holding company from settling certain class action suits which would impact the group's directors' and officers' liability insurance.[195] The bankruptcy court

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190. 517 U.S. 706, 716 (1996).

191. In re Aloisi, 261 B.R. 504, 512 (Bankr. M.D. Fla. 2001).

192. In re Jacobs, 149 B.R. 983, 990 (Bankr. N.D. Okla. 1993).

193. Jones v. Hoel, 211 F. Supp. 2d 823, 827–28 (E.D. Tex. 2002).

194. *See* In re White, 851 F.2d 170 (6th Cir. 1988); In re French, 139 B.R. 476 (Bankr. D. S.D. 1992).

195. In re Reliance Group Holdings, 273 B.R. 374, 380–81, 383 (Bankr. E.D. Pa.. 2002).

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refused to grant discretionary abstention in the insurance matter, but concluded that the tax sharing agreement posed questions in "an undeveloped area of Pennsylvania law which impacts the state's interest in the regulation of the insurance industry."[196] "Under principles of comity, it is appropriate to abstain and allow the Commonwealth Court to decide the Trust Action's state law issues."[197] The court first decided that bankruptcy code's discretionary abstention was in order with regard to the tax refund due to these unresolved issues of state law and then worked its way through the *Burford* abstention criteria and concluded that abstention was in order under this policy as well.[198] The court relied on portions of the Pennsylvania Insurance Holding Company act. The court explained,

> There appears to be no case law interpreting that portion of the Insurance Holding Company Act (particularly 40 P.S. § 991.1405—"Standards and management of an insurer within a holding company system") which the Commissioner contends must be reviewed to determine the relief requested in the Trust Action. Among other things, Section 991.1405 requires all transactions within a holding company system to be "fair and reasonable," but these terms are not specifically defined. In this situation, it is appropriate to defer and allow the state courts to interpret first the state's regulatory statutes, especially with respect to the statutory scheme established by the state's insurance act.[199]

Yet the court concluded that the resolution of issues pertaining to the insurance policies were not unsettled state law issues meriting abstention, explaining,

> [r]esolution of the Emergency Petition [the insurance issue] involves more "ordinary" issues of contract interpretation based upon the coverage, named assureds, and other provisions of the Lloyds Policies. These are not novel or unsettled issues of state law; the primary concern that led me to conclude that discretionary abstention is appropriate in the Trust Action [the tax refund issue], is not present here.[200]

It would appear that the *Reliance* court has attempted to divide the

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196. *Id.* at 402.
197. *Id.* at 401.
198. *Id.* at 403–04.
199. *Id.* at 399–400.
200. *Id.* at 402.

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jurisdictional issues and cede those in doubt to the Commissioner. Yet, the use of the Holding Company Act as a shelter from a contract interpretation issue would seem a more convenient port in the jurisdictional storm than navigating new legal waters.

On the other hand, the very recent *Amwest* decision in California casts much more significant doubt on the ability to refrain from abstention just because the asset is in the custody of the bankruptcy court. One of the bankruptcy judge's alternative bases for her decision was to abstain from the proceeding while the state court made its determination.[201] This was based upon three motivations: an issue of state law, the unlikely prospect of the debtor's reorganization, and a desire to promote judicial economy by collapsing two proceedings to interpret the tax allocation agreement.[202] Again, it remains to be seen if other courts will embrace this as precedent, but it is significant that Mr. Millner argues that Judge Mund had rejected abstention in the *Superior National* case because it "involved no intricate questions of state law."[203]

Reliance and *Amwest* appear to have obscured the grounds for abstention which were by no means clear before. If these two decisions are followed as precedent, abstention may become much more common in conflicts with an insurance insolvency court, even if the disputed asset is in the possession of the bankruptcy court.

D. Other Devices

1. Exceptions to the Automatic Stay and Statutory Conflicts

Insurance regulators may argue that they are entitled to an exception from the automatic stay in bankruptcy because they are exercising their police powers as provided by 11 U.S.C. § 362(b)(4). This exception has generally not been upheld when the state is enforcing a pecuniary interest or seeking a pecuniary advantage. This was the conclusion of the bankruptcy court in *Reliance Group Holdings, Inc.*[204] The police powers exception did not provide an exception to the automatic stay because the receiver was seeking a pecuniary advantage over other creditors.[205] Because a receiver reaching outside of the insolvent state is generally on a

201. In re Amwest Ins. Group, 285 B.R. 447, 456 (Bankr. C.D. Cal. 2002).
202. *Id.*
203. Milner, *supra* note 182, at 3.
204. 273 B.R. 374 (Bankr. E.D. Pa. 2002).
205. *Id.* at 386.

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quest for pecuniary assets, the police powers exception would be of limited value.

Insurance insolvency courts seeking to reach beyond their borders can run into difficult statutory roadblocks in other states. A bank was allowed to collaterally attack the full faith and credit status of an order arising out of a Tennessee receivership in *Tennessee ex. rel. Sizemore v. Surety Bank.*[206] As insolvency courts seek to impose their will on bankruptcy courts in other states, they must make sure they have the proper statutory authority to do so.

2. Equitable Remedies

A recent tactic by insurance receivers is to petition the bankruptcy court to ask for equitable relief in the form of a constructive trust over the assets they claim. This method was explored in detail in a New York bankruptcy.[207] The New York Superintendent of Insurance claimed a tax refund was the property of an insurer in liquidation, First Central Insurance Company.[208] The bankruptcy court interpreted the tax allocation agreement between the parent and the insurance subsidiary in light of New York contract and constructive trust laws.[209] As a result, the court concluded that the refund was the property of the bankruptcy estate under the Bankruptcy Code.[210] The Superintendent was not entitled to a constructive trust on any portion that belonged to the insolvent insurer.[211] Even though the tax allocation was based upon a circular disseminated by the New York Department of Insurance, the court performed a straightforward contract analysis, followed by applying the New York factors for a constructive trust.[212] There was no mention of McCarran-Ferguson or special aspects of insurance law (other than the circular). In a very interesting sidelight, the court uses as precedent, a case involving a bank insolvency where the Resolution Trust Company was barred from the same type of relief sought by the New York Superintendent in *First Central.*[213] The "business of insurance" was nowhere to be found.

206. 200 F.3d 373, 375 (5th Cir. 2000).
207. In re First Cent. Fin. Corp., 269 B.R. 481 (Bankr. E.D. N.Y. 2001).
208. *Id.* at 484.
209. *Id.* at 489–502.
210. *Id.* at 502.
211. *Id.* at 501.
212 *Id.* at 494.
213. *Id.* at 497.

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In *Reliance Group Holdings*,[214] the bankruptcy court took the opposite approach in examining the tax allocation agreement in that case. As discussed above, the bankruptcy court decided to abstain on both the discretionary abstention grounds under the Bankruptcy Code, 28 U.S.C. § 1334(c)(1) and under *Burford*.[215] The court remanded the question of a constructive trust in respect to payments under the tax sharing agreement and allowed the state court to decide the matter.[216] The court distinguished *First Central* on the grounds that a comparable insurance statute was not at issue and because of the misconduct of the officers of the holding company in that case, even though the *First Central* decision contains no mention of any New York insurance holding company regulation and minimizes the impact of the misconduct on the contract issue.[217] As suggested above, the holding in *Reliance* appears to be an attempt to balance the various conflicting interests and may have been motivated by a desire to leave the interpretation of the tax agreement (and therefore the constructive trust issue) to a local court.

3. Property Actions Outside the Estate

So far this discussion has assumed that the asset sought is a tangible item or cash physically possessed by one estate or the other. It is quite possible that the asset is an obligation from a third party. In this case, possession is simply a determination that the estate is due the money from the third party. This situation could result in a hybrid of the in rem discussion in Part I. If the receiver of the insolvent insurer claimed ownership of the obligation, the debtor could ask the bankruptcy court to determine that the obligation was property of the bankruptcy estate and then pursue the obligor directly, thus avoiding a confrontation with the state receivership court. The third party's logical response could be to place the obligation into an interpleader action. This fact pattern remains hypothetical, but could provide a means to have conflicting claims worked out without the constraints of the McCarran-Ferguson Act.

214. 273 B.R. 374 (Bankr. E.D. Pa. 2002).
215. *Id.* at 401.
216. *Id.* at 401–02.
217. *First Central*, 269 B.R. 481.

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E. Laying the Gauntlet at Congress' Feet

The Supreme Court clearly believes that Congress has the power to regulate banks and that power can be used to supercede state insurance regulation. "There is no reason to think that Congress believed state insurance regulation beyond its constitutional powers to affect—insofar as Congress exercised those powers to create, to empower, or to regulate national banks."[218] The First Circuit has invited Congress to resolve the ambiguities left by *Fabe* and *Garcia* between the Federal Priority Statute and conflicting state insolvency regulation:[219]

> Congress could easily fix the problem, as it has already done for ordinary bankruptcies. . . . But this is a matter for the legislature, not the courts. Among other reasons, the optimal answer might well be something other than letting each state fix its own quite short limit for federal claims.[220]

Congress used the Bankruptcy Code to provide some relief to banking regulators and to define the relationship between bank regulators and bank holding company bankruptcy. In 1994, Congress amended the Code through section 365(o) in order to grant priority to obligations arising out of commitments to maintain the capital of depository institutions.[221] This mix of being subject to the bankruptcy system while having a priority to benefit regulators seems an attempt to make the two systems work together.[222] It could make sense to have this type of coordination between the bankruptcy process and insurance regulation.

In the final analysis, it is up to Congress to set up predictable rules to govern the conflicts described in this Comment. Predictable rules will help participants avoid jurisdictional battles that consume judicial resources. The Constitution gives Congress the power to extend the bankruptcy code to insurance or alternatively to exempt insurance holding companies from it, therefore granting state regulators sole power to adjudicate insurance holding company insolvencies. But Congress has often declined invitation by the courts to exercise its powers, with the pointed example of the time taken to reform bankruptcy jurisdiction in the wake of the Supreme Court's

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218. Barnett Bank of Marion County, N.A. v. Nelson, 517 U.S. 25, 42 (1996).

219. Ruthardt v. United States, 303 F.3d 375 (1st Cir. 2002).

220. *Id.* at 385.

221. 11 U.S.C. § 365(o) (2000).

222. The author is indebted to Professors Patricia McCoy and John Day for their assistance in understanding the impact of banking regulation, but the views are those of the author alone.

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decision in *Marathon*.[223] A significant joint insolvency between an insurance company and a bank may be the irresistible invitation Congress requires.

Conclusion: Part II

It would appear that the law may not favor an exercise of jurisdiction by the state receivership court over an asset in the possession of a bankruptcy estate. The conditions of McCarran-Ferguson may not be satisfied so as to provide reverse preemption and constitutional issues would suggest that the bankruptcy court should exercise its jurisdiction. However, the recent case law suggests deference to the state court.

In the final analysis, the issue presented in Part II is a much more difficult question of law than the issue discussed in Part I. The three tax refund cases clearly show how problematic the law in this area is. Even though prior opinions have clearly stated the bankruptcy court's jurisdiction in determining tax liabilities of bankrupt entities,[224] the three tax refund cases cited in Part II come to different results on what to do. *First Central* decides the fate of a tax refund in the bankruptcy court on state contract and constructive trust grounds,[225] *Reliance* uses both a bankruptcy discretionary abstention and a *Burford* abstention to send the matter back to state insolvency court to determine the destiny of the refund and whether a constructive trust should be implicated,[226] and *Amwest* simply declares that the bankruptcy court is pre-empted from action by McCarran-Ferguson, or in the alternative, will use discretionary abstention to refrain from interpreting the tax allocation agreement.[227]

The well-defined tests of the McCarran Ferguson Act provide much less guidance in Part II than they did in Part I. Traditional rules of

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223. N. Pipeline Constr. Co. v. Marathon Pipe Line Co., 458 U.S. 50 (1982). Congress did not enact 28 U.S.C. § 157, which cured the defect, until 1984.

224. The court in *In re Sharon Steel Corp.*, 119 B.R. 502 (Bankr. W.D. Pa 1990) observed that:

> While there may be limits on bankruptcy court jurisdiction over the affairs of a wholly-owned subsidiary, we think it clear that the debtor's right to be included with such subsidiary in a unitary group for tax purposes, if otherwise entitled thereto by applicable law, involves a determination of the amount or legality of a tax on the debtor, a matter within the jurisdiction conferred by [11 U.S.C] § 505.

Id. at 503.

225. In re First Cent. Fin. Corp., 269 B.R. 502 (Bankr. E.D.N.Y. 2001).

226. In re Reliance Group Holdings, 273 B.R. 374, 400–01 (Bankr. E.D. Pa. 2002).

227. *Amwest*, 285 B.R. at 456.

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jurisdiction and authority begin to come into play. When looking at the question posed in Part II, specific statutory guidance becomes more important as does a natural deference to the proceedings in another court. Just a few years ago, the tendency would have been for the bankruptcy court to hold onto the asset and determine its fate on its own. In light of the recent decisions, the Supreme Court will need to provide guidance in how much jurisdiction the bankruptcy courts should maintain or relinquish. If the country experiences a rash of very large insurance insolvencies, the spotlight may turn on Congress to take some action, yet Congress has historically been very slow to act on difficult issues which pit the states against the federal government.

All of the jurisdictional wrangling would be troubling to third party creditors of a bankrupt financial holding company and especially to a bank regulator confronted with the need to recover lost assets of a troubled bank in the same corporate family with an insolvent insurer. Not only must creditors defer to state regulators when assets are in possession of the insolvent insurer, but perhaps when they are in the possession of the holding company as well. If both a bank and an insurer entered insolvency, what would happen if both claimed an interest in a tax refund held in their bankrupt holding company? Would the bank regulator have to seek relief in the state receivership court to get his share of the refund? If the two most recent decisions turn out to govern, that could be exactly where financial convergence has sent him.[228] A bank regulator from Dallas could end up in an insolvency court in Augusta, Maine with different rules and a different agenda than bank regulators will find familiar. Let us hope he dresses warmly for it could be a long cold winter before the receivership court decides to return the bank's share of the refund.

228. Under Gramm, Leach, Bliley, a bank regulator is entitled to expedited review of his predicament by a Circuit Court of Appeals as provided by 15 U.S.C § 6714, but this may not apply to other depositary institution regulators and, as mentioned above, this is little comfort if the Circuit Court either abstains or reaches for McCarran-Ferguson to send him back to the state court.

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THE FOREIGN IRREVOCABLE LIFE INSURANCE TRUST AS ASSET PROTECTION: POTENTIAL FOR ABUSE AND SUGGESTIONS FOR REFORM

Richard Lewis[*]

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INTRODUCTION

Asset protection is a relatively new branch of estate planning for the ultra-wealthy.[1] The goal of asset protection is to protect as well as possible the client's assets from future creditors. If in the course of developing an asset protection strategy, one can effectively avoid income, estate and gift tax, gain the flexibility to pass wealth on to future generations virtually tax free, maintain a high degree of financial privacy, and avoid being found in contempt of court for failing to repatriate assets, then so much the better for the client. One such strategy is the combination of a foreign irrevocable life insurance trust with a private placement variable life insurance policy (also "foreign ILIT"). The foreign ILIT effectively recreates the foreign grantor trust: a trust that prior to the 1996 Small Business Job Protection Act enjoyed a wealth of tax and security advantages.[2] In addition to the tax benefits that accrue to life insurance, the client enjoys the comfort of financial privacy, and the added protection of having her assets beyond the reach of creditors and restitutionees.

Asset protection trusts have produced much commentary and controversy.[3] Indeed, Congress addressed some of these concerns with the Small Business Job Protection Act of 1996.[4] But many issues remain unresolved, and the asset protection trust market is growing, not shrinking.[5]

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1. Gideon Rothschild, *Establishing and Drafting Offshore Asset Protection Trusts*, ASSET PROTECTION STRATEGIES 47 (Alexander A. Bove, Jr. ed., 2002).

2. Leslie C. Giordani, *Foreign Life Insurance Strategies*, *in* 2 INT'L TRUST & ESTATE PLANNING 538 (ALI-ABA ed., 2002).

3. *See, e.g.,* Robert T. Danforth, *Rethinking the Law of Creditors' Rights in Trusts*, 53 HASTINGS L.J. 287 (2002); Eric Henzy, *Offshore and "Other" Shore Asset Protection Trusts*, 32 VAND. J. TRANSNAT'L L. 739 (1999); Lynn M. LoPucki, *The Death of Liability*, 106 YALE L.J. 1, 3 (1996); Stewart E. Sterk, *Asset Protection Trusts: Trust Law's Race to the Bottom*, 85 CORNELL L. REV. 1035 (2000).

4. Small Bus. Job Prot. Act 1996, PL 104-188 §§ 1901–1907, Aug. 20, 1996, 110 Stat. 1755. Among the many changes to the income tax laws regarding foreign trusts, the '96 Act amended the definitions of "United States Person" and "Foreign Trust" (26 U.S.C. §§ 7701(30)(E), (31)(B)) which "changed income tax law and reporting . . . in two significant areas: (1) for U.S. beneficiaries who receive distributions from trusts created by foreign persons, and (2) for U.S. persons who create foreign trusts." Giordani, *supra* note 2, at 537 n.3.

5. *See* Henzy, *supra* note 3, at 740.

> The use of offshore asset protection trusts to "keep chips out of the pot" has exploded in the last decade. In 1994, one commentator estimated that approximately $1 trillion was held in offshore trusts. Less than five

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With the wave of corporate scandals, rogue directors and officers, and the loss by shareholders of billions of dollars of wealth, the issue of protecting assets from creditors and from those awarded money damages in civil suits is particularly relevant today.

Over the course of this past year we have watched America's leading corporations fall to ruins. In late 2001 Enron, the energy behemoth, filed for bankruptcy, leaving thousands of its employees heavily invested in Enron stock penniless.[6] Failing to notice highly suspect transactions, its auditor, Arthur Andersen, took center stage in the Enron fiasco. Andersen's problems multiplied when it became evident that its "record retention" policy ensured the destruction of any potentially incriminating evidence. Following a felony conviction for obstruction of justice, Arthur Andersen could no longer audit publicly traded companies.[7]

In June of 2002, "WorldCom's audit committee said it had uncovered . . . $3.8 billion [in] accounting irregularities."[8] Later that summer, WorldCom "expand[ed] its planned financial restatement to $7.2 billion . . . as a result of additional accounting irregularities."[9] WorldCom, like Enron, filed for bankruptcy protection in July of 2002.[10] With a plan to restructure $41 billion in debt, WorldCom's bankruptcy became the largest in United States history.[11] And in what may turn out to be the most extreme example of executive corruption, "Tyco's former CEO and ex-finance chief [were] charged with stealing over $170 million."[12] These are a few among many

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> years later, Britain's Home Secretary Jack Straw estimated in a recent unpublished report that $6 trillion is now held in offshore trusts.

Id. (citations omitted). *See also Fraudulent Tax Schemes: Testimony Before the Committee on Finance, U.S. Senate United States General Accounting Office GAO*, (Apr. 11, 2002) (Statement by Michael Brostek, Director of Tax Issues) (estimating 505,000 United States taxpayers used offshore trusts resulting in tax losses ranging from $20–$40 billion).

6. John R. Emshwiller, *Enron Report Suggests Officials Knew About Secretive Partnership*, WALL ST. J., Feb. 19, 2002, at A2.

7. Laurie P. Cohen & John Hechinger, *Tyco Suits Say Clandestine Pacts Led to Payments*, WALL ST. J., June 18, 2002, at A3.

8. Michael Schroeder, *SEC Files Civil Suit Against WorldCom*, WALL ST. J., June 27, 2002, at A3.

9. Laura Saunders Egodigwe, et al., *A Year of Scandals & Sorrow*, WALL ST. J., Jan. 2, 2003, at R10.

10. *Id.*

11. *Id.*

12. *Id.* This figure increased after further investigation. Andrew Ross Sorkin reported in the New York Times that Denis Kozlowski has now been "charged with looting [Tyco] of

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corporate scandals that came to light in the past two years. Not surprisingly, corporate malfeasance took its place at the forefront of the national debate, prompting, *inter alia*, tougher regulations,[13] and the creation of an accounting oversight board within the SEC.

As the dust settles, many questions remain unanswered. And as far as litigation is concerned, a number of former executives find themselves the subject of both criminal and civil suits. This begs the question: should damage awards, settlements or orders of restitution ever materialize, will the claimants and creditors ever be able to collect? The answer to this question may depend on how effectively these executives have moved their wealth into asset protection trusts.

This Comment takes up the issue of asset protection in the "post-Enron" environment. Specifically, it examines the use of the foreign trust in conjunction with an offshore private placement variable life insurance policy. This instrument, when properly designed, "can place wealth in a tax-free investment environment at a low cost, achieve protection against future creditor risk and local economic risk, gain financial privacy, and enjoy superior flexibility with regard to the policy's underlying investments."[14] One of the more appealing features of this asset protection strategy is that it effectively re-creates the foreign grantor trust—the former tax "efficient" offshore trust that the Small Business Protection Act of 1996 attempted to destroy. While Congress has addressed the issue of abusive offshore trusts in the past, that structure remains an attractive and viable means of protecting wealth. In the "post-Enron" environment, the question Congress must face is how to better regulate these trusts.

Congress seemed poised, at least before the midterm election of 2002, to address some of these concerns. For example, Senate Finance Chairman Max Baucas and Senator Charles Grassley sponsored a pension bill whose goal it is "to stop executives from enjoying tax breaks by shifting deferred compensation to overseas accounts and out of reach of creditors in bankruptcy cases."[15] In addition, Congress intervened to block a major United States tool manufacturer from relocating offshore for the sole purpose of avoiding United States income taxes. In an unexpected move,

more than $600 million." Andrew Ross Sorkin, *Life Without a Jet, and Other Laments*, N.Y. TIMES, Dec. 15, 2002, § 3, at 1.

13. *See* Egodigwe, *supra* note 9.

14. Giordani, *supra* note 2, at 536.

15. Rob Wells, *Executives Who Conceal Funds Overseas May Face a New Tax*, WALL ST. J., Aug. 15, 2002, at D2.

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the House and Senate showed strong support for legislation to "penalize companies that move abroad for tax reasons . . . ."[16] Caving in to pressure from the SEC and Congress, Stanley Works abandoned its plan to relocate offshore to avoid United States income tax.[17]

Assuming, *arguendo*, Congress is willing to revisit the issue of the offshore trust, this Comment explores the legitimacy of the foreign ILIT as an asset protection strategy, and what changes in the law are necessary to better regulate these trusts. The legitimacy question addresses the moral and ethical issues associated with asset protection. In addition to the moral and ethical dilemmas endemic to the foreign ILIT, this Comment further argues that the relevant laws governing this strategy should be reformed because (1) the present structure is incompatible with goals expressed by Congress in passing the Small Business Job Protection Act of 1996, and (2) the financial privacy afforded by the foreign ILIT, in the extreme case, opens the door for directors and officers to defraud their company, shareholders and the market in general by facilitating a rather effective means of securities fraud. The proposed reforms target the laws that engender the three most attractive elements of the foreign ILIT as an asset protection trust: Financial Privacy, Financial Security and Tax Efficiency. It is difficult to imagine enforceable legislation that would abolish the offshore trust as an asset protection strategy. But it is possible to implement reforms that would eliminate, or substantially weaken the more attractive elements of the foreign ILIT, thereby removing much of the incentive from the initial decision to move wealth offshore.

The Comment begins with a brief overview of the foreign trust and private placement variable life insurance policies, and describes how, when combined, these two entities create a powerful asset protection, and tax efficient device.

I. ASSET PROTECTION AND FOREIGN LIFE INSURANCE POLICIES

A. Overview

The offshore trust is not new development. In fact, "[i]n 1994, it was estimated that one trillion dollars of foreign trust funds were held in"

16. Phyllis Plitch & Glenn R. Simpson, *Bowing to Pressure, Stanley Works Drops Plan for Bermuda Tax Move*, WALL ST. J., Aug. 2, 2002, at A1.

17. *Id.*

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offshore trusts.[18] "[O]ffshore jurisdictions have been favored for decades by foreigners to escape forced heirship provisions in their home countries, to avoid hostile government seizure, or to obtain favorable tax benefits."[19] However, the use of such trusts for the *express purpose* of asset protection is a recent development. This phenomenon grew as foreign jurisdictions began to adopt asset protection legislation. The Cook Islands was the first to enact such legislation in 1989.[20] "To date, 19 jurisdictions have enacted such legislation to encourage the use of trusts to protect assets from creditors."[21]

Traditionally, offshore trusts were used to protect assets from future, *unknown creditors*, not for purposes of aggressive "judgment proofing" or "to avoid income or estate taxes."[22] However, the rise of the foreign private placement life insurance policy has fundamentally changed the use of foreign trusts. If the settlor's lawyer constructs the trust carefully, and designs the policy properly, offshore trusts, combined with these offshore policies, can be an exceedingly powerful device to ensure not only protection from creditors, but tax-free growth, withdrawals, loans, estate and gift tax efficiency, and the ability to pass these benefits on to the next generation with "minimal transfer tax liability."[23]

B. Setting up the Irrevocable Life Insurance Trust

Because domestic forms of asset protection exist, the decision to go offshore comes only after it is determined that the domestic alternatives are insufficient. In most cases, the decision to go offshore is pursued when the client has substantial liquid assets to protect, or when she is exposed to

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18. James T. Lorenzetti, *The Offshore Trust: A Contemporary Asset Protection Scheme*, 102 COM. L.J. 138, 140 (1997).

19. Rothschild, *supra* note 1, at 47.

20. *Id.*

21. *Id.*

22. Lorenzetti, *supra* note 18 at 48. *See generally* LoPucki, *supra* note 18.

> A U.S. person who establishes a foreign trust is subject to the grantor trust rules if any beneficiary is a U.S. person. Such trusts may also be deemed grantor trusts by virtue of certain retained powers or interests. Furthermore, existing reporting requirements mandate filing returns upon the creation of a foreign trust or the transfer of assets to such a trust.

Id. (citing I.R.C. §§ 673–677, 679, 6048(c), 6677(a) (West 2002).

23. Giordani, *supra* note 2, at 7. *See also* J. Richard Duke, *Uses of Offshore Life Insurance in International Planning*, *in* ASSET PROT. STRATEGIES 224 (Alexander A. Bove, Jr. ed., 2002).

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claims the judgment or settlement of which will be pursued aggressively by the creditor against assets in the United States.[24]

Once the decision to go offshore has been reached, the next question is where? The real issues here concern whether the jurisdiction recognizes foreign judgments, and "the period of limitations for fraudulent conveyances."[25] Some jurisdictions are more favorable than others. For example, in

> the Cook Islands, the Bahamas, and Gibraltar, the courts will not recognize a U.S. judgment, and the period of limitations for fraudulent conveyance purposes is two years, or *less*. For instance, under Gibraltar law, if the transfer to the trust did not render the settlor insolvent (the burden of proof being on the attacker in an action brought in that jurisdiction), then there is *no* waiting period—the protection of those trust assets is *immediate*. And in the Cook Islands, a creditor attacking the trust must prove *beyond a reasonable doubt* that the settlor intended to defraud that particular creditor in order to reach trust assets.[26]

After selecting the appropriate jurisdiction, the trust must be carefully structured "to avoid the onerous foreign trust reporting requirements, but, more importantly, to avoid the potential negative application of I.R.C. § 684."[27] The adverse effects of section 684 of the Internal Revenue Code (I.R.C.) may be avoided by structuring the trust as a domestic trust for

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24. Alexander A. Bove, Jr., *The Mechanics of Establishing an Offshore Trust*, *in* ASSET PROT. STRATEGIES 60 (Alexander A. Bove, Jr., ed. 2002).

25. *Id.* at 61.

26. *Id.* at 62 (emphasis in original).

27. Giordani, *supra* note 2, at 541. I.R.C. § 684 (West 2002) reads in relevant part:

> (a) In general. Except as otherwise provided in regulations, in the case of any transfer of property by a United States person to a foreign estate or trust, for purposes of this subtitle, such transfer shall be treated as a sale or exchange for an amount equal to the fair market value of the property transferred, and the transferor shall recognize as gain the excess of
>
> (1) the fair market value of the property so transferred, over
>
> (2) the adjusted basis (for purposes of determining gain) of such property in the hands of the transferor.
>
> (b) Exception. Subsection (a) shall not apply to a transfer to a trust by a United States person to the extent that any person is treated as the owner of such trust under section 671.

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income tax purposes. A trust will be classified as domestic for income tax purposes if: "(i) a court within the United States is able to exercise primary supervision over the administration of the trust, and (ii) one or more United States persons have the authority to control all substantial decisions of the trust."[28] The second requirement can be met by naming a person within the United States as a trust protector. The protector is:

> [i]n simple terms . . . the watchdog of the trustee and the trust assets. A person given the task of assuring proper management of a trust by its trustees. The office of protector is not standard in U.S. trusts, but it is very common in foreign trust arrangements. The protector holds negative or "veto" powers under the terms of the foreign trust instrument. The protector usually has the power to remove and replace the trustee and must consent to major decisions by the trustee (e.g., distributions, addition or removal of beneficiaries, change of situs, etc.).[29]

With the office of protector established in the United States, the trust will be foreign for legal purposes, but domestic for tax purposes. The importance of this dual classification becomes clear when the foreign trust purchases the insurance policy.

The settlor of the trust funds the ILIT through a gift, which "will place both the premiums and the policy beyond the reach of the settlor's

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28. 26 U.S.C. § 7701(30)(E) (2002).

29. William A. Ensing, *Using a Trust Protector in Asset Protection Planning*, *in* ASSET PROT. STRATEGIES 89 (Alexander A. Bove Jr., ed., 2002). It should be noted that the designation of a United States person as protector over a foreign trust could defeat the "protection" element of the trust in the event of a civil suit or bankruptcy proceeding. There, the trust agreement must be carefully constructed:

> [P]rovisions must be included to cause removal of the protector . . . from that position in the event of a perceived substantial threat to the trust corpus. Failure to provide for the dismissal of the . . . protector and elimination of the trust protector position or replacement with a person not under the control of a U.S. court could expose the trust assets to attachment and the settlor and any other domestic U.S. person in the role of trust protector to a citation for contempt. Where a retained trust protector may still reside in the United States, or the resignation of a U.S. trustee has not been effected or is subject to question, a court might be able to issue a contempt citation to force the U.S. trust protector or trustee to direct the foreign trustee to produce the requisite assets to satisfy a creditor's claim.

Id. at 96–97.

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creditors, assuming the funding is not a fraudulent transfer."[30] However, for the gift to be deemed "complete" the settlor must not maintain or reserve any power over the gift's disposition.[31] In other words, the settlor "should not retain a testamentary power of appointment."[32] With the gift successfully conveyed, the ILIT will purchase a foreign private placement variable life insurance policy. The assets in the trust will be depleted over time through premium payments on the policy. As discussed below, the foreign ILIT creates a formidable asset protection strategy in addition to multiple tax "efficient" consequences.

C. Purchasing the Policy

Private placement variable life insurance policies offer "qualified investors the ability to select asset management beyond the predetermined asset management choices offered in the retail variable life insurance products."[33] This allows the ultra-wealthy to continue to use existing investment managers to manage the offshore policy investments. These products exist in the domestic market, however "many domestic carriers will agree to engage a policy owner's pre-selected investment manager only with a premium commitment of $20,000,000 or more at a significant out-of-pocket cost to the purchaser."[34] With "transactions involving only $5,000,000 of premium"[35] commitment, the offshore private placement market offers a cost-efficient alternative to the domestic market.

The lower premium commitment required to get into the offshore private placement market can be attributed to its freedom from the bureaucracy and strict regulations imposed by the United States. However,

30. Peter Spero, *Using Life Insurance and Annuities for Asset Protection*, 28 EST. PLAN. 12, 13, (Jan. 2001).

31. 26 C.F.R. § 25-2511-2(b) (2002).

32. Giordani, *supra* note 2, at 542. *See also* Gideon Rothschild, *International and Asset Protection Planning; Uncovering the Myths and Realities*, 301 PLI-TAX LAW AND EST. PLAN. COURSE HANDBOOK SERIES 563, 604 (February 2001) ("Where . . . 'the [settlor] cannot require that the trust's assets be distributed to the [settlor] nor can the creditors of the [settlor] reach any of the trust's assets . . . the settlor has parted with dominion and control so as to have made a completed gift of the assets transferred to the trust." (citing Rev. Rul. 77-378, 1977-2 C.B. 347(2002))).

33. Giordani, *supra* note 2, at 536. Offshore policies reference "qualified purchaser" or "accredited investor" in their "offering memoranda." *Id.* at 536 n.2. These terms refer to set standards in U.S. securities laws. *Id.* Unlike domestic policies, the offshore policy, if improperly designed, is not subject to SEC regulation. *Id.*

34. *Id.* at 536.

35. *Id.*

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unless carefully designed, the offshore policy may trigger SEC regulation. There are several issues the planner must carefully navigate in this context.

1. "Insurance" v. "Investment"

Offshore private placement policies are not purchased, generally, for the insurance element. Rather, "most investors are drawn to private placement variable life insurance for its tax benefits, investment flexibility, and price structure."[36] The death benefit is rarely a principal concern for the investor. As such, planners design these policies "in a way that maximizes cash accumulation and that reduces death benefit so that the cost of insurance affects the cash value to the smallest extent possible."[37] This design structure raises compliance issues with I.R.C. §§ 7702 and 817(h).

a. I.R.C. § 7702

The Code defines life insurance as "a contract which is a life insurance contract under the applicable law, but only if such contract meets the cash value accumulation test or the two-pronged test comprised of the guideline premium test and cash value corridor test."[38] The two tests will have

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36. *Id.* at 547.

37. *Id.* (internal abbreviations omitted).

38. *Id.* I.R.C. § 7702 (West 2002) states in relevant part:

> (b) Cash value accumulation test for subsection (a)(1).
>
> (1) In general. A contract meets the cash value accumulation test of this subsection if, by the terms of the contract the cash surrender value of such contract may not at any time exceed the net single premium which would have to be paid at such time to fund future benefits under the contract . . . .
>
> . . . .
>
> (c) Guideline premium requirements. For purposes of this section—
>
> (1) In general. A contract meets the contract premium requirements of this subsection if the sum of the premiums paid under such contract does not at any time exceed the guideline premium limitation as of such time.
>
> (2) Guideline premium limitation.—The term "guideline premium limitation" means, as of any date, the greater of[:]
>
> (A) the guideline single premium, or
>
> (B) the sum of the guideline level premiums to date.
>
> (3) Guideline single premium.
>
> (A) In general. The term "guideline single premium" means the premium at issue with respect to future benefits under the contract . . . .
>
> . . . .

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dramatically different results from client to client. The important point to recognize is that I.R.C. § 7702 exists to "disqualify policies created for their investment component without regard to the actual relationship between the cash value and the contractual death benefit."[39] If a policy is deemed not in compliance with I.R.C. § 7702, regardless of whether it is foreign or domestic, it will not enjoy the "tax advantages afforded to life insurance."[40]

b. I.R.C. § 817(h)[41]

In addition to the definitional criteria required for compliance with I.R.C. § 7702, "variable life insurance policies also must comply with tests under I.R.C. § 817(h) in order to qualify as life insurance."[42] Section

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(d) Cash value corridor for purposes of subsection (a)(2)(B). For the purposes of this section—

(1) In general. A contract falls within the cash value corridor of this subsection if the death benefit under the contract at any time is not less than the applicable percentage of the cash surrender value.

39. Giordani, *supra* note 2, at 547.

40. *Id.*

41. I.R.C. § 817(h) (West 2002) states in relevant part:

(h) Treatment of certain nondiversified contracts.

(1) In general. For purposes of subchapter L . . . section 7702(a) (relating to definition of life insurance contract), a variable contract (other than a pension plan contract) which is otherwise described in this section and which is based on a segregated asset account shall not be treated as [a] . . . life insurance contract for any period (and any subsequent period) for which the investments made by such account are not, in accordance with regulations prescribed by the Secretary, adequately diversified.

(2) Safe harbor for diversification. A segregated account shall be treated as meeting the requirements of paragraph (1) for any quarter of the taxable year if as of the close of such quarter

(A) it meets the requirements of section 851(b)(3), and

(B) no more than 55 percent of the value of the total assets of the account are assets described in section 851(b)(3)(A)(i).

42. Giordani, *supra* note 2, at 548.

In its simplest form, each "segregated asset account" must contain at least five investments, and no one investment may represent more than 55% of the value of the separate account's assets, no two investments may constitute more than 70%, no three investments may comprise more than 80%, and no four investments may make up more than 90% of the separate account's value.

Id.

817(h) requires diversification among the investments in the policy.[43] If the policy fails to meet the diversification requirements, the cash value accumulation within the policy will be taxed as ordinary income.[44] Like section 7702, the diversification requirements under I.R.C. § 817 exist to disqualify policies that aim at maximizing investment income without regard to the insurance component of the policy. In other words, the Code seeks to insure that life insurance policies are in fact *life insurance policies*, and not mere investment strategies that enjoy all the tax benefits of life insurance without actually being life insurance.

2. The Securities and Exchange Act of 1933

The Securities and Exchange Act of 1933 (the "'33 Act") applies to foreign insurance carriers. However, this Act will only apply if the SEC determines that the foreign insurance carrier sold the policy to a person within the United States in violation of the securities laws.[45] Of particular concern is the manner in which such a person learns of the offshore policy.

The securities laws provide for exemptions from registration requirements under the '33 Act. One such exemption is Regulation S ("Reg. S").[46] Most offshore funds rely on Reg. S to avoid registration requirements under the '33 Act. "In general, the registration requirements under Section 5 of the 1933 Act do not apply to offers and sale of securities occurring outside the U.S."[47] Two requirements must be satisfied to avoid registration under the '33 Act under Reg. S:

> (i) offers of the offshore fund shares are made only to persons located outside the U.S. and buy-orders are accepted only from persons located outside the U.S.; and (ii) no activities are undertaken that have the purpose of or can reasonably be expected to have the result of "conditioning" the market in the U.S. to purchase the offshore fund shares. If the selling efforts condition the U.S. market to purchase offshore fund shares, this is deemed to be

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43. Gary S. Lesser, Lawrence C. Starr, LIFE INS. ANSWER BOOK, FOR QUALIFIED PLANS AND EST. PLAN. 2-21 (1998).
44. I.R.C. § 817(h)(2000).
45. Duke, *supra* note 23, at 227.
46. 17 C.F.R. § 230.903.
47. Duke, *supra* note 23, at 224–25.

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> "directed selling efforts" that require registration under the 1933 Act.[48]

Failure to meet the Reg. S exemption will cause the policy to be issued in violation of United States securities laws. At that point, the SEC may obtain injunctions against the foreign insurer as well as bringing criminal charges.[49] The injunction would "prohibit[] the foreign insurance carrier from issuing further policies in the U.S. . . ."[50] From the point of view of the "insured," the injunction creates two potential problems:

> First, such prior issued policies may no longer be a priority of the foreign insurance carrier and, second, the insurance carrier may not attempt to comply with the . . . Reg. S exemption with respect to the further issuance of the same or similar policies on the lives of U.S. persons.[51]

Recall, financial privacy is a principal concern for any asset protection strategy.[52] Exemption from SEC registration requirements is a significant means of achieving financial privacy.[53] The challenge, then, is to ensure that the policy qualifies for the Reg. S exemption. As noted above, whether the requirements of Reg. S will be satisfied has everything to do with how the United States settlor learns of the offshore policy.

Simply put, whether the Reg. S requirements are satisfied depends on whether the United States settlor learns of the policy from an insurance agent or from "[a] professional, such as a lawyer . . . ."[54] If an insurance agent within the United States recommends an offshore policy on behalf of a foreign insurance carrier, that agent's recommendation "to a U.S. person to acquire variable life insurance

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48. *Id.* at 225 (citing John A. Sellers, *Regulation of Offshore Offers and Sales of Securities*, 1 OFFSHORE FIN. U.S.A. 32–35 (1999)).

49. *Id.*

50. *Id.*

51. *Id.* at 228.

52. *Id.* at 224. *See also* Denis Kleinfeld, *Choosing an Offshore Jurisdiction*, ASSET PROTECTION STRATEGIES 74 (Alexander A. Bove, Jr., ed. 2002).

53. Compliance with Reg. S has substantial benefits at the state level as well. "If the offshore life insurance carrier complies with Reg. S, the carrier generally is not subject to the state department of insurance rules of the state where the U.S. person resides." Duke, *supra* note 23, at 224. One advantage of having the policy free from state regulation is that the assets in the policy will not be subject to state "creditor friendly" provisions.

54. *Id.* at 227.

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from a foreign insurance carrier is 'conditioning the market' in the U.S. to acquire variable life insurance—a security—in violation of the Reg. S exemption."[55] The reason the insurance agent's recommendation triggers a Reg. S violation has to do with the fact that the "agent's primary business activities are selling life insurance."[56]

Unlike the insurance agent, selling insurance policies is not a lawyer's primary business activity. Rather, the lawyer is engaged in providing legal services, and "[t]he recommendation of insurance is incidental to and only a part of the legal"[57] services rendered. As such, the recommendation of offshore variable life insurance by a lawyer "does not appear to be 'conditioning' the market in the U.S. to acquire offshore variable life insurance."[58]

Avoiding the registration requirements of the '33 Act under the Reg. S exemption appears fairly straightforward: all that is required is that the lawyer, not an insurance agent, recommend the offshore variable life insurance policy. It is worth noting at this point that the lawyer that handles these types of transactions is a specialist. She may not be selling insurance policies as her primary business activity, but she certainly designs these asset protection strategies as her primary business activity. As such, is there any meaningful distinction in this context between the "professional" and the "insurance agent?" This issue will be further explored below in suggesting amendments to the laws that enable, and make appealing, such asset protection strategies.

With the basic structure of the foreign ILIT in place, the benefits of combining these two instruments can be more easily identified. There are three principle elements of the foreign ILIT that make it an appealing form of asset protection: (1) Financial Privacy; (2) Security; and (3) Tax Efficiency.

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55. *Id.* at 226. Other negative consequences of having a United States insurance agent recommend the policy include the possibility that the foreign insurance carrier will be treated as the agent's principal. Should this occur, the sale of the policy will be treated as having occurred within the United States. *Id.*

56. *Id.*

57. *Id.* at 227.

58. *Id.*

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D. Benefits of the Foreign ILIT as an Asset Protection Strategy

1. Financial Privacy

If the goal of any asset protection trust is to protect present wealth from future claimants and creditors, then it is imperative that information regarding the trust and its beneficiaries remain undisclosed. The foreign ILIT meets this demand for confidentiality in a number of ways. First, as summarized above, the purchase of a foreign life insurance policy from a foreign insurance company can qualify for Reg. S exemption. Qualifying for this exemption will ensure that the SEC does not learn about the sale of the policy—an attractive proposition to number of clients.[59]

Second, "[m]any foreign jurisdictions provide that insurance policies must be held in strict confidence."[60] Therefore, even if a regulating body undertook to investigate these policies, the jurisdiction in which they reside would prohibit disclosure. Finally, it is a lawyer that puts this strategy together, thus the settlor of a foreign ILIT benefits from the added protection of attorney-client privilege. The foreign ILIT, therefore, provides multiple layers of confidentiality: the foreign jurisdiction will not disclose policy information; sale of the policy can be exempted from registration under Reg. S; and various other details concerning the client and the transaction will be further protected behind attorney-client privilege.

2. Financial Security

Protecting assets from future creditors, claimants and restitutionees is one of the traditional roles of the foreign trust.[61] This remains the case with the foreign ILIT. Many foreign jurisdictions will not recognize United

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59. *See* text *infra* at 26–27. In the extreme case, the freedom from registration under Reg. S could open the door for securities fraud. *See Efforts to Eliminate Tax Havens: Testimony Before S. Permanent Subcom. on Investigations*, (July 18, 2001) (statement of Robert M. Morganthau, Manhattan District Attorney): "The absence of responsible supervision in off-shore jurisdictions . . . encourages players in the financial markets to engage in reckless behavior which, [as recent New York securities fraud cases] taught us, will likely have disastrous consequences for our domestic financial institutions and the economy . . . ."

60. Duke, *supra* note 28, at 224. Some "exceptions may apply with respect to disclosure of tax information, including provisions under tax treaties with the U.S." *Id.*

61. *See* Barry S. Engel, Eric D. Sanderson and Edward D. Brown, *Asset Prot. Plan. and Contempt of Court*, ASSET PROT. STRATEGIES 347 (Alexander A. Bove, Jr. ed., 2002).

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States court orders, and many jurisdictions have short statutes of limitation, so that even if the assets were fraudulently conveyed, unless the fraud was discovered relatively quickly, the trust will not be easily busted.[62] Because United States judgments will often not be recognized in these jurisdictions, creditors and claimants are forced to initiate proceedings in the jurisdiction in which the assets are located. Litigation abroad is expensive and difficult. This added inconvenience may sufficiently deter some creditors and claimants from pursuing legal action in foreign jurisdictions.

In addition to the trust friendly laws of the foreign jurisdiction, a flee-clause is usually included in the trust agreement. A flee clause is a provision to "permit a change of (1) trustees, (2) the situs of the trust, or (3) its assets."[63] Such provisions "give the trustee or a trust protector a discretionary power to change the situs by appointing new trustees, removing assets to another jurisdiction, or amending the trust to comply with the trust of a new jurisdiction."[64] The trust agreement can be so structured that the flee clause is automatically triggered by any number of specific events. For example, "[i]f an action is commenced against the trust or the trustees in the original trust jurisdiction, the original trustee is automatically removed and the custodian trustee assumes sole responsibility. This would then force a creditor to commence an action anew in the custodian trustee's jurisdiction."[65]

Finally, in addition to the above stated obstacles to accessing assets in a foreign trust, the settlor will likely be able to avoid a court order to repatriate assets by invoking the impossibility defense:[66]

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62. *See generally* Kleinfeld, *supra* note 52, at 73–85.

63. Rothschild, *supra* note 1, at 53.

64. *Id.*

65. *Id.* at 54.

66. *See generally* Engel, et al., *supra* note 61. *See also* Badgley v. Santacroce, 800 F.2d 33 (2d Cir. 1986). The court summarized the impossibility defense as follows:

> The purpose of civil contempt, broadly stated, is to compel a reluctant party to do what a court requires of him. Because compliance with a court's directive is the goal, an order of civil contempt is appropriate only when it appears that obedience is within the power of the party being coerced by the order. A court's power to impose coercive civil contempt is limited by an individual's ability to comply with the court's coercive order. A party may defend against contempt by showing that his compliance is factually impossible.

Id. at 36 (citations omitted).

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> Contempt proceedings are typically initiated when a party to a lawsuit is ordered to perform an act and the party so ordered fails to perform the act requested. The court will then hold a hearing and ask the party why he or she failed to comply with the order. If the party simply refuses to comply with the order, an order of contempt will issue.
>
> If however, the party was factually not able to comply, a court may not hold the party in contempt. This is known as the "impossibility of performance" defense, which is a complete defense to a charge of contempt.[67]

If properly established, the trust agreement will include a duress clause. The clause will identify a court order to repatriate assets as an act of duress. Once a court order issues, the duress clause will be trigged automatically, and the trustee, therefore, will be prohibited, by the terms of the trust agreement, from releasing assets from the trust. Therefore, the settlor, regardless of his requests to the contrary, will be denied access to assets within the trust; it will be impossible for the settlor to comply with the court order.

Two notable decisions have raised questions about the efficacy of the impossibility defense:[68] *Federal Trade Commission v. Affordable Media, LLC*[69] and *Goldburg v. Lawrence (In re Lawrence)*.[70]

Affordable Media involved a husband and wife team. In 1995 they created an irrevocable trust in the Cook Islands "in an effort to protect their assets from business risks and liabilities by placing the assets beyond the jurisdiction of the United States courts."[71] The Andersons were "named as co-trustees of the trust."[72]

In 1997, the Andersons embarked on what the Ninth Circuit dubbed a classic "Ponzi scheme."[73] The Andersons formed Financial Growth Consultants, LLC which subsequently raised as much as $13 million from investors, retaining $6.3 million in commissions for itself.[74] In April, 1998, the Federal Trade Commission "filed a complaint . . . charging the

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67. Engel et. al, *supra* note 61, at 349.
68. *See generally* Engel, et al., *supra* note, 61; Sterk, *supra* note 3.
69. 179 F.3d 1228 (9th Cir. 1999)
70. 238 B.R. 498 (Bankr. S.D. Fla. 1999).
71. *Affordable Media,* 179 F.3d at 1232.
72. *Id.*
73. *Id.* at 1231.
74. *Id.* at 1232.

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Andersons, Financial, and others with violations of the Federal Trade Commission Act . . . and the Telemarketing Sales Rule for their participation in a scheme to telemarket fraudulent investments to consumers."[75] The district court subsequently "entered a preliminary injunction against the defendants . . . requir[ing] the Andersons to repatriate any assets held for their benefit outside of the United States."[76]

The Andersons faxed a letter "instructing [the Cook Islands trustee] to . . . repatriate the assets to the United States."[77] The trustee notified the Andersons that the court order was an "event of duress" and pursuant to the trust instrument, the Andersons were being removed as co-trustees, and the trust assets would not be repatriated.[78] The district court held the Andersons in civil contempt for failing to comply with the court order.[79] Three hearings followed to "permit the Andersons to purge themselves of contempt, and the district court judge ultimately ordered the Andersons be taken into custody."[80]

The Ninth Circuit affirmed the district court's contempt order.[81] The court noted that

> the Andersons were not only trustees, but also protectors of their trust, positions they retained at the time of the district court order. Because the trust instrument provided the protectors with discretion to determine whether an event of duress has occurred, the court concluded that the Andersons had not established that the district court had committed clear error in finding that they retained power to enforce repatriation of trust assets.[82]

Stephan Jay Lawrence was a successful options trader in the 1980's.[83] Lawrence used Bear, Stearns & Co., Inc. as his trading clearinghouse.[84] Following the stock market crash of 1987, Lawrence "and his companies experienced a margin deficit with Bear, Stearns."[85] Disputing the amount

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75. *Id.*
76. *Id.*
77. *Id.*
78. *Id.*
79. *Id.* at 1233.
80. Sterk, *supra* note 3, at 1101.
81. *Affordable Media*, 179 F.3d at 1243.
82. Sterk, *supra* note 3, at 1102.
83. In re Stephan Jay Lawrence, 227 B.R. 907, 911 (Bankr. S.D. Fla. 1998).
84. *Id.*
85. *Id.*

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of margin deficit, Lawrence commenced an arbitration proceeding lasting forty-two months.[86] The proceeding resulted in an award in favor of Bear, Stearns in an amount in excess of $20 million.[87]

Just two months prior to "the arbitration award against [Lawrence] . . . [he] allegedly settled [and funded] the Lawrence Family 1991 Intervivos Trust in the Jersey Channel Islands."[88] Soon thereafter, Lawrence amended the trust moving "the proper law of the trust to the Republic of Mauritius."[89] Mauritius is notoriously debtor friendly.[90]

Lawrence filed a chapter 7 petition in 1997.[91] Objecting to Lawrence's petition to discharge his debt, Bear, Stearns filed a motion to compel Lawrence to respond to its discovery requests and turn over trust assets.[92] After three days of hearings, the bankruptcy court, finding Lawrence's testimony wholly without credibility, granted the motion to compel.[93] When Lawrence failed to comply with the court order, Bear, Stearns moved the bankruptcy court to hold Lawrence in civil contempt. The court rejected Lawrence's defense of impossibility, concluding that:

> While impossibility is a recognized defense to a civil contempt order, the law does not recognize the defense of impossibility when the impossibility is self-created. [Lawrence] has testified that he voluntarily established the [Mauritian] Trust in 1991. Since the provisions which he now relies upon in order to substantiate his inability to comply with the Turn Over Order were of his own creation, he may not claim the benefit of the impossibility defense.

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86. *Id.*
87. *Id.*
88. *Id.* at 912.
89. *Id.* at 912 n.10.
90. *See* Kleinfeld, *supra* note 52, at 73.

> Mauritius is an independent country located in the Southern Indian Ocean east of Madagascar and Southern Africa . . . . The Offshore Trust Act 1992 of Mauritius was intended to be particularly favorable to settlers in establishing trusts. The legislation excludes any remedy arising from the bankruptcy of the settlor. A creditor, to be successful, must be able to prove beyond a reasonable doubt that the offshore trust was settled with the intent to defraud the existing creditors when the property was transferred to the trustee.

Id. at 80.

91. *Lawrence*, 227 B.R. at 911.
92. *Id.* at 909–10.
93. *Id.* at 909.

> Giving credence to [Lawrence's] argument would be tantamount to succumbing to the pleas for sympathy from an orphan who has killed his own parents![94]

The court found Lawrence in civil contempt.[95] The court ordered Lawrence to comply with the previous order to repatriate trust assets, and ordered that he be incarcerated until he satisfactorily complied with the order to repatriate trust assets.[96]

Affordable Media and *Lawrence* appear to suggest that the impossibility defense can be ineffective, thus severely weakening an essential component of the offshore asset protection trust. However, the decisions in both *Affordable Media* and *Lawrence* are more accurately attributed to poor structuring of the trust instrument. In *Affordable Media*, the Anderson's named themselves as 1) a co-trustee, 2) the protector, and 3) they retained discretionary power to determine when an event of duress occurred.[97] Given these facts, it is clear that the court properly rejected the Andersons impossibility defense, not because the court was hostile to the existence of the foreign trust, but because it was possible for the Andersons to comply with the order to repatriate the trust assets. Similarly in *Lawrence,* the trust agreement left Lawrence substantial powers, for example, the power "to remove and replace trustees in his absolute discretion."[98] In addition, while Lawrence appears to have been disenfranchised as beneficiary, and clarified as "Excluded Person," "it does not appear that the clarification was irrevocable. It appears that the

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94. *Stephan Jay Lawrence*, 238 B.R. at 501.

95. *Id.*

96. *Id.* at 502–03.

97. *Affordable Media*, 179 F.3d at 1243 n.13.

> The provisions of the trust also make clear that the Andersons' position as protectors gives them control over the trust. In provisions of the trust agreement that the Andersons conveniently fail to reference, the trust agreement makes clear that the Andersons, as protectors, have the power to determine whether or not an event of duress has occurred . . . . Moreover, the very definition of an event of duress that the Andersons assert has occurred makes clear that whether or not an event of duress has occurred depends upon the opinion of the protector . . . . Therefore, notwithstanding the provisions of the trust agreement that the Andersons point to, it is clear that the Andersons could have ordered the trust assets repatriated simply by certifying to the foreign trustee that in their opinion, as protectors, no event of duress had occurred.

Id.

98. *In re Lawrence*, 227 B.R. at 912 n.12.

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Mauritian trustee could again amend the trust, for example, after [Lawrence] were to obtain a discharge by [the bankruptcy court]—and again deem [Lawrence] to be a beneficiary."[99] In addition to the poor drafting of the trust agreement, the court found Lawrence to be utterly without credibility.[100] It was the unique, and particularly egregious, set of facts in the *Lawrence* case, combined with the fact that he retained absolute discretionary power to change trustees that led the court in *Lawrence* to its finding of contempt. As one commentator summarized: "These decisions do not provide new developments in the law of contempt, and are precedent only for cases similar thereto."[101]

The impossibility defense remains an effective and powerful means of avoiding civil contempt. Of particular interest are the Ninth Circuit's closing remarks in affirming the district court's finding of civil contempt in *Lawrence*:

> As we affirm the challenged orders, we are constrained to remind the district and bankruptcy courts that civil contempt sanctions are intended to coerce compliance with a court order. In *Wellington* we acknowledged that, [w]hen civil contempt sanctions lose their coercive effect, they become punitive and violate the contemnor's due process rights. The district court must make an individual determination in each case whether there is a realistic possibility that the contemnor will comply with the order.

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99. *Id.*

100. *Id.* at 500.

> This court concurs with the previous findings . . . that [Lawrence] is not credible. This court therefore has no doubt that [Lawrence] retains the requisite power to cause the return of the trust *res* to the United States in compliance with the Turn Over Order . . . . Thus, the court does not believe [Lawrence's] conclusory denials that he cannot undo what he did and that he is powerless to repatriate the trust *res* to the Chapter 7 estate and the compliance with the Turn Over Order is impossible . . . . The efforts by [Lawrence] to claim an impossibility defense are nothing more than part of his continuing efforts to hinder, delay and defraud the creditors of his bankruptcy estate.

Id. at 500–01.

101. Engel et al., *supra* note 61, at 363.

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> We are mindful that, although incarceration for civil contempt may continue indefinitely, it cannot last forever.[102]

In a recent article, Professor Stewart Sterk observed that the *Affordable Media* and *Lawrence* cases fail "to answer one critical question: For how long will a court be willing to incarcerate an offshore trust settlor for civil contempt?"[103] Professor Sterk points out that:

> a settlor's failure to purge his contempt after sitting in jail for months or even weeks may establish to a court's satisfaction that the settlor is indeed unable to arrange repatriation of trust assets, establishing a defense to civil contempt. Finally, even if a court remains convinced that the settlor has the power to arrange repatriation and that enough incarceration might induce the settlor to repatriate, the court might simply believe that indefinite incarceration is inappropriate without express statutory sanction.[104]

Some commentators have characterized *Affordable Media* and *Lawrence* as the exception rather than the rule:

> If contempt law really was a tool courts could be expected to utilize in the typical case, the authors suspect we would have seen it used before. After the passage of 12 or more years, we have now seen only two cases in which contempt powers were utilized. One of those cases involves noncompliance when compliance could have taken place. The other of these two cases involves a fraudster who was absolutely devoid of any believability.[105]

3. Tax Efficiency

Life insurance policies enjoy the same federal income tax advantages whether onshore or off. Therefore, "earnings on policy cash values, including dividends, interest and capital gains, are not taxable to the policy owner as they accumulate within the policy . . . ."[106] In addition, if the insured dies during the duration of the contract, the death benefit passes to

102. In re Stephan Jay Lawrence, 279 F.3d 1294, 1300 (9th Cir. 2002) (citing Commodity Futures Trading Comm'n v. Wellington Precious Metals, Inc., 950 F.2d 1525, 1530 (11th Cir. 1992) and United States v. O.C. Jenkins, 760 F.2d 736, 740 (7th Cir. 1985)).

103. Sterk, *supra* note 3, at 1103.

104. *Id.* at 1103–04.

105. Engel et al., *supra* note 61, at 364.

106. Giordani, *supra* note 2, at 539.

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the beneficiary tax-free.[107] Finally, if properly constructed, the insured may withdraw and borrow against the policy without realizing taxable income.[108]

In order to withdraw from a policy without realizing taxable income the policy must meet the criteria established in I.R.C. § 7702A for a Modified Endowment Contract ("MEC").[109] In 1988, Section 7702A was added to the code by "the Technical and Miscellaneous Revenue Act of 1988, Section 5012(c)(1) in an effort to prevent certain perceived abuses of life insurance policies."[110] Section 7702A works in tandem with I.R.C. Section 72(v) to "prevent future use of life insurance as an investment vehicle."[111] Section 7702A establishes the "seven-pay" test. Briefly,

> [A] policy fails the seven-pay test and is characterized as an MEC if the cumulative premiums paid at any time during the first seven years of the contract exceed the sum of the maximum net level premiums that would have been paid on or before such time if the contract provided for paid up future benefits after the payment of seven level annual premiums.[112]

Any distribution from a life insurance contract that fails the seven-pay test (thus characterized as an MEC policy) will be regarded as income to the extent there is income in the contract.[113] If the policy owner wishes to have tax-free access to the cash value of the policy during the insured's lifetime, she must establish a non-MEC policy. "Generally speaking, non-MECs are

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107. I.R.C. § 101(a) (West 2002).

108. Lesser et al., *supra* note 43, at 2-1.

109. "An MEC is any contract that meets the requirements of a life insurance contract and fails to meet the seven-pay test." Duke, *supra* note 23, at 230 (citing I.R.C. §§ 7702A(a)(1)(B) and 7702(g)(1)(C); Rev. Rul. 91-17, 1991-1 C.B. 190). I.R.C. § 7702A states in relevant part:

> (b) 7-Pay test. For purposes of subsection (a), a contract fails to meet the 7-pay test of this subsection if the accumulated amount paid under the contract at any time during the 1st 7 contract years exceeds the sum of the net level premiums which would have been paid on or before such time if the contract provided for paid-up future benefits after the payment of 7 level annual premiums.

110. JAMES C. MUNCH, JR., FIN. AND EST. PLAN. WITH LIFE INS. PROD. 32 (1990). After the Tax Reform Act of 1986, single premium life insurance became known as the last tax shelter. *Id.*

111. *Id.* at 34.

112. DUKE, *supra* note 23, at 230 (citing I.R.C. § 7702A(b)).

113. Munch, *supra* note 110, at 34.

characterized by a premium paid over four or five years and MECs are characterized by a one-time, up-front premium payment."[114] Of course, for those clients whose principal purpose for using this strategy is asset protection and wealth transfer, MEC status is irrelevant.

In addition to the income tax advantages that accrue to the foreign ILIT, it also provides a means of reducing estate taxes. Recall, the settlor of the trust makes an irrevocable gift in an amount sufficient to cover the premium commitment on the policy. That amount is thus removed from the estate of the settlor, and therefore not subject to estate tax. Finally, with careful planning, the settlor will be able to minimize gift tax obligations.

II. QUESTIONS OF LEGITIMACY AND POTENTIAL FOR ABUSE

Asset protection trusts have been repeatedly criticized as illegitimate. The most compelling argument against these trusts is a moral one: "you should keep your promises and pay your debts because it is the right thing to do."[115] Commentators have argued that the appropriate response to this concern is that "limits be placed on both the amounts that can be sheltered from creditors in a trust and the categories of creditors against whom spendthrift protection is effective."[116] This argument fails to address the principle objection: one has a moral obligation to pay one's debts. "There is something disturbing about a country that would allow debtors to leave their debts unpaid and still enjoy an extravagant lifestyle."[117] Professor Danforth's argument would effectively allow the debtor to determine its liability to its creditors, within certain limits of course, through the use of asset protection trusts. However, it is the role of the bankruptcy court, not the debtor, to determine what amount of debt will be discharged.

A second, perhaps more persuasive argument goes as follows: "allowing potential debtors to shelter their assets from creditors 'threatens the system of civil enforcement of obligations' by, among other things, removing the deterrence element associated with our liability system."[118] Professor Lynn LoPucki captured the essence of this problem in a 1996 Yale Law Journal article:

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114. Giordani, *supra* note 2, at 548.

115. Danforth, *supra* note 3, at 364 (quoting Karen E. Boxx, *Gray's Ghost—A Conversation About the Onshore Trust*, 85 IOWA L. REV. 1195, 1259 (2000)).

116. *Id.*

117. *Id.*

118. *Id.*

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> Law is a system for controlling human behavior. In contemporary society, governments enforce law by essentially two mechanisms: incarceration and liability. These roughly correspond to the two spheres of the legal system: the criminal and the civil. In the criminal sphere, the wrongdoer is threatened with imprisonment; in the civil sphere, the wrongdoer is threatened with deprivation of wealth. Liability is crucial because it is one of only two principal means by which governments enforce law.
>
> The liability system enforces liability through the entry and forcible collection of judgments for the payment of money. Although liability is most closely associated with products liability and other tort actions, money judgments are also the means for enforcing contracts, civil rights, labor and employment law, environmental regulations, federal tax law, intellectual property law, most kinds of property rights, and just about every other kind of law on the books. Without liability, the American legal system would be radically different.[119]

Professor LoPucki identifies offshore asset protection trusts as a leading judgment proofing strategy.[120]

Some commentators have responded that asset protection trusts are "a reasonable response to a runaway tort system."[121] This response misses the point: even if the Congress undertook serious tort reform, it would nevertheless remain the case that tort suits would continue to result in judgments against tortfeasors. The argument thus stands: for a system of civil liability to remain effective, the threat of wealth deprivation must be real. To the extent asset protection trusts are an exceedingly powerful "judgment proofing" strategy, they remain a formidable threat to our system of civil liability.

The above two arguments are familiar, and apply generally to offshore asset protection trusts. However, there are additional reasons specific to the foreign ILIT to find it objectionable. First, as noted above, the Small Business Job Protection Act of 1996 addressed the issue of abusive use of

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119. LoPucki, *supra* note 3, at 3–4 (internal citations omitted).

120. *See id.* at 32–38.

121. Danforth, *supra* note 3, at 364 (citing Barry Engel, *Roundtable Discussion, The International Trust*, 32 VAND. J. TRANSNAT'L L. 779, 794 (1999)).

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offshore trusts. One important element of that legislation was the elimination of the foreign grantor trust. This feature is significant because it removed powerful incentives to move assets offshore: in particular, tax avoidance.[122] The foreign ILIT, however, effectively restores "grantor" status to the foreign non-grantor trust. One noted practitioner in the field is candid about this fact:

> Despite the effective elimination of the foreign grantor trusts (created by certain foreign persons) and all of the attendant benefits, all is not lost. When planning on behalf of a trust to which these rules apply, the goal is to reclassify trust income as something that is exempt from income tax *in order to mirror the structure of the old foreign grantor trusts.* Life insurance fulfills this goal because income earned inside the policy is not taxed currently to the owner of the policy. Moreover, income distributed from the policy during the life of the insured is generally non-taxable under current law, if properly structured. Finally, all amounts paid out of the policy to the policy beneficiary as death benefit are not subject to U.S. income tax.[123]

The foreign ILIT is arguably consistent with the letter of the law, but it rather clearly violates the spirit of the '96 Act, which made express changes to the law of foreign trusts to curb abusive use of such trusts.[124] The

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122. *See* Giordani, *supra* note 2, at 537 n.3.

> The 1996 Act effectively eliminated the grantor trust status of these foreign trusts by treating a person as owning assets of a trust only if that person is a U.S. citizen, U.S. resident, or domestic U.S. corporation. As a result, a foreign person who creates a trust is no longer considered the owner of the trust's assets, and the trust is classified as a non-grantor trust. When a trust has been classified as a foreign non-grantor trust, it is possible for the trust to defer U.S. federal income taxation because, ordinarily, the earnings of such a trust would not be taxed directly by the U.S., with some exceptions. However, *when income is distributed from the trust to a U.S. beneficiary, it is taxable to such U.S. beneficiary.*

Id. at 537–38 (emphasis added; internal citations omitted).

123. *Id.* at 538–39 (emphasis in original).

124. *See* 142 CONG. REC. S3740 (daily ed. Apr. 19, 1996) (statement of Sen. Moynihan):

> Once assets move offshore, it has been difficult for the IRS to enforce the tax laws. Foreign bank secrecy laws preclude the IRS from uncovering the information necessary to determine what is owed. Central to the legislative solution that I have proposed are provisions designed to provide the IRS with better information on foreign trusts. The bill would

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foreign ILIT, therefore, is not only objectionable on grounds generally applicable to offshore asset protection trusts, but also for its ability to circumvent measures duly enacted to minimize abusive use of offshore trusts.

In addition, the foreign ILIT opens the door for securities fraud. Recall, part of the appeal of the private placement variable life insurance policy to the ultra-wealthy is the ability to individually tailor the insurance product. It offers clients "the ability to select asset management beyond the predetermined asset management choices offered in retail variable life insurance products. This is attractive to high net worth clients who may have existing managers that they would prefer to designate to manage policy investments."[125] When such investment flexibility is combined with the type of financial privacy the foreign ILIT affords, the possibility for abuse becomes apparent. High net worth clients, who happen also to be directors or officers of United States corporations, may find the foreign ILIT is an effective vehicle for trading on inside information; for neither the public nor the SEC has knowledge of the existence of either the policy or the insured. Undoubtedly this would be an extreme instance of abuse. However, in the post-Enron environment it is difficult to imagine a situation ripe with fraudulent potential that wouldn't be exploited by someone.

The foreign ILIT exists as a powerful and attractive asset protection device because of the financial privacy it affords, its ability to effectively protect wealth from future claimants and creditors, and the tax benefits it enjoys as an insurance product. But the foreign ILIT is made possible by virtue of small details in the relevant laws governing this strategy. In the next Part, I consider various ways in which these laws could be reformed so as to remove, or significantly diminish, the incentives that presently make the foreign ILIT an attractive strategy.

> substantially strengthen the obligations of taxpayers to report information to the IRS and impose penalties with genuine deterrent effect for failure to do so.
>
> The bill would also close a number of loopholes in the existing grantor trust tax rules. These rules specify when the existence of a trust will be ignored for tax purposes because the creator of the trust retains sufficient control over the assets transferred to be treated as continuing to own the assets.

Id.

125. Giordani, *supra* note 2, at 536.

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III. SUGGESTIONS FOR REFORM

There exist three main incentives for establishing an offshore life insurance trust: Financial Privacy, Financial Security, and Tax Efficiency. One way to limit the potential for abuse of foreign ILITs is to remove, as much as possible, the incentives for setting up such a trust.

A. Financial Privacy

One potentially effective means of reforming the relevant laws governing foreign ILITs is to remove the element of financial privacy. Under the current law:

> A variable life insurance policy is classified as a security and the sale to a U.S. person requires compliance with U.S. securities laws. In accordance with Reg[ulation] D, securities offered and sold outside the U.S. are not required to be registered under the 1933 Act and Regulation S may be relied upon for such offers and sales . . . .
>
> In general, two requirements are necessary to avoid registration under the 1933 Act in relying on the Reg[ulation] S exemption: (i) offers of the offshore fund shares are made only to persons located outside the U.S. and buy orders are accepted only from persons located outside the U.S.; and (ii) no activities are undertaken that have the purpose of or can reasonably be expected to have the result of "conditioning" the market in the U.S. to purchase the offshore fund shares. If the selling efforts condition the U.S. market to purchase offshore fund shares, this is deemed to be "directed selling efforts" that require registration under the 1933 Act.[126]

As indicated above, compliance with Regulation S is simple: a lawyer, as opposed to an insurance agent, recommends the insurance product to the client.[127] This is sufficient

> [b]ecause the recommendation of insurance is only *incidental to the services provided by the lawyer* . . . recommending offshore variable life insurance does not appear to be conditioning the market in the U.S. to acquire

126. Duke, *supra* note 23, at 224–25.
127. *Id.* at 227.

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> offshore variable life insurance, nor does it appear that the lawyer . . . is acting as an agent for a foreign life insurance carrier.[128]

Setting up and funding a foreign ILIT is a highly specialized legal practice. For some lawyers, putting these types of trusts together comprises the lawyer's entire practice. It would not be unreasonable to treat the lawyer as an agent of the foreign insurance carrier in this instance, or to constrain the definition of "incidental" such that lawyers practicing in this area would not be covered under this exemption, thus requiring registration under Regulation D. Registration would substantially diminish the attraction of the foreign ILIT since the element of financial privacy would be significantly weakened.

It will remain the case that the foreign jurisdiction will "require strict confidentiality" as regards insurance policies.[129] But the SEC will learn that "XYZ Trust of Jersey" purchased a $20 million foreign life insurance policy. So alerted, the SEC could investigate how the trust was funded. It would be a rather short line back to the settlor. And if the settlor is a director or officer in a United States corporation, she is less likely to be willing to use the trust in an abusive manner.

B. Financial Security

The most powerful and attractive element of the foreign ILIT is its protection mechanism. The inability for United States courts to assert personal jurisdiction over foreign trustees makes it exceedingly difficult for creditors or claimants to compel repatriation of trust assets. Professor Sterk summarizes the problem nicely: "physical power remains an important force in shaping the law of personal jurisdiction. Courts serve no significant purpose and undermine their authority if they take jurisdiction over cases in which they would be powerless to afford a victorious plaintiff an effective remedy."[130] The problem for the United States is how to penetrate a feature of the foreign trust that is created by the laws of foreign jurisdictions unwilling to recognize judgments and orders of United States' courts.

Commentators have identified one method of penetrating the security feature of the offshore trust: bankruptcy courts could exercise more power

128. *Id.* (emphasis added).
129. *Id.* at 224.
130. Sterk, *supra* note 3, at 1093.

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over settlors of foreign trusts.[131] In recent decisions, bankruptcy courts have denied the settlors' applications for discharge.[132] Having his application for discharge denied, the settlor would be faced with a stark choice: either repatriate the assets or live with the debt. For some, the risk of being denied a discharge by a bankruptcy court because of the foreign ILIT may diminish the attraction of this trust. However, the reality is, those that are willing to go to such great lengths to protect their wealth from creditors may be willing to live with the debt. Professor Sterk observes: "if an offshore trust can provide generously for a settlor's relatives and, indirectly, for the settlor, the settlor may be willing to live indefinitely with a judgment debt hanging over his head—even if the settlor will consequently be unable to purchase and maintain tangible property within the United States."[133]

A more effective method of negatively affecting the decision to move assets offshore is to make the transaction much more expensive. Currently, "[a]n excise tax of one percent is due on each premium payment made to a foreign life insurance company for a life insurance policy issued to a citizen or resident of the U.S. as the insured . . . ."[134] A substantial increase in the excise tax would offset the beneficial tax treatment of the foreign ILIT; and to that extent, such an increase would reduce the appeal of the foreign ILIT.

C. Tax Efficiency

Finally, the insurance element of the foreign ILIT entitles the insured and beneficiary to the same tax advantages afforded life insurance in the United States.[135] This feature of the foreign ILIT makes it particularly

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131. *See generally id. See also* Henzy, *supra* note 3, at 760.

132. Sterk, *supra* note 3, at 1103, 1108:

> [The *Portnoy* court] invoked the "continuous concealment" doctrine to hold that a debtor who transferred assets to an offshore asset protection trust could be denied a bankruptcy discharge based on [11 U.S.C] 727(a)(2) . . . even if the initial transfer had occurred more that a year before the petition date.

See Marine Midland Bank v. Portnoy, 201 B.R. 685 (Bankr. S.D.N.Y. 1996); In re Lawrence, 227 B.R. 907 (Bankr. S.D. Fla. 1998).

133. Sterk, *supra* note 3, at 1112.

134. Duke, *supra* note 23, at 237; I.R.C. §§ 4371, 4372.

135. Giordani, *supra* note 2, at 539.

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attractive since the Small Business Protection Act of 1996 abolished the foreign grantor trust, and with it, considerable tax benefits.[136]

As mentioned above, one approach to reducing the tax "efficiency" of the foreign ILIT is to increase the excise tax due on premium payments to offshore insurance policies, thus offsetting the tax advantages usually afforded life insurance. A second, more radical, alternative is to deny foreign life insurance policies the tax advantages presently enjoyed by domestic policies. I.R.C. § 101 provides a blanket exclusion from gross income amounts received from a life insurance contract by reason of death.[137] As discussed above, the foreign ILIT can be used to pass wealth to future generations without paying estate tax.[138] Briefly, the foreign ILIT serves to remove wealth from the estate of the settlor. Upon death, the assets gifted to the ILIT are not included in the estate of the deceased.[139] Thus, no estate tax is due on those assets. But notice, upon death, the death benefit of the foreign ILIT, funded by the deceased with assets that would have been subject to the estate tax, passes to the beneficiary tax-free. A compelling argument could be made for creating a foreign ILIT exception to I.R.C. § 101, so that amounts received by reason of death from a foreign ILIT *will be* taxable income. Such an exception would serve to both restore balance between the income and estate tax systems, and remove a considerable incentive to move assets into a foreign ILIT. In addition, the foreign ILIT would be rendered consistent with the spirit of the Small Business Protection Act of 1996.

CONCLUSION

The foreign ILIT is a powerful mechanism for protecting assets from future creditors and adverse judgments. It is also an excellent way to enjoy tax-free growth and pass wealth from generation to generation virtually tax-free. The foreign ILIT is an exceedingly sophisticated structure

136. *Id.*

137. I.R.C. § 101(a) (West 2002).

138. Duke, *supra* note 23, at 228.

139. Giordani, *supra* note 2, at 541. I.R.C. § 2042 deals specifically with proceeds from life insurance for estate tax purposes. Proceeds from life insurance will not be included in the estate of the deceased as long as the decedent did not retain any incidents of ownership, including a reversionary interest. *See also* Duke, *supra* note 23, at 239. In the context of the foreign ILIT, the settlor makes a gift to a foreign irrevocable trust. The settlor retains no reversionary interest or powers of appointment. Therefore, the assets within the foreign ILIT are not included in the estate of the settlor for estate tax purposes.

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designed exclusively with the ultra-wealthy client in mind. Notwithstanding the familiar criticisms of the offshore asset protection trust, the foreign ILIT presents a unique problem because of the type of client for whom it was created. In a post-Enron environment, we know that corporate America has a credibility problem. And we have witnessed the excesses directors and officers have enjoyed at the expense of creditors and shareholders. Those directors and officers, and undoubtedly others to follow, will soon be expected to return at least some of the wealth they raided from corporate coffers. In the meantime, the laws governing asset protection trusts should be reconsidered with a goal toward minimizing the availability of judgment proofing techniques.

There is little that can be done about the individual that is willing to move assets offshore at a considerable cost. But much can be done about asset protection strategies, such as the foreign ILIT, that not only exist as formidable asset protection mechanisms, but also as attractive vehicles for tax-free investing and wealth transfer. Such strategies invite abuse. By removing, or significantly diminishing, the incentives for establishing a foreign ILIT, the decision to move assets offshore in this manner will be less obvious. As a result, the outbound flow of wealth will begin to slow. With less wealth moving offshore, the potential for, and effect of, abusive use of offshore trusts will diminish.

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FROM THE JOURNALS: INSURANCE LAW ABSTRACTS

Edited by Tatiana Connolly[*]

BAD FAITH CLAIMS

Jeffrey E. Thomas, Crisci v. Security Insurance Co.: *The Dawn of the Modern Era of Insurance: Bad Faith and Emotional Distress Damages*, 2 NEV. L.J. 415 (2002).

This Note explores the impact of the California Supreme Court's decision in *Crisci v. Security Insurance Co.*, 426 P.2d 173 (Cal. 1967), a case which typifies the doctrine of "bad faith" and discusses its impact on the role of emotional distress damages in bad faith claims. It concludes that emotional distress damages play a useful role in the context of insurer bad faith law.

In *Crisci*, an insured apartment building owner sued her insurer for refusing, in bad faith, to settle within her policy limits for an accident that befell one of her tenants. As a result of her insurer's breach of its duty to settle and a subsequent jury verdict well over her policy limits, Crisci was left destitute. She sued for the excess of the judgment over her policy limit and for emotional distress damages and was successful on both counts.

Although the doctrine of bad faith can be traced back to the early 1900s, Thomas points out that *Crisci* popularized it and contributed to its development in several ways: by establishing the implied covenant of good faith and fair dealing as the basis for a bad faith refusal to settle a claim, by establishing that the claim sounded in tort as well as in contract, and by considering whether an insurer would accept a settlement offer in the absence of policy limits to be determinative as to whether it has breached its duty. However, Thomas argues that *Crisci's* most groundbreaking contribution was its sanction of emotional distress damages in the bad faith context. Thomas suggests that *Crisci* contributed to the availability of emotional distress damages in the bad faith context both directly, by

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providing the authority upon which other cases adopted liberal approaches (in which such damages are generally available) and compromise approaches (in which substantial damages are a precondition), and indirectly, by providing a legal context for courts to address a request for emotional distress damages. Moreover, Thomas contends that *Crisci* has the potential for further influence as only twenty states have addressed the issue.

Given that law is not yet settled in many states, Thomas posits several normative arguments in support of emotional distress damages that endorse the liberal approach to emotional distress damages. First, Thomas argues that emotional distress damages should be permitted to compensate victims, regardless of whether under tort or contract. Thomas explains that mental distress is a part of the policyholder's damages, thus refusing to grant emotional distress damages inadequately compensates victims. Second, Thomas claims that criticisms associated with emotional distress damages do not apply to the circumstances of insurance bad faith for two reasons: (1) concerns about false and marginal claims can be quelled by the avoidance of bad faith conduct and (2) concern regarding excessive jury awards can be discounted because only a small fraction of bad faith cases go to trial. Finally, Thomas presents a simple quantitative model for evaluating the impact of allowing emotional distress damages. Through this hypothetical model, based on incidents of bad faith proceeding trial, total damages, and total costs, Thomas illustrates that the concern regarding overpayment for emotional distress damages is greatly exaggerated. Ultimately, this Note highlights the utility of emotional distress damages in the context of insurer bad faith law.

HEALTH INSURANCE

Frank N. Darras & David T. Bamberger, *Standards and Timeliness in Medical Insurance Actions: The Insured's Perspective*, 23 WHITTIER L. REV. 679 (2002).

This Article addresses the problems faced by plaintiffs' lawyers who try to take on Health Maintenance Organizations ("HMOs") in California and discusses ways to tackle these roadblocks. It also outlines many of the standards imposed on HMOs by the courts, legislature, and accreditation groups in California and stresses the importance of having a familiarity with these standards when initiating litigation against an HMO.

The first common roadblock the authors discuss is the claim of Medicare preemption. Oftentimes Medicare administrative review statutes

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will preempt a patient's claim of wrongful refusal to provide benefits when an HMO denies coverage to a patient who is qualified for Medicare. Yet, with the recent U.S. Department of Health and Human Services confirmation that tort claims or contract claims under state law are not preempted by Medicare and with numerous courts opinions that have flatly rejected Medicare preemption claims, the Medicare roadblock appears to be surmountable.

Another common roadblock discussed by the authors is forced arbitration. Arbitration clauses exist in many health care policies, but the authors suggest that a plaintiff's attorney need not be bound by these clauses. The authors suggest several possible arguments a plaintiff's attorney can make to circumvent arbitration and get the case into court.

The next roadblock the authors discuss is the Employee Retirement Income Security Act of 1974 ("ERISA") preemption. When a claim is preempted by ERISA, a plaintiff's attorney may only receive limited remedies; recovery is limited to benefits owed and reasonable attorney's fees. To circumvent ERISA preemption, the authors suggest bringing suit under California's new HMO liability statute. Typically, ERISA will preempt state laws that are related to employee benefit plans unless the state laws "regulate insurance." Because the California Legislature passed the new HMO statute that permits employees to sue their employer-provided HMO and receive unlimited damages, the authors argue that the Legislature intended to regulate insurance and therefore the HMO liability statute should be protected from ERISA preemption. They point out that protection from ERISA preemption is not unique. Several groups are excluded, such as independent contractors, government and church employees, sole proprietors, partners, and spouses. The Department of Labor provides a "safe harbor" for certain plans. Finally, courts, including the U.S. Supreme Court and federal district courts, have shown signs that they are receptive to arguments about ERISA preemption.

After discussing the various roadblocks and how to circumvent them, the authors offer advice on how to plead against HMOs. The authors propose various theories of liability that may be alleged. While the new California liability statute will assist pleadings because it imposes liability on HMOs who fail to furnish covered benefits, the authors note that, even without the code courts, have found and will continue to find HMO liability under other theories. These theories include bad faith, third-party beneficiary of contract between HMO and physician provider group, tortuous breach of contract, interference with doctor-patient relationship, intentional misrepresentation, negligent misrepresentation, breach of fiduciary duty, vicarious liability for medical negligence of HMO

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physicians, intentional infliction of emotional distress, and unfair business practices.

Next, the authors advise that, in drafting a complaint against an HMO or opposing demurrer, a plaintiff's attorney should have a firm understanding of the standards imposed upon HMOs. They note that these standards appear in several places such as statutes, regulations and appellate decisions. They then highlight some of the most significant standards such as continuity of care and ready referral to other providers, basic health care services, quality of care, ready availability and accessibility of services, utilization review standards, emergency care, prompt utilization review, communication of utilization review decision, grievance procedures and independent review, and reimbursement of uncontested claims.

In addition to being familiar with the standards binding HMOs, the authors suggest that plaintiffs' attorneys become familiar with California's unfair claims settlement practices statute and its fair claims settlement practices regulation. This statute and regulation impose many duties upon the parties, including prompt investigation, prompt communications, prompt decisions on claims, prompt settlements, fair settlement offers, prompt explanation or denials, and no unnecessary investigation.

Before concluding, the authors discuss several duties that are imposed upon HMOs. These include the duty of good faith and fair dealing, which is imposed by the courts, and the duty to maintain specific standards, imposed by the National Committee for Quality Assurance. The authors conclude that it is difficult to take on an HMO in California, but it can be done.

Sharona Hoffman, *AIDS Caps, Contraceptive Coverage, and the Law: An Analysis of the Federal Anti-Discrimination Statutes' Applicability to Health Insurance*, 23 CARDOZO L. REV. 1315 (2002).

In this Article, Hoffman argues that despite several decades of anti-discrimination laws, serious discrepancies exist along discriminatory lines regarding health insurance coverage. With extensive analysis of the Americans with Disabilities Act ("ADA") and Title VII of the 1964 Civil Rights Act (prohibiting employment discrimination based on gender), Hoffman demonstrates that despite some equivocal language, the legislative intent clearly contemplated uniform provisions of employer-based health insurance regardless of disability and gender. Nevertheless, many courts have read these provisions too narrowly and have, as a result, not provided adequate relief.

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Hoffman points out that employers can provide discriminatory insurance policies and survive an ADA suit if they can show economic reasons for doing so and have not evaded the purposes of the ADA. Ironically, the author notes, anti-discrimination laws may provide a serious incentive to employers to provide no health insurance plans at all because, if an employer does not provide health insurance to any employee, she cannot be accused of providing different plans based on discriminatory intent. Also, an increasingly popular benefit plan for employers is to provide all employees with a set dollar amount that can be used to purchase health insurance. This move also avoids any charges of discrimination.

Finally, Hoffman concludes by noting three ways to mend the sometimes discriminatory effect of health insurance coverage. First, more federal statutes could be enacted designed specifically to end discriminatory insurance practices. Second, while it may only be a "partial solution," additional insurance regulation could be handled by the states. Finally, a centralized, federal agency similar to the EPA or FDA could be created to fully regulate the health care industry.

David A. Hyman, *Two Cheers for Employment-Based Health Insurance,* 2 YALE J. HEALTH POL'Y L. & ETHICS 23 (2001).

This Article evaluates the strengths and weaknesses of employment-based health insurance. It concludes that employment-based health insurance, when compared to alternatives, remains the best option for health care coverage.

Hyman begins his discussion by providing a historical background to the development of employment-based health insurance. Prior to World War II, very few employees received health care coverage through their employers. During World War II, however, the government imposed price controls and froze wages causing employers to compete with each other through fringe benefits, such as health benefits. Employment-based health coverage began to rapidly increase. Around the same time, the Internal Revenue Service ruled that insurance paid by employers did not constitute income to employees, essentially creating a subsidy. Also, in the 1940s and 1950s, labor unions began to aggressively negotiate generous benefit packages and health insurance was a top priority. Today, roughly 177 million Americans receive health insurance through employment-based coverage. While sixty-five million Americans receive health care coverage through Medicare, Medicaid, or other governmental programs, approximately thirty-nine million Americans lack any health care coverage.

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Hyman acknowledges that this gap in coverage is one problem with a system of employment-based health coverage and discusses several other problems that such a system poses. For example, employment-based coverage creates mismatches between employers and employees and between employee groups and individual employees because the groups typically have different incentives, preferences, and operate with different levels of information. Also, employer-based insurance can negatively impact employee mobility when the policies contain waiting periods or exclusions on pre-existing conditions. Additionally, due to the Employee Retirement Income Security Act of 1974 ("ERISA"), employee-based health insurance plans are effectively unregulated because ERISA preemption prevents state-level regulation of employee benefit plans and ERISA does not contain substantive regulation of health benefits.

Even with its shortcomings, however, Hyman argues that employment-based health insurance, with some incremental changes, remains the best option. First, employment-based health insurance helps to solve market imperfections such as unequal bargaining grounds because many employers understand the health care industry as well as the insurers. Second, it helps to improve market conditions through its creation of efficiencies of scale. Third, employment based insurance promotes comprehensive coverage by mitigating problems of adverse selection. Finally, it allows for systematic cross-subsidies, greater flexibility of design, and more coverage arrangement innovations.

Next, Hyman evaluates alternatives to employment-based health care coverage to further test his support for this system. He finds that reforms risk creating responses that are "socially inefficient" and may cause the population as a whole to be worse off. Additionally, adverse selection is likely to increase without employee-based coverage. Finally, implementing structures such as private purchasing associations creates efficiency risks and risk adjustment problems.

Hyman does not maintain that employer-based coverage is a perfect system. Instead, he argues that it is the best system presently available, and that by implementing reforms incrementally, the system can be improved. To improve the system, Hyman makes three recommendations. First, he suggests implementing a tax subsidy reform to ensure uninsured coverage. Second, he advocates ERISA reform in the areas of coverage, state regulation, and insurer liability. Finally, he supports greater use of purchasing cooperatives. By implementing these reforms and other modest incremental changes, he concludes that the shortcomings of employment-based health insurance coverage can be addressed and health care coverage

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can improve without creating widespread disruptions in our health care system.

James B. Roche, *After* Bragdon v. Abott: *Why Legislation is Still Needed to Mandate Infertility Insurance*, 11 B.U. PUB. INT. L.J. 214 (2002).

This Note addresses the failure of the Supreme Court's decision in *Bragdon v. Abbot* to rectify the problem of employer refusals to accommodate employees who wish to undergo infertility treatments, and health insurer refusals to provide coverage for infertility related health expenses.

Roche begins by illustrating the three main defenses used by insurance companies in their denial of coverage for infertility treatment. The first defense used is that infertility is not an illness. Roche notes that in limited cases infertility has been considered an illness when the court defines illness as a deviation from the healthy or normal condition of a bodily function. A second defense presented by insurance companies is that artificial insemination is not a treatment. The basis of this argument is that the procedure does not cure the problem but merely circumvents it. Again Roche points out that in some insurance plans that the term "treatment" is given a broad definition wherein artificial insemination has been considered a treatment. A final defense frequently used is that fertility treatment is not medically necessary. Roche notes that a court has never found that infertility treatments are medically necessary.

Next, Roche discusses the different theories under which plaintiff's have tried to gain coverage for infertility treatment. The first theory Roche describes is a claim under the Americans with Disabilities Act ("ADA"). Infertility was deemed a disability under the ADA, but courts have held that an employer's failure to provide infertility insurance does not violate the ADA. Second, the author evaluates the argument that the failure of an insurance plan to provide for in vitro fertilization violates Title VII of the Civil Rights Act. Courts have rejected this argument holding that it only comes into play if female employees were denied benefits for surgical impregnation. Third, Roche outlines the argument that a denial of coverage violates the Family and Medical Leave Act. He suggests that this argument will fail unless one can show that their infertility resulted in depression, which constitutes a serious health condition.

The author concludes by describing the present state of insurance for infertile couples. He argues that the Supreme Court's failure to extend *Bragdon* to mandate infertility insurance is a sign that the issue should be taken up the legislature.

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Sara Rosenbaum, et al., *Devolution of Authority and Public Health Insurance Design: National SCHIP Study Reveals and Impact on Low-Income Children*, 1 HOUS. J. HEALTH L. & POL'Y 33 (2001).

This Article presents interim findings from a multi-year, nationwide study of separately administered State Children's Health Insurance Programs ("SCHIP"). SCHIP are administered directly under the devolved authority of the SCHIP statute—not as an extension of Medicaid—and provide additional funds to states to establish insurance programs for certain targeted low income children. In this Article, the authors explore the two basic aspects of separate SCHIP design and discuss the policy implications of the two programs for low income children and for Medicaid.

First, the authors present the two basic aspects of SCHIP design. The first aspect, and most fundamental from a legal perspective, is whether states choose to design their SCHIP programs as individually enforceable, legal entitlements when given that opportunity. The second aspect is the extent to which separately administered state SCHIP programs are based on comprehensive managed care systems and how well these programs interact with Medicaid. The authors evaluate these aspects in their review of the SCHIP programs to draw conclusions about how well the programs are functioning.

In evaluating the first aspect, the authors found that when given the option to design programs that operate as enforceable legal entitlements, states choose not to do this. Despite the rapid response that states had in enacting SCHIP, indicating a high degree of state interest in expanding coverage for low-income children, most states did not choose to entitle near-poor children to public health insurance under either federal or state law. In fact, most state laws creating separate SCHIP programs do not even obligate the state to cover eligible children to the maximum level of available funding.

When evaluating the second aspect, the authors found that most states build comprehensive, managed care agreements when administering separate SCHIP programs. But rather than using SCHIP to create seamless care systems as children move up the economic ladder by consolidating SCHIP and Medicaid revenues into combined managed care contracts, most states elect to separate children into distinct contractual bins by sponsorship status. The authors point out that this practice enables state agencies to design different conditions of participation, standards of coverage and operation, and other contractor requirements for these

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contractual "bins". Additionally, it also potentially permits contractors to participate in one program but not the other.

The authors suggest that based on these findings, SCHIP might have a further "isolating effect" on state policies toward the poorest of children and might eventually erode Medicaid's policy goal of providing "mainstream" health care to America's low-income children.

Nathaniel S. Shapo, *The Regulation of Managed Care Organizations and the Doctor-Patient Relationship,* 30 J. LEGAL STUD. 669 (2001).

Based on his experience as the chairman of the Illinois Comprehensive Health Insurance Plan ("ICHIP"), Shapo discusses the impact of legislation, regulation, and the courts on managed care organizations (MCOs), and explores whether all of these actors should be involved in MCO oversight. Uncertain as to whether the courts will positively or negatively impact MCOs, Shapo finds that courts, through though class actions and judicially created vicarious liability, have the potential to fundamentally impact MCO market conditions.

Shapo begins by discussing his experience with ICHIP. ICHIP, a state-subsidized pool of insurance for high-risk uninsurable people, ran into severe financial difficulties during the 2001 fiscal year. The fiscal crisis caused the board members of ICHIP to cap enrollment, create a waiting list, and then choose between eliminating coverage for those on the waiting list or imposing restrictions on all enrollees. Hoping to achieve the latter, the board imposed strict cost controls. Through the use of cost controls, they were able to abolish the waiting list and provide coverage for all. Shapo posits that the choices he faced were the same as those faced by the health care market as a whole, just on a smaller scale.

Next, Shapo evaluates the recent impact of legislative, administrative, and judicial proceedings on managed care in Illinois. In 1999, the Illinois legislature passed the Managed Care Reform and Patients Right Act (the "Act") that grants new rights to MCO patients without creating liability for MCOs. The legislature failed to define many key terms in the Act undefined, leaving the Department of Insurance to fill in the gaps. The legislature made a conscious decision to explicitly exclude MCOs from liability, however the Illinois courts created an exception to this exclusion. They found that MCOs could be held vicariously liable for physicians' actions if the method of compensation used by the MCO exerted control over the physicians' decisions.

In comparing the position of the courts to the Act and the authority of insurance regulators over MCOs, Shapo notes that the courts now grant

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plaintiffs more rights than the Act and permit plaintiffs to scrutinize MCO cost controls more than state regulators. Shapo is uncertain whether this new layer of judicial oversight will improve care or financially burden MCOs and thereby decrease access to care. He leaves it to time to determine.

Next, Shapo looks deeper into the interaction between the courts and MCOs by focusing on class actions. He attempts to evaluate whether they complement or interfere with the regulatory state. After exploring recent court actions and assessing both sides of the argument, Shapo concludes that too many factors were involved in the class action suits to fairly establish the actual impact of class actions on the market place. He posits that class actions will have the practical effect of both assisting and competing with the regulatory state.

Before concluding, Shapo discusses the hostile relationship between physician groups and MCOs and reveals the significant impact that physicians have had in MCO legislation and lawsuits. While conceding that it is difficult to determine the relative affects of legislation, market forces, and lawsuits on MCO regulation, Shapo notes that organized physicians' groups are certain to have an impact in each area. Shapo concludes by emphasizing the great potential impact that the court may have on MCOs through class actions and judicially created vicarious liability.

Katherine Swartz, *Justifying Government as the Backstop in Health Insurance Markets*, 2 YALE J. HEALTH POL'Y L. & ETHICS 89 (2001).

This Article explores whether government intervention in the health care system could help to solve some of the problems inherent in a system that lacks universal health care. It concludes that government intervention could increase efficiency and the overall welfare of the country.

Swartz begins her evaluation by analogizing a universal health care system to a government's disaster relief system. She looks at the disaster relief system as a "blueprint" for how the government might reduce inefficiency in health insurance markets. She notes that in the areas of property, casualty, and liability insurance, the government permits insurers to function competitively while it increasingly provides disaster relief, thereby taking responsibility for the worst or highest risks. She proposes that if the government took on the same role in the health care system – taking responsibility for the costs of people with the highest risks or medical care expenses – then the health care system would be more efficient and social welfare would increase.

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Swartz next discusses two economic justifications for involving the government in improving the health insurance system. The first justification is for the redistribution of resources, although Swartz notes that there is no clear mechanism for providing health insurance to everyone without hurting the interests of some people. The second justification is to facilitate economic efficiency or prevent market failure. In this area, Swartz remarks that debates over government intervention have almost always turned on whether certain causes of market failure exist in the health care system. Swartz then focuses on one known cause of market failure as it applies to health insurance: asymmetric information. According to Swartz, imperfect information between health providers and applicants results in inefficient markets because health insurance providers generally do not know all of the reasons for which the applicant is seeking to obtain insurance and consequently providers are forced to screen out high-risk people. Screening out these individuals requires the carriers to spend resources, and the consequence of the expenditures is limited access to health insurance for those perceived to be high-risk applicants; increased spending for less care is inefficient. Similarly, asymmetric information causes carriers to waste money and effort competing with each other to select the greatest number of low-risk people. Swartz concludes that the costs of creating and using selection mechanisms are a measure of the inefficiency that exists in health insurance markets.

Next, Swartz sets forth how the government can act to improve efficiency in the health insurance system. She suggests that insurance beneficiary selection could be truly random and carriers would not have to spend as much on selection mechanisms to avoid high-risk people if the government covers the costs of the worst risks. She puts forward two options for the government: (1) provide financial coverage outright or (2) take on the role of reinsurer. She argues that a health care program structured similarly to Medicare, Medicaid, or the Veteran's Administration's health care program and that covers the medical expenses of the top one to two percent of the high-risk group would drastically reduce carriers' incentives to spend resources on selection mechanisms. If the government acted as a reinsurer, it could pay a portion of the costs of the individuals whose medical expenses exceed a certain threshold amount, such as $30,000 or placement in the 98th or 99th percentile of the entire population's distribution of medical expenses. Such an arrangement would result in carriers having far less incentive to avoid high-risk people.

In sum, the author believes that government intervention in the health care system would ultimately lead to a more efficient system that more

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high-risk people could benefit from, resulting in increased economic welfare for the country.

Rory Weiner, *Universal Health Insurance Under State Equal Protection Law*, 23 W. NEW ENG. L. REV. 327 (2002).

This Article illustrates the failure of the Clinton health care reform plan to achieve universal health care coverage. The author offers a means to achieving that goal by suggesting a state constitutional remedy.

Weiner begins by reviewing the emergence of state constitutionalism and discusses how legal advocates have used state constitutional law to expand the right to public education. The author argues that universal health care advocates use a similar tactic as public education advocates used to overcome the large disparities in funding and educational quality between rich and poor school districts.

Weiner then identifies and analyzes both explicit and implicit health care provisions contained in state constitutions and finds that these provisions are scarce. Because of their scarcity, the author concludes that utilizing these provisions would not be an effective way of expanding access to health care. Instead, Weiner suggests exploring whether a state's constitution contains a constitutional interest in fair equality of opportunity.

Next, Weiner provides a preliminary sketch of a health care equal protection theory, a framework within which one could challenge a state's health care financing laws under the state's equal protection clause. First, Weiner sets forth an overview of state equal protection law and explains why it may be a powerful tool for expanding access to health care. Then the author argues that, assuming one can interpret a state constitution to protect fair equality of opportunity, having one's health care needs met is an interest that deserves heightened state constitutional scrutiny. Next, the author analyzes the relationship between health insurance, access to hospitals and doctors, and a person's well being; this analysis explains the connection between having health insurance and preventing, restoring, and maintaining one's normal opportunity range. The author then examines how a state government's role in financing health insurance and/or health care may violate the state's equal protection clause. Weiner argues that once the state undertakes a duty of financing health insurance, it must do so in a constitutionally neutral manner so as not to exclude any constitutionally protected options.

Finally, Weiner tests this framework by applying it to Massachusetts' health care financing laws. He concludes that these laws may violate the state's equal protection guarantees because they unequally distribute access

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to health care, thereby burdening some residents' fair equality of opportunity interests.

INSURANCE—GENERAL

James M. Fisher, *Insurer or Policyholder Control of the Defense and the Duty to Fund Settlements*, 2 NEV. L.J. 1 (2002).

This Article presents four scenarios that may arise when an insurer and policyholder attempt to settle a claim and argues that in non-breach situations the party controlling the defense should be responsible for the funding obligation.

Fischer begins by laying out each scenario. He first discusses the "standard" case in which the insurer provides an unconditional defense of the claim. In the standard case, the policyholder tenders the claim to the insurer thereby conferring upon the insurer the authority to defend or settle the claim. Control of the defense is the "hallmark of the standard cases," and creates privity between the insurer and the policyholder and, as such, the insurer is responsible for paying the costs of the defense and any recovery, up to the policy limits, to the claimant. Next, Fisher outlines the non-standard case of an insurer's breach of the duty to defend. The promise to defend is broader than the promise to indemnify. An insurer is required to defend a claim even if it is unsure whether the claim is actually covered by the policy. Only where there is no potential that the claim is covered may an insurer refuse to defend. As such, an insurer breaches this duty when it refuses to defend such a case. The second non-standard case is that in which a conflict of interest exists between the insurer and the policyholder. A conflict of interest usually centers around whether the claim is covered. In such a case, the insurer may pay for counsel selected by the policyholder in order to preserve its right to contest coverage. The third non-standard case is that in which the policyholder is in control of the defense pursuant to the agreement of the parties. In such a case, the insurer only promises to indemnify for covered losses.

After laying out these four scenarios, Fisher argues that extending the doctrine of insurer-breach cases—the first non-standard case in which there is no question regarding funding and no question of fault—to non-breach cases would be a mistake. Instead, he suggests a uniform approach to funding settlements for the non-standard, non-breach cases and proposes that the party in control of the defense should advance the funds to settle the claim. Fischer argues that the bifurcation of the settlement of the suit from control of the defense is impractical and inefficient. Control affects

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the value of the claim and the price at which one might settle. Additionally, if control is divided and the reimbursement of funds is conditioned on obtaining informed consent from the party with payment responsibility, the party with the payment responsibility can act in his own interest and withhold consent, frustrating and complicating settlement. Instead of relying on consent, reimbursement should be allowed when the settlement is reasonable on the merits and non-collusive.

Fisher also examines what he believes to be several unsatisfactory alternatives. The first would allocate funding obligations on the basis of each party's exposure. Such an approach is untenable because of the practical impossibility of distinguishing between control and settlement. The second approach is based on the assumed certainty that coverage and non-coverage exposures are defined. According to Fisher, such definition is often problematic and uncertain. Another approach is the case in which the party in control may not settle for its own account without the consent of the other party. The problem with this method is that it creates an "implied right to consent" that is not present in the insurance contract. The last approach that Fisher rejects is judicial approval of the settlement. All this approach accomplishes is the delay of funding until the coverage litigation is concluded and could lead to opportunistic alliances.

Deborah S. Freeman and Celia Eggert, *Exploration of Policyholder Information Ownership Rights Under the Three Existing Insurance Agency Systems in the United States,* 32 W. NEW ENG. L. REV. 409 (2002).

This Article explores the three different insurance agency systems – the Independent Agency System, The Exclusive Agency System, and the Direct Response Agency System – that have evolved in America over the last seventy to eighty years, and evaluates the impact each system has had upon these ownership rights. Additionally, this Article provides the guidance necessary to determine the particular type of relationship that exists between an agent and the insurance company and, based upon that relationship, the means to decide who holds the superior ownership rights to vital policyholder information. While the three agency systems are not new classifications, these types of lawsuits are increasing because insurance companies have failed to clearly define, through either contract or usage, the requirements of the agency systems used by them.

In the first section of the Article, Freeman discusses the evolution of the three distinct insurance agency systems and the method necessary to categorize a particular relationship. The three possible insurance agent systems are (1) the independent agency system; (2) the exclusive agency

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system; and (3) the direct response agency system. Under the first system, the American Agency system, insurance agents are free to sell products through more than one company. This system consists of several components: the insurance company has no direct contact with the insured; the policy is issued by the agent and countersigned by him; the agent has the power to cancel or amend the policy; the agent collects the premiums and makes remittance on his own to the company; the agent may switch companies upon the expiration of the policy or may cancel the policy during its term and place the risk in another company. In the second system, the exclusive agency system, exclusive agents represent 'niche' insurance companies that satisfy the unmet needs of potential policyholders. These niche insurance companies arose from uninsured individuals who banded together to create insurance companies in order to provide the insurance they desired at prices they believed reflected their own particular risks and circumstances. The third type of insurance agency system is the direct response agency system. This system also evolved from the 'niche' insurance companies. But in this type of agency system, the agent can only sell the insurance from the company he represents and is considered an employee.

Next, Freeman examines how insurance companies contractually use the three system definitions to detail who owns the policyholder information. She then looks at how the courts classify the insurance company-agent relationship absent contractual provisions and how the courts decide who owns the vital policyholder information.

Freeman concludes by expressing her belief that policyholder information is the most valuable business asset for both agents and insurance companies. When disputes arise over its ownership, determining what type of a relationship exists between an agent and an insurance company is critical. Categorizing that relationship as either exclusive, independent, or direct response and then properly assigning the agent to one of the three agency systems provide for both a consistent method of analysis and some ease in determining whether the individual policyholder information belongs to the agent or the insurance company.

D. Chris Harkins, *The Writing is on the Wall . . . and Inside It: The Recent Explosion of Toxic Mold Litigation and the Insurance Industry Response*, 33 TEX. TECH L. REV. 1101 (2002).

This Comment discusses the potentially burgeoning area of toxic mold litigation and explores how the insurance industry could appropriately respond to the recent explosion of litigation in this area.

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Litigation involving toxic mold claims is relatively new and is expanding rapidly. According to Harkins, these characteristics are reminiscent of asbestos litigation in the early 1970's. Because of the similarities, Harkins analogizes toxic mold litigation to asbestos litigation and argues that the insurance industry should look to its experience with asbestos litigation as a guide to handling toxic mold litigation. In both of these toxic tort areas, Harkins asserts that insurers face similar problems and therefore the manner in which courts handled asbestos litigation will aid in determining how they are likely to handle toxic mold litigation. For example, Harkins notes that toxic mold litigation is likely to face the difficult issue of delayed manifestation of disease and a lack of clear medical evidence demonstrating a direct link between the disease and its cause. Because courts evaluated this issue in asbestos litigation, Harkins asserts that insurers can use this analysis to discern how courts may assess and decide toxic mold issues.

Harkins next evaluates toxic mold issues in the context of the entire insurance industry and considers how the industry, fearing liability, is likely to respond to the recent litigation explosion. Noting that questions of when liability is triggered are extremely difficult to prove in this type of case, Harkins suggests that insurance companies are not likely to assert a defense that coverage did not exist at the time when the triggering event took place. Instead, insurers are likely to attempt to shelter their liability under a general pollution exclusion clause. Whether such a maneuver will be successful depends on the courts.

In closing, Harkins notes that several states are working on legislative solutions to toxic mold. Through legislation they hope to balance homeowners' coverage concerns with the industry's fear of massive liability.

Edward J. Jange & Paul M. Schwart, *Modern Studies in Privacy Law: Notice, Autonomy and Enforcement of Data Privacy Legislation: The Gramm-Leach-Bliley Act, Information Privacy, and the Limits of Default Rules,* 86 MINN. L. REV. 1219 (2002).

This Article looks at the new rules for financial privacy in the Gramm-Leach-Bliley Act ("GLB Act") of 1999 and evaluates how well the GLB Act has accomplished its aim to provide "the most comprehensive federal privacy legislation in history." After providing background to the GLB Act and considering theoretical works about information sharing and "defaults", the Article concludes that the GLB Act has not adequately

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protected privacy and sets forth recommendations for improving privacy protection.

The authors begin by describing the GLB Act. They briefly discuss both the non-privacy aspect of the statute and then turn to the provisions of the GLB Act that protect privacy, found in Title V of the statute. The authors focus on four important components in the privacy provision: notice, choice, data protection, and enforcement. To ensure that customers are informed about their financial institutions' privacy policies, the GLB Act requires financial institutions to send annual privacy "notices" to all of their customers disclosing the institutions' privacy practices. It also requires financial institutions to give their customers the opportunity to choose not the have personal information shared with non-affiliated companies through an "opt-out" provision. To further ensure customer privacy, the GLB Act requires financial institutions to develop policies to protect confidential financial information from fraudulent access. It also assigns enforcement rights to seven different federal agencies, and enforcement includes assessing criminal penalties.

The authors note that despite the GLB Act's efforts to increase the protection of financial privacy, industry leaders and privacy advocates are dissatisfied overall with the GLB Act. Criticism centers on the incomprehensibility of GLB Act notices and the opaqueness of the opt-out provisions in the notices. The authors contend that current GLB Act notices are structured so that customers are discouraged from opting-out.

To aid in understanding where the GLB Act has gone wrong, the Authors discuss theoretical works that explain how information sharing and "defaults" or background rules fill in gaps in agreements. The Authors focus on three characteristics of default rules: majoritarian, information forcing, and norm enforcing. Majoritarian defaults seek to approximate the terms on which most parties would likely agree if they had bargained for the terms. Information forcing defaults attempt to eliminate information asymmetries between parties by penalizing the better-informed parties when they do not share their information. Norm enforcing defaults endeavor to change or focus the behavior of parties by referencing contractual norms or policies. After analyzing the first two default rules, the authors conclude that they do not sufficiently fill in the gaps of the GLB Act. They then turn to norm enforcing defaults and attempt to determine the normative role of information privacy law. The authors focus on two normative views of privacy, individual privacy control over data and information privacy as a value constitutive of society. They conclude that the latter, information privacy, is a value constitutive of a

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democratic society, and suggest that democratic institutions must be involved in creating the rules that apply to the use of personal data.

The authors suggest that where the GLB Act went awry was in its interpretation of privacy as the "control" of data and not as a value constitutive of society. Accordingly, this view of privacy resulted in a notice and opt-out approach requiring mandatory notice with a majoritarian or information forcing default, neither of which is optimal for the GLB Act. The authors suggest that an opt-in arrangement, where customers must expressly permit financial organizations to share their information, may better protect consumers because financial institutions may be forced to bargain with customers to obtain their information and thereby may mitigate information asymmetries between the parties.

In conclusion, the authors propose that privacy may best be protected through a "mixed regime of mandatory and default, or waivable, background rules" rather than extensive reliance on any specific "opting" plan.

Louis J. Papa & Anthony Basile, *No-Fault Insurance Fraud: An Overview*. 17 TOURO L. REV. 611 (2001).

This Article critiques New York's no-fault automobile insurance and the implementation of the thirty-day rule. The authors argue that, together, no-fault insurance and the thirty-day rule provide an easy target for fraudulent claims.

In 1996, the New York Legislature introduced the thirty-day rule that stipulates that insurance companies must deny or pay a no-fault claim benefit within thirty days. Originally, the rule was designed to expedite insurance transactions and secure benefits for genuinely injured claimants. However, the authors argue that as a result of the statutorily mandated quick turn-around time, which gives insurance companies a limited amount of time to investigate the merits of each claim, some New Yorkers have developed schemes known as "Personal Injury Mills" to fraudulently bilk insurance companies.

The authors argue that the exponential rise of fraudulent claims in New York is directly tied to the enactment of the thirty-day rule. They note that from 1996 to 2001 in New York, suspicious automobile fraud was up an astounding 848%. However, the authors suggest that the problem could be significantly lowered simply by giving insurance companies more than thirty days to investigate a claim if they suspect fraud. The authors assert that this solution would not be burdensome for genuinely injured clients

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because when the insurers do not suspect fraud, the insurers should still be able handle their clients' claims within thirty days.

Jeffrey W. Stempel, Lachs v. Fidelity & Casualty Co. of New York: *Timeless and Ahead of Its Time*, 2 NEV. L. REV. 319 (2002).

This Casenote discusses the New York Supreme Court Case of *Lachs v. Fidelity & Casualty Co. of New York*, 118 N.E.2d 555 (N.Y. 1954). Stempel argues that Robert Keeton's seminal work, *Insurance Law Rights at Variance with Policy Provisions I*, 83 HARV. L. REV. 961 (1970), mischaracterizes *Lachs* as a case that "tortured" insurance policy language in order to construe the policy to provide coverage. Instead, Stempel suggests that *Lachs* incorporated the reasonable expectations approach some twenty years before Keeton coined the term. According to Stempel, the Court in *Lachs* took a "comprehensive, context-sensitive, eclectic approach" to insurance policy interpretation that looked beyond mere text to intent, purpose, expectations, and public policy.

The issue facing the Court in *Lachs* was whether proceeds should be paid on a flight insurance policy purchased from a vending machine by a passenger who subsequently boarded an airplane that crashed during take-off, killing everyone on board. The insurer refused to pay the benefits on the policy because the fine print of the policy stated that it only applied to "scheduled" flights (those conducted regularly by major airlines) and the passenger had boarded what it believed to be a "non-scheduled" flight (those conducted irregularly by non-major airlines). However, by employing what Stempel describes as a "holistic approach" to contract construction, the Court found in favor of the policy's beneficiary. Among other factors, the Court considered that a reasonable consumer may not know the difference between scheduled and non-scheduled flights, that the vending machine was located just outside the terminal of an airline that routinely operated non-scheduled flight, and that the advertisement above the machine ambiguously flaunted the words "Airline Trip Insurance".

Stempel suggests that while some may discount the case as an odd subset of insurance law given that it involved non-mainstream kinds of marketing and coverage, *Lachs* succinctly illustrates the range of considerations on which a court may reflect. After reviewing general ground rules of contract and insurance coverage, Stempel discusses the reasonable expectations analysis in the context of *Lachs*. Borrowing from Keeton, Stempel relates that the reasonable expectations doctrine, in its "pure" form, stands for the proposition that coverage should be afforded where the policyholder had objectively reasonable expectations of

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coverage, despite capricious language to the contrary. After reviewing *Lachs*, Stempel posits that the Court utilized a "moderate-to-weak" version of the reasonable expectations approach, one which justified its interpretation of the policy terms based on the expectations of the policyholder. Stempel highlights the comprehensive approach to insurance policy construction employed by the Court in *Lachs*. Instead of focusing solely on the text of the policy, the Court decided the case upon "context and common sense". Where ambiguity clouds interpretation, Stempel suggests that Courts adopt broad based policies that are sensitive to "facts, fairness, and public policy".

Jeffery Thomas, *Insurance Implications of September 11 and Possible Responses*, 34 URB. LAW 727 (2002).

This Article discusses the impact September 11 has had on the insurance industry, explores how this has effected cities, and then suggests possible approaches cities may take to address the insurance industry's response.

Thomas begins by putting the scope of the impact of September 11 in context. He compares the losses from September 11 to the losses from previous catastrophes and finds that the September 11 losses were at least two times greater than the previous largest natural single-event loss and at least ten times greater than the largest man-made disaster. He also notes that these losses were not limited to one area of insurance, such as property insurance, but were spread throughout the insurance industry.

After briefly commenting on customer satisfaction with the insurance industry's response in the immediate aftermath of the September 11, Thomas discusses how the insurance industry as a whole responded to the attack. First, insurers sought government assistance. The House of Representatives passed a bill to limit the risk of future terrorism-related losses, but the Senate failed to vote on such a bill. Then, realizing that the government was not going to act quickly, the industry started to exclude terrorism-related losses from coverage. Initially reinsurers adopted these exclusions. Then the National Association of Insurance Commissioners ("NAIC") endorsed a terrorism exclusion for primary commercial property and casualty insurers. The NAIC found that without reinsurance coverage a major loss from another terrorist attack could bankrupt many insurers.

Thomas next turns to the terrorism exclusion and discusses its three elements: (1) a terrorist activity must have caused the event; (2) a requisite terrorist intent must accompany the activity; and (3) the losses must exceed a specified threshold or be of a specified type. The last element, the

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amount of the losses, Thomas states is the threshold element. The terrorism exclusion will only apply when a loss exceeds twenty-five million dollars, however, losses can be aggregated. The first two elements, Thomas notes, are very broad and could be interpreted to include activities that one would not normally consider terrorism, such as Internet hacking.

After discussing the exclusion, Thomas focuses on the impact the exclusion has on cities. First, the broad scope of the exclusion, as noted above, indicates that cities will face risks of insured losses beyond those caused by terrorists. Second, risks associated with third-party liability claims are greater for cities than private-property owners because of the breadth of duties undertaken by city governments. But, Thomas notes, the terrorism exclusion does not necessarily mean the end of insurance coverage for terrorist acts because some insurers are beginning to offer stand-alone terrorist coverage. Presently, however, such coverage is limited in scope and expensive.

The high cost of terrorism insurance is not the only cost that cities face as a result of September 11. Cities also face rising costs from the insurance industry as a whole. Additionally, cities have encountered indirect costs from September 11 such as a decrease in bank loans for commercial properties that are not fully insured.

Finally, Thomas presents several strategies that cities may adopt to protect themselves from losses due to future acts of terrorism. First, cities could obtain terrorism coverage from private insurance if such a market properly develops. But if such a market does not develop, Thomas suggests that cities consider several alternatives: legislative solutions, judicial solutions, alternatives to third-party insurance such as self-insurance and captives, and catastrophe bonds. With each alternative, however, difficulties arise. Politics inhibits the passage of legislation. Judicial solutions are generally limited to marginally narrowing the scope of the terrorism exclusions, and the effectiveness of the alternatives to third party insurance depends upon the existence of reinsurance. While catastrophe bonds are problematic in that they are new and untested, Thomas concludes that they are the most promising solution because they do not rely on a reinsurance market to create their own broad financial mechanism for pooling risks and cities are already familiar with bond financing.

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INTELLECTUAL PROPERTY INSURANCE

Keith A. Dotseth & Johanna J. Hillard, *Intellectual Property in an Information Economy: Sailing Uncharted Waters: Insurance Coverage for Intellectual Property Disputes Arising from the Internet*, 28 WM. MITCHELL L. REV. 1125 (2002).

This Article looks at the challenges that intellectual property disputes on the Internet pose to the insurance industry. After setting forth the availability of insurance coverage for non-Internet intellectual property and for Internet-based claims in general, the Article focuses on the importance of the role of the insureds and insurers in positively influencing the newly developing Internet intellectual property insurance.

The authors begin by noting that insurance coverage for intellectual property litigation arising from the Internet is "uncharted territory" and involves the intersection of three areas: (1) insurance coverage for non-Internet intellectual property disputes; (2) insurance coverage for Internet-related disputes; and (3) the increase in Internet related intellectual property disputes.

In the first area, the authors discuss how recently courts have been more willing to find insurance coverage in the standard commercial general liability ("CGL") policies for certain claims of intellectual property infringement. Generally, coverage is found under the category of "advertising injury". However, the insurance coverage does not apply equally to the different intellectual property regimes. For example, insurance policies generally expressly cover the cost of defending copyright infringement claims that occurred during advertising activity. But for claims of trademark infringement during advertising activities, coverage is generally not expressly provided for in the policy and courts have interpreted the policies both to include and exclude coverage. With patent claims, most courts have refused to find insurance coverage under the typical provisions of the CGL policy.

In the second section, the authors focus on Internet insurance coverage in two main areas, performance torts and publishing torts. Performance torts include claims of physical destruction of property in cyberspace, such as the destruction of data. Publishing torts include content-based wrongs, such as defamation or invasion of privacy claims, and intellectual property claims. The authors note that insurance coverage in this area is nascent and does not provide a firm ground for predictability.

Next, the authors turn to the risks arising from the three intellectual property regimes and discuss the legislative initiatives undertaken to

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address such risks on the Internet. Specifically, it discusses two major legislative initiatives addressing intellectual property violations on the Internet: (1) the Digital Millennium Copyright Act of 1998 which indicates the federal government's recognition that with copyright both information use and transmission have to be monitored and (2) the Anticybersquatting Consumer Protection Act of 1999 which creates a civil action against those who intend in bad faith to profit from another party's trademark or who registers a trademark that is identical, confusingly similar or dilutive of a famous mark. There have been no such initiatives for patents because of the nature of patent law.

Finally, the authors focus on the importance of insureds and insurers in the development of Internet intellectual property law and suggest steps that these actors can take to facilitate the positive development of new law in this area. For insureds, the authors suggest conducting careful analysis of risks, close scrutiny of current insurance programs and staying abreast of Internet intellectual property law. For insurers, they recommend revisiting standardized forms and amending or creating specialized policies to cover the new risks. They also advise insurers to adequately train underwriters so that risks can be properly assessed, reminding the insurers that the definition of risk may be broad due to the international nature of the Internet.

LIABILITY INSURANCE

Walter J. Andrews and Michael S. Levine, *Is There Insurance Coverage for Lawsuits Against the Firearm Industry?* 2 NEV. L.J. 533 (2002).

This Article examines the issue of insurance coverage for law suits against the firearm industry. Due to a recent wave of suits against the industry, the industry has tried to turn to its insurers to cover the expenses of litigation and to indemnify it for any amounts it might become obligated to pay. The authors examine the issues dealing with the availability of insurance for such claims and ultimately conclude that insurers have potentially significant defenses to demands for such coverage.

The authors first discuss the major groups that are attempting to sue the firearm industry and set forth the grounds for their suits. The three major groups that are attempting to sue the firearm industry are the government, public interest groups, and victims of gun violence. Within the government, as of August 1, 2001, at least thirty-two municipalities and one state attorney general filed lawsuits against the firearms industry.

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Their allegations included public nuisance, negligent distribution of products, and production of products with inadequate safety systems. They also generally included three theories of liability: promotion of an underground gun market for criminals, failure to prevent shootings by unauthorized gun users, and false and deceptive advertising about the safety benefits of guns. In addition to the government, two public interest groups, the National Association for the Advancement of Colored People ("NAACP") and the National Spinal Cord Injury Association ("NSCIA"), have also filed suits against the gun industry. They seek mandatory safety requirements and education for gun dealers. The final major group attempting to sue the firearm industry is the actual victims of gun violence and their survivors. This group is seeking more traditional types of relief such as monetary damages for death or injuries.

Next the authors explore several reasons why the firearm industry has been unsuccessful in its attempts to obtain coverage from their insurers for these claims. First, they discuss a critical requirement of liability insurance, which is that the injury must result from an "occurrence". Generally, an occurrence is an accidental event. For gun liability, the occurrence requirement creates a problem because criminal activity usually is not accidental but intentional or volitional. As a result, insurers will be able to deny coverage for injuries resulting from criminal acts on the basis that the injuries did not result from an "occurrence".

The second reason the authors assert that the firearm industry has been unable to obtain insurance coverage for firearm claims is due to late notice of occurrence. The authors state, assuming *arguendo* that these suits do allege an "occurrence", certain members of the gun industry may have failed to provide timely notice of that occurrence, which is often required by liability policies. The authors assert that it is unlikely that members of the firearm industry notified their insurer each time their product was involved in criminal activity, and as a consequence it is likely that most of the industry has failed to satisfy a timeliness requirement.

The third reason discussed by the authors is the "expected or intended" exclusion. Liability insurance policies generally exclude coverage for bodily injury or property damage that is "expected or intended from the standpoint of the insured." The authors argue that the marketing techniques frequently used by the industry are clearly directed towards those looking to use the product for criminal activity. Such an intention would bar recovery from insurers who include such an exclusion in their policy.

Another reason the firearm industry has been unsuccessful in obtaining coverage for gun liability lawsuits is that liability insurance policies

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generally only permit recovery for "bodily injury" or "property damage", as those terms are defined in the policies. Many of the claims filed against the gun industry, however, seek damages for alleged improper business practices by the firearm industry, such as deceptive advertising or negligent distribution of products. These claims typically fall outside of the scope of coverage because they are not the direct cause of the injuries or damages.

In addition, insurers will reject outright some claims when they seek injunctive relief rather than compensatory relief. Insurers frequently do not cover injunctive claims because their liability policies cover only the sums the insured is obligated to pay "as damages". Injunctive relief does not qualify as "damages", and neither do requests for civil penalties, pre-judgment and post-judgment interest and costs, and attorneys fees.

A final reason that the firearm industry has been unsuccessful in its attempts at obtaining coverage for claims is the "products hazard" exclusion found in some liability policies. This exclusion bars coverage for gun liability lawsuits because the suits arise out of the policyholder's own product and off the policyholders' property.

The authors conclude that the firearm industry is not entitled to coverage for lawsuits that attack the manner in which it does business and predict that the firearm industry's demands for coverage of gun liability claims will continue to be hotly disputed.

LIFE INSURANCE

Semin Park, *Going Public and Listing of Life Insurance Companies on Stock Markets and Profit Sharing in Korea: A Legal Study,* 14 COLUM. J. ASIAN L. 129 (2000).

This Article analyzes the contentious debate surrounding the issue of listing life insurance companies on the Korean stock exchange and concludes that the stock from these companies should be listed on the exchange.

Park explains that listing life insurance companies on the Korean stock exchange has been a hotly debated issue because the Korean financial system traditionally has been largely government controlled. As a result of this control, the issuance of public stock for these companies has raised a number of difficult issues. Essentially these problems can be distilled down to one: the corporate structure of the life insurance companies. The government has recently allowed these companies to take the form of corporations, but traditionally they have been structured as mutual companies. The difference between these two forms is that corporations

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are forms to facilitate profit-making activity and provide dividends for shareholders, whereas mutual companies were designed to provide low cost life insurance for its members. The primary legal issue, then, is whether shareholders or subscribers should benefit from the resulting marginal profit if stocks are listed. The marginal value is the difference between the pre-listing, and post-listing value of the stock. As mentioned, Korean life insurance companies take the form of mutual companies, but are increasingly being organized as corporations. Therefore, as mutual companies the subscribers should benefit from any increased value of the company, but under a corporate scheme, the shareholders benefit.

Moreover, serious practical problems exist with listing life insurance stocks. Because Korea has never publicly listed life insurance companies, significant differences of opinion may exist regarding the proper price of the stocks. Park concludes both that Korean life insurance company stocks should be made public and that the marginal profit should go to the shareholders.

MARINE INSURANCE

Peter Nash Swisher, *Insurance Causation Issues: The Legacy of* Bird v. St. Paul Fire & Marine Ins. Co., 2 NEV. L.J. 351 (2002).

This Article analyzes the evolution of legal causation from its hybrid tort and insurance origins and discusses the effect that Benjamin Cardozo's seminal causation decisions have on present-day insurance law.

Swisher begins with a discussion of the tort law foundation to legal causation, exploring the origins of causation in fact ("but for" causation) and proximate (or legal) cause. After outlining such conceptions as foreseeability, duty, breach, and damages as developed in Cardozo's *Palsgraf v. Long Island Railroad Co.*, 162 N.E. 99 (1928) and other prominent cases, Swisher turns to the issue of legal causation in insurance law. Swisher notes important differences between the conception of causation in tort law and in insurance law. While in the tort law context, a plaintiff must prove by a preponderance of the evidence that the defendant owed a duty to the plaintiff, that he breached that duty, that his breach caused the plaintiff's damages, and that actual damages resulted, in the insurance law context, one must consider the coverage provisions of the policy, the occurrence of the event, the loss or damage, and the "connector" between the event and the loss. Swisher comments that what *Palsgraf* is to tort law, *Bird v. St. Paul Fire & Maine Ins. Co.*, 120 N.E. 86 (N.Y. 1918) is to insurance law.

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In *Bird*, the plaintiff's vessel was damaged by a concussion of air that was caused by an explosion some thousand feet away, that in turn was caused by a fire that was caused by an earlier explosion, which was caused by a fire that resulted from an unknown cause beneath some railroad freight cars. At issue in the case was whether the $675 loss suffered as a result of the second explosion was covered under the for insurance policy provisions. Cardozo found for the defendant insurer in accordance with the reasonable expectations of the contracting parties, rather than the objective, direct-versus-indirect, foreseeability tort test. However, such a determination is based, in part, on proximity and remoteness and, as such, Cardozo did not completely abandon tort law principles.

Next, Swisher considers whether, after *Bird*, the necessary causal nexus must be the "immediate" cause of the loss or whether it can also be the "efficient" proximate cause in the context of an insurance claim. He argues that courts be permitted to apply either rule according to which would provide coverage in a contract dispute. Similarly, Swisher explores multiple concurrent causation issues. He contends that the best approach to concurrent causation is to require the finding of a covered dominant or predominant cause, as that method accounts for both the insurer's contractual rights as well as the insured's reasonable expectation of coverage. Swisher then contends that, in accordance with *Bird*, courts ought to able to recognize either a "substantial" or a "sufficient" causal nexus test when justice and equity so require. Lastly, Swisher discusses coverage for acts "expected or intended" by the insured, noting that the courts have split regarding this determination. In conclusion, Swisher argues that regardless of the standard chosen, a court must employ rules with flexibility in order to validate the reasonable expectations of the contracting parties.

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