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FEAR IS THE KEY: A BEHAVIORAL GUIDE TO UNDERWRITING CYCLES

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INTRODUCTION

Connoisseurs of espionage thrillers will note the homage to a giant of that genre, Alistair MacLean, that lurks in the title of this study of underwriting cycles. MacLean, who wrote such classics as *The Guns of Navarone*[1] back in the fifties and sixties, titled one of his lesser-known tales *Fear is the Key*.[2] In borrowing his title, I hope in this article to

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1. ALISTAIR MACLEAN, THE GUNS OF NAVARONE (Doubleday ed. 1957).
2. ALISTAIR MACLEAN, FEAR IS THE KEY (Doubleday ed. 1961).

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highlight an aspect of underwriting cycles that has been little discussed in the literature of insurance: namely, the role played in creating underwriting cycles by the motivations and attendant behaviors of the thousands of people who daily participate in the insurance market.[3]

An "underwriting cycle" has been defined as the:

> tendency of property and liability insurance premiums, insurers' profits, and availability of coverage to rise and fall with some regularity over time. A cycle can be said to begin when insurers tighten their underwriting standards and sharply raise premiums after a period of severe underwriting losses. Stricter standards and higher premium rates often bring dramatic increases in profits, attracting more capital to the insurance industry and raising underwriting capacity. On the other hand, as insurers strive to write more premiums at higher levels of profitability [following a hard market], premium rates may be driven down and underwriting standards relaxed in the competition for new business. Profits may erode and then turn into losses if more lax underwriting standards generate mounting claims. The stage would then be set for the cycle to begin again.[4]

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3. The author has observed insurance market behavior from three distinct vantage points during a twenty-year career in the insurance field. First, in private law practice, he litigated insurance coverage cases both for and against insurers in the context of "mass tort" events including asbestos-related injuries, environmental liability, and savings and loan failures. Upon leaving private practice to enter the insurance business, he joined Executive Risk Inc., a specialty professional liability carrier formed in response to the hard market of the mid-1980s which quickly grew to become one of the top three writers of directors and officers—or "D&O"—insurance worldwide. Executive Risk was acquired by the Chubb Corporation in 1999, and thereafter Mr. Fitzpatrick served for several years as chief underwriting officer of Chubb's executive and professional liability division, Chubb Executive Risk. Chubb, established in 1882, is the 12th largest property and casualty insurer in the United States.

4. HARVEY W. RUBIN, BARRON'S DICTIONARY OF INSURANCE TERMS 436 (Barron's ed., 1995) (1987). One industry observer has divided the underwriting cycle into three typical phases, beginning at the "top" of a cycle: (i) the "reunderwriting phase," when companies coming to terms with prior years' losses impose strict new underwriting and pricing controls; (ii) the "competition phase," when insurers—confident that they have overcome their past underwriting deficiencies—aggressively seek market share, and (iii) the "crunch phase," when profit margins already undermined by excessive competition are compounded by an extraordinary loss event, leading to market contraction and a return to the reunderwriting phase. *See* Barbara D. Stewart, *Profit Cycles in Property-Liability Insurance, in* 1 ISSUES IN INSURANCE 301-05 (John D. Long & Everett D. Randall eds., Am. Inst. For Prop. & Liab. Underwriters 1984).

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While all businesses are cyclical to some extent in a market economy, it has been observed that cycles in the property-casualty insurance industry do not coincide with the general business cycle, nor are they reliably contracyclical.[5] Indeed, insurance cycles reflect more volatility than other business cycles; that is, they have "higher highs" and "lower lows."[6] It is this relative volatility that produces the regular "crises" in various insurance markets (e.g., medical malpractice) that seem not to lose their capacity to shock a consuming public long inured to the general business cycle.

Traditional analyses of underwriting cycles have—not surprisingly—addressed the phenomenon from the perspective of economics. But, while economics has much to teach us about the nature and mechanics of underwriting cycles, it is less successful in tracing the fundamental causes of the behaviors it describes.[7] One economist put her finger on the problem twenty years ago when she noted in this context that "insurance supply is as psychological as it is financial."[8] Thus, although psychologists and sociologists may dispute precisely whose turf is to be traversed in seeking to determine the influence of basic emotions—including fear[9]—on behavior in the insurance market, it is to this unfamiliar ground that the student of underwriting cycles must turn to gain a complete understanding of the phenomenon.[10]

Note, by the way, the reference to "underwriting cycles" in the plural, as speaking of "an" underwriting cycle is clearly a misnomer. There are, in fact, as many underwriting cycles as there are products in the property and casualty insurance market.[11] Some cycles proceed independently of one

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5. Stewart, *supra* note 4, at 294-95.

6. *Id.* at 295 (citing Exhibit 5-9). The relative volatility of profit cycles in the insurance business is perhaps not surprising when we reflect that consumers of commercial insurance purchase the product specifically to shift financial volatility from their own businesses. *See also* William Wilt, et al., *Leverage in All the Right Places,* REINSURANCE: GLOBAL INSIGHTS, Oct. 1, 2003 at 4, 7.

7. *See* Tom Baker, *Insuring Liability Risks, in* 29 THE GENEVA PAPERS ON RISK AND INSURANCE 99-100 (Jan. 2004).

8. Stewart, *supra* note 4, at 291.

9. *See, e.g.*, Andrew Tudor, *A (Macro) Sociology of Fear?*, THE SOCIOLOGICAL REVIEW, 238, 241-46 (May 2003).

10. That the author is neither an economist, a psychologist, nor a sociologist may be taken as either proof of the benefits of a liberal arts education or yet further evidence of the hubris of lawyers. The reader may decide.

11. *See* Stewart, *supra* note 4, at 305 ("While every profit cycle goes through three phases . . . not every line of insurance experiences the same phase at the same time."); *see also* Roberta Romano, *What Went Wrong with Directors' and Officers' Liability Insurance?*, 14 DEL. J. CORP. L. 1, 2-3 (1989) (observing, *inter alia*, the inapplicability of

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another—it would, for example, be difficult to draw a direct connection between the recent securities litigation-induced hard market in directors and officers (D&O) insurance and the mold-driven tightening of the homeowners insurance market. Other cycles will be linked. For example, there has historically been a predictable lag between hard D&O insurance markets and hard markets in errors and omissions (E&O) insurance for law and accounting firms, because malpractice claims against professionals will typically be asserted only after underlying D&O suits against their corporate clients have been resolved.[12] The frequency and depth of underwriting cycles will differ based on a variety of product specific factors, such as developments in particular areas of the law and the length of time it takes for claims to mature under a particular coverage—the so-called "tail."[13] But, before considering further the specific properties of underwriting cycles, let us first consider the existing literature in this area.

I. Traditional Views of Underwriting Cycles

Most explanations of the property-casualty underwriting cycle take a deterministic approach – viewing the insurance market as responding to abstract economic forces.[14] These explanations tend to focus on three features of insurance economics. First, many commentators have observed that the insurance industry defies the expectation of elementary economics that markets will swiftly move toward equilibrium through the dynamics of supply and demand because insurers cannot determine their "cost of goods sold"—that is, the total of their claims and other expenses—until after, and in some cases until *long* after, they have priced and sold an insurance

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portions of the literature of general liability underwriting cycles to explain cycles in D&O liability insurance).

12. *See* Thomas M. Hamilton & Ronald E. Mallen, *The Market Place: The Year in Review*, LAW OFFICE GUIDE TO PURCHASING LEGAL MALPRACTICE INSURANCE 1 (2002) (summarizing the perceived causes of the "unusually hardening market" in lawyers' malpractice insurance).

13. *See* Scott E. Harrington & Patricia M. Danzon, *The Economics of Liability Insurance*, *in* HANDBOOK OF INSURANCE 291-92 (Georges Dionne ed., 2000). A number of insurance product cycles may coincide closely enough, however, to create a "hard market" generally discernible to consumers of insurance. A wave physicist would presumably describe this phenomenon as one of "constructive interference." The author acknowledges, however, that he is no more a physicist than he is an economist, a psychologist, or a sociologist.

14. *See* Ralph Winter, *The Insurance Cycle: An Economist's Perspective*, 274 ETUDES ET DOSSIERS 21- 28 (2003); Scott E. Harrington & Greg Niehaus, *Volatility and Underwriting Cycles*, *in* HANDBOOK OF INSURANCE 657 (Georges Dionne ed., 2000).

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policy.[15] Second, analysts of underwriting cycles point to the impact of interest rates on pricing in the insurance market. Because investment income on reserves makes up a significant portion of insurance company earnings, insurance prices will increase in a period of declining interest rates as insurers seek to offset shrinking investment income with larger underwriting margins.[16] Economists of this school also note the impact of "capital shocks," *i.e.*, large claims causing rapid, unanticipated impairment of the capital bases of insurers.[17] Third, commentators have posited that expansions and contractions of *reinsurance* capacity, that is, in the secondary market where primary insurers seek to spread the risks they underwrite, are a significant contributor to underwriting cycles.[18]

A. The Pricing Problem and the Winner's Curse

The inability of insurers to calculate their "cost of goods sold" at the time they price their products is perhaps the most fundamental factor distinguishing the insurance market from other markets. It is also the least understood by consumers of insurance. The implications of this "pricing problem" are far-reaching; indeed, it all but guarantees that pricing volatility and periodic constrictions of supply will be inevitable in the insurance market, as insurers react to unforeseen changes in the underlying liability environment that affect policies written in earlier periods, or simply to having "guessed wrong" in their pricing in a stable liability environment.[19]

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15. *See* Robert F. Wolf, *Actuary Counters Hunter on Med Mal Insurance Crisis*, NAT'L UNDERWRITER, Nov. 11, 2002, at 10.

16. *See* Tom Baker, Research on Medical Malpractice: Implications for Tort Reform in Connecticut at 11 (Jan. 2, 2003) (unpublished report for Connecticut Trial Lawyers Association). Of course, another way of looking at this dynamic is to observe that insurers periodically pass on the benefits of increased interest rates to consumers in the form of lower premiums.

17. *See, e.g.*, Harrington & Niehaus, *supra* note 14, at 669-70.

18. *See, e.g.*, Hamilton & Mallen, *supra* note 12, at 2; Romano, *supra* note 11, at 18-19.

19. In his recent Geneva Lecture, Professor Tom Baker cataloged the many types of uncertainty, or risk, that must be taken into account by insurers facing the "pricing problem." These include:

(1) "baseline risk," which is the existing risk of loss based on past experience, assuming no change; (2) "developments risk," which is the risk relating to developments that change the rate or cost of loss during the insured period; (3) "contract risk," which is the risk relating to the drafting and interpretation of insurance policies; and (4) "financing risk," which is the risk relating to changes in investment performance and the insurance pricing cycle.

Baker, *supra* note 7, at 129-30. Each of these main categories of risk has subsets, of course, further compounding the challenge posed to insurers by the "pricing problem." For

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One upshot of the "pricing problem" is that insurers repeatedly rob the Peter of their present risk pool to pay the Paul of some prior year's pool whose premiums turned out to be insufficient to fund its liabilities. This process also works in reverse, of course, when insurers' actual experience is *more favorable* than anticipated, allowing them to release excess reserves to offset poor results experienced in later periods – robbing Paul to pay Peter in this instance. To put it another way, the risk spreading function of insurance has a temporal aspect as well as its more familiar "horizontal" one.[20] But the bottom line is that pricing uncertainty, and hence variability of supply, are built into the very nature of insurance.

The impossibility of calculating a "correct" price at the time of sale of a product whose ultimate cost will be affected by future events, coupled with the commoditized nature of insurance products, also creates perfect conditions for the so-called "Winner's Curse." The Winner's Curse is an economic theory hypothesizing that the winning participants in an auction will typically pay too much for the auctioned item – or, in the insurance context, charge too little to win a customer – because the nature of an auction is to favor the bidder with the most optimistic assessment of the value of the underlying asset.[21] As we will see, the insurance market – particularly in "long tail" lines of business – is particularly fertile ground for instances of the Winner's Curse.

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example, Professor Baker lists the following subcategories of "developments risk" alone: (i) injury developments risk, (ii) injury cost developments risk, (iii) standard of care developments risk, (iv) legal developments risk, and (v) claiming developments risk. *Id.* at 130-38.

20. Temporal risk spreading is another little understood aspect of insurance markets, and the capital allocation decisions that underlie them. As Professors Harrington and Danzon have observed:

Increases in risk associated with changes in tort liability rules, proclivities to bring suit, and other factors require insurers to hold more capital to be equally safe. Total capital costs increase as more capital is held, thus providing a positive link between increased risk of claim cost forecast error and prices. Increased risk of forecast error for liability insurance claims need not imply that liability insurance necessarily requires more capital than certain other types of coverage. For example, the long-tail associated with liability claims may allow insurers time to respond gradually to unexpected increases in costs, an option not available for catastrophe property losses. A key point, however, is that intertemporal increases in risk for a line of business will increase the amount of capital and price needed to offer coverage in that line.

Harrington & Danzon, *supra* note 13, at 292.

21. *See, e.g.*, Jeremy Bulow & Paul Klemperer, *Prices and the Winner's Curse*, RAND JOURNAL OF ECONOMICS (2002).

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B. The Interest Rate Problem and "Capital Shock" Theory

As is perhaps obvious from the foregoing, the "interest rate problem" is related to, and indeed an element of, the "pricing problem." Insurance companies invest the bulk of premiums collected as reserves against "incurred but not reported" claims; such invested reserves are universally known by the acronym "IBNR." It often surprises insurance consumers to learn that interest income earned on such investments typically dwarfs actual underwriting profits (*i.e.*, premiums collected less claims payments and other expenses) in generating the earnings of an insurance company, and that many insurance companies prosper for years on end while consistently producing underwriting losses. Indeed, the affinity of financial sage Warren Buffet for insurance company investments is entirely attributable to his recognition that IBNR reserves generate a substantial "float" that can be positively arbitraged through prudent investing.[22]

It is the very importance of investment income in determining the success or failure of an insurance company that raises the "interest rate problem" – what Professor Baker refers to as "financing risk"[23] – to the status of a prime mover in the dynamics of underwriting cycles. Insurers, whether stock companies or mutual organizations, must generate return on their capital and invested reserves in order to survive over the long term.[24] Thus, unforeseen changes in the investment environment will have a disproportionate impact on their market behavior. Put simply, insurers faced with diminishing investment returns will be forced to create greater underwriting margins through rate increases or toughened underwriting standards in order to generate earnings. Thus, the "interest rate problem" can be a significant contributor to a "hardening" period in the cycle, just as unexpectedly robust investment returns (as in the mid-1990s) can extend a soft portion of the cycle by propping up companies with poor or negative underwriting margins.

In the same way that unforeseen decreases in investment returns can create a "crunch" in the cycle, events leading to unexpected impairment of

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22. *See* BERKSHIRE HATHAWAY INC., 2002 ANNUAL REPORT 7-8 (2003).

23. Baker, *supra* note 7, at 98-100.

24. Although it may seem theoretically possible that a company with extraordinary underwriting margins could prosper notwithstanding substandard investment income, low barriers to entry in the insurance market will attract new capital to any line of business that can sustain pure underwriting profitability for any length of time, driving prices – and underwriting margins – down. *See generally* Stewart, *supra* note 4, at 290-301. Investment income, for better or worse, is vital if an insurer is to generate relatively steady returns to either investors (in the stock company setting) or policyholders (in the mutual company setting) over the long term.

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the insurance industry's capital base have also been identified as catalysts for market contractions. Because regulators and rating agencies require that liability insurers maintain certain fixed premium to capital (or "surplus") ratios, capital impairments caused by extraordinary losses not otherwise reserved for will leave insurers no choice but to restrict their available capacity until new capital can be raised. While perhaps not the cause of underwriting cycles in and of themselves, so-called "capital shocks" often serve to set off, or at least to hasten the arrival of, a hard portion of the cycle.[25] The September 11 attacks have become the paradigmatic example of this phenomenon,[26] although industry observers correctly note that the "hard" market cycle of 2001-2002 was already in progress prior to September 11, 2001;[27] the catastrophic losses suffered on that date simply accelerated and heightened the peak of that portion of the cycle.

C. Reinsurance as a Contributor to Underwriting Cycles

The last of the traditional explanations for underwriting cycles is the most circular in its reasoning. Numerous commentators have identified expansions and contractions in *reinsurance* capacity as a powerful force in driving underwriting cycles.[28] The most compelling support for this hypothesis was provided in 1994 by Professors Harrington and Danzon, whose research indicated that moral hazard in the form of the ability of primary insurers to shift losses to reinsurers could be correlated with price-cutting behavior in the primary market.[29]

While it is certainly true that primary insurance markets react to expansions and contractions in available reinsurance capacity, the flaw in this theory is that reinsurance markets, like the primary insurance markets they support, are cyclical and, indeed, react to the same economic (and behavioral) forces that drive underwriting cycles in the primary insurance market. In other words, the reinsurers are part of the larger insurance market—not an external agency acting on that market. Moreover, underwriting cycles in the reinsurance market do not maintain a predictable sequential relationship with cycles in the primary market—that is, they do

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25. *See, e.g.*, Winter, *supra* note 14, at 27; Harrington & Niehaus, *supra* note 14, at 669-73; Stewart, *supra* note 4, at 304.

26. *See* Winter, *supra* note 14, at 28.

27. *See, e.g.*, Wilt, *supra* note 6, at 7; WINTER, *supra* note 14, at 26.

28. *See, e.g.*, Hamilton and Mallen, *supra* note 12, at 2; ROMANO, *supra* note 11, at 18-19.

29. Scott E. Harrington & Patricia M. Danzon, *Price Cutting in Liability Insurance Markets*, 67 THE JOURNAL OF BUSINESS, Oct. 1994, at 530.

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not always precede them, as a "causal" relationship would require.[30] On balance, reinsurers are best viewed as joint venturers with the primary insurers they support, sometimes winning and sometimes losing in the bargain, but certainly not an independent force in the generation of underwriting cycles.

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In June of 2003, the U.S. General Accounting Office issued a report seeking to explain the recent contraction of capacity in the medical malpractice insurance market.[31] In its findings, the GAO invoked all of the theories discussed above. Specifically, the GAO found that increasing claim costs, and the difficulty faced by insurers in predicting ultimate losses (that is, the "pricing problem") "appeared to be the greatest contributor to increased premium rates" in the period 1998-2001.[32] The GAO also identified as secondary but contributing causes (i) decreasing investment income on insurers' portfolios (the "interest rate problem"), (ii) vigorous competition for market share leading insurers to under-price their policies (the "winner's curse"), and (iii) increasing reinsurance costs.[33] But the GAO's analysts, like the economists and industry observers who preceded them, concentrated on the "proximate" causes of the medical malpractice crisis, without delving more deeply to discover what might be called the "ultimate" causes. Put another way, the GAO study accurately reported *what* had occurred in the medical malpractice market and described the mechanics of *how* it had occurred, without finally addressing the more fundamental question: *Why*? It is this question that the next section will seek to address.

30. *See* Wilt, *supra* note 6, at 6 ("[a]s a point of interest, the fact that primary markets turnd before the reinsurance industry [prior to 9/11] defies conventional industry norms. Traditionally, changes in reinsurance capacity have driven the primary markets (the 'tail wagging the dog' phenomenon.')."). The Morgan Stanley analysis includes a chart comparing the primary and reinsurance market cycles in casualty insurance from 1988 through 2004, demonstrating graphically the absence of a predictable cause and effect relationship between the two. *Id.* at 7, exhibit 6.

31. U.S. GENERAL ACCOUNTING OFFICE, PUB. GAO-03-702, Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates (June 2003) (hereinafter "GAO Report").

32. *Id.* at 4.

33. *Id.* at 4-5.

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III. A Behavioral Approach to Underwriting Cycles

Although the traditional economic explanations of underwriting cycles add to our understanding of the phenomenon, as explanations for the cyclical nature of insurance markets they go only so far. Proponents of the interest rate school may, for example, point to data indicating that absolute levels of liability have remained constant over time in a particular area such as medical malpractice as proof of their thesis, but this assertion overlooks the fact that individual insurers each view the world from a particular point on the continuum of market participation, and each is either benefited or burdened by its relative position.[34] In the same way, pricing uncertainty arises even in long-established lines of insurance, not only from changing conditions in the underlying environment, but also from the fact that different market players have different levels of access to relevant loss data and different approaches to assessing future risk.[35]

But, while identifiable phenomena such as the "pricing problem" and the "interest rate problem" can be viewed as immediate causes of the unusual volatility of liability insurance markets, other forces are at work at a more basic, behavioral level – forces that are given particular reign by the lack of certainty inherent in pricing a product designed to indemnify unpredictable future losses. First and foremost is competition for revenue and market share, which as a practical matter drives the day-to-day behavior of underwriters to a far greater degree than concerns with ultimate profitability. Underwriters – like everyone else in business – are motivated by (i) the desire for financial reward and (ii) fear of losing employment or opportunities for advancement. And, during all but the absolute peaks of the underwriting cycle, underwriters are evaluated according to the amount of premium they can generate.

The second factor is what can best be described as the ebb and flow of bureaucratic influence within an insurer that accompanies shifts in perceived profitability. The third factor is the influence of insurance agents

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34. As noted above, *supra* note 20, insurers may, by virtue either of their mix of business or the relative level of impairment of their capital by "legacy claims" in areas such as asbestos, enjoy advantages over their competitors in terms of their capital adequacy. *See* Harrington & Danzon, *Economics of Liability Insurance, supra* note 13; *Cf.* Wilt, *supra* note 6, at 5-6 (discussing the impact of rating agency downgrades of established property reinsurers on their competitive position in relation to new market entrants).

35. *See* Harrington & Danzon, *Price Cutting in Liability Insurance Markets, supra* note 29, at 520-22, 530-31 (theorizing, correctly in the author's view, that "heterogeneous information" available to individual insurers will lead to downward pressure on prices and the "winner's curse" effect, but noting that their empirical research failed to support this hypothesis).

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and brokers on the pricing behavior of insurers, and the consequences of that influence.

A. *Compensation Structures and Underwriting Cycles: It's About the Bonuses, Stupid!*

It bears pausing here to reiterate this rather striking fact: insurers typically compensate underwriters – that is, the analysts who determine which risks will be insured and (to varying extents) what rates will be charged – primarily on the basis of the premiums they generate (the "top line"), rather than on the ultimate profitability of the books of business they produce (the "bottom line"). There are many understandable reasons for this, most obviously the difficulty of motivating and retaining key personnel with promises of compensation payable – if at all – years in the future. Of equal significance, it must be observed, is that insurance companies themselves have incentives to maximize top-line growth in the short term, as will be discussed in the next section. In any event, the upshot is that insurance companies tend under normal circumstances to create powerful incentives – namely, the "carrot" of increased salary, bonus compensation, and promotion, and the "stick" of career stagnation or outright job loss – for underwriters to sell as many policies as possible at whatever price the market will bear.

This disconnect between the incentives provided to underwriters and the long term interest of the insurer (and its capital providers) in generating *profitable* premium growth is a key element in creating market cycles. Many companies seek to mitigate this tension by designing long-term incentive compensation plans for underwriters that are tied to profitability, but such speculative potential compensation does little to motivate the vast majority of underwriters. First, underwriters – like most people – are more sensitive to short-term incentives (Will I get a year-end bonus? Will a poor annual review cost me that promotion?) than they are to more speculative, deferred benefits. Moreover, the structure of the employment market in property-casualty insurance provides regular opportunities for "good producers" to move from company to company in search of greener financial pastures. In fact, the absence of significant barriers to entry in the insurance market[36] makes for a robust employment environment and all but guarantees that an underwriter can parlay a talent for short-term premium production into a series of ever higher paying jobs at different companies.[37]

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36. Stewart, *supra* note 4, at 288-89.

37. *Cf.* Wilt, *supra* note 6, at 8, 16 (noting the "transportability of underwriting teams" as contributing to the concerns of rating agencies with the long-term profitability prospects

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Thus, short term incentives to produce top-line growth and a "sellers'" job market combine to ensure that few underwriters in long-tail lines stay in one job long enough to suffer for, or even learn from, their past mistakes.

Cynics in the insurance industry call this the "write and run" phenomenon. More serious, however, is the recognition that George Santayana's observation that "[t]hose who cannot remember the past are condemned to repeat it"[38] might well have been coined to describe the insurance market.

B. Profitability and Power

A similarly unrecognized, but important, contributor to the dynamics of underwriting cycles is the ebb and flow of bureaucratic power among various constituencies within insurance companies that attends changes in perceived profitability. For our purposes, three functions that exist within every insurer must be considered: underwriters, claims adjusters, and actuaries. Underwriters, as noted above, write the policies and make risk selection and pricing decisions at the "micro" level.[39] Claims adjusters deal with insureds – and tort plaintiffs in the context of third-party liability coverage – and are the first to see the results of the coverage decisions made by the underwriters. Actuaries are charged with setting prices for a company's insurance products (subject to regulatory parameters) at a "macro" level, as well as analyzing the financial results of the risk selection, rating, and claims expense management efforts of the underwriters and claims adjusters.[40] Not surprisingly, each group tends to view the world from a particular perspective, and the relative influence of each group on the senior management of an insurer will significantly influence that insurer's corporate behavior.

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of the reinsurance industry as well as the threat to disciplined underwriting caused by the tendency of underwriters "to make the rounds from company to company").

38. GEORGE SANTAYANA, THE LIFE OF REASON: INTRODUCTION AND REASON IN COMMON SENSE 284 (Charles Scribners Sons 2d ed. 1905).

39. While underwriters typically must price policies according to "rating plans" approved by state insurance regulators, they retain discretion to apply various "rating modifiers" to individual insureds and thus make material pricing distinctions among them.

40. For the purposes of this discussion, I have not explored the additional layer of tension that exists in insurance companies between so-called "pricing actuaries" – who are operationally aligned with the underwriting function – and so-called "reserving actuaries" – who are operationally aligned with the claims function. Although it is difficult to generalize from company to company, it would be consistent with my analysis to posit that pricing actuaries will be relatively empowered in periods of perceived profitability while reserving actuaries will gain relative influence as results are seen to deteriorate.

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1. Perspectives on Profitability: Accident Year vs. Calendar Year Analysis

It is crucial to understand, in this context, that insurance companies measure profitability from several viewpoints – most importantly from the perspectives of "accident year" and "calendar year" results. In an "accident year" analysis, losses are matched to premiums written in the year those losses arose. In "calendar year" analysis, however, losses incurred (that is, paid or reserved) in a given year are netted against premiums earned in that same year, irrespective of when the losses being paid first arose.[41] Simplistically speaking, an underwriter or actuary will look to accident year results to determine how profitable a line of business has been, while a chief financial officer or a shareholder will look to calendar year results to determine how a company is doing from a purely financial perspective in the current period.

Of course, it doesn't take our friend Warren Buffet to figure out that the two views may yield very different answers to the question: How are we doing? – depending on the growth characteristics of a book of business.[42] For example, a company which is growing its premium base quickly can continue to report positive calendar year underwriting results – for a while anyway – even if its accident year results from prior years are deteriorating, because the old losses are being compared to the current

41. A third perspective—"policy year" analysis, wherein losses incurred in a given year are matched to premiums for *policies written* in that year—is also utilized by insurers, particularly in estimating a "rate need" or "rate redundancy" to be expected in the insurer's going forward business.

42. In this context, the *GAO Report* similarly observes:

Paid and incurred losses give different pictures of an insurer's loss experience, and examining both can help provided a better understanding of an insurer's losses. Paid losses are the cash payments an insurer makes in a given year, irrespective of the year in which the claim giving rise to the payment occurred or was reported. Most payments made in any given year are for claims that were reported in previous years. In contrast, incurred losses in any single year reflect an insurer's expectations of the amounts that will be paid on claims reported in that year. Incurred losses for a given year will also reflect any adjustments an insurer makes to the expected amounts that must be paid out on claims reported during previous years. That is, as more information becomes available on a particular claim, the insurer may find that the original estimate was too high or too low and must make an adjustment. If the original estimate was too high, the adjustment will decrease incurred losses, but if the original estimate was too low, the adjustment will increase them.

GAO Report, *supra* note 32, at 16. The GAO's comment, although focusing on the difference between "paid" and "incurred" loss rather than on the "calendar" vs. "accident" year distinction discussed above, also captures the analytical disconnect that can occur as insurers view their results from different perspectives. The GAO's observation also captures the "temporal" risk spreading phenomenon discussed above, *supra* note 31.

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period's larger premium base. A company whose premium base is shrinking, on the other hand, will be saddled with untenable calendar year results even if its accident year results are improving. This creates a significant disincentive for companies to shrink their books of business even when that would seem to be the prudent course from a pure underwriting perspective, as if demands of investors for continuing revenue and earnings growth were not already a sufficient disincentive. Another source of the incentive for insurers to promote top-line growth, even at the expense of long-term profitability, is investment income generated by increased cash flow.[43] Coupled with the opportunities for such income, the calendar year orientation of financial reporting provides strong bureaucratic leverage to the growth-oriented underwriting camp.

2. Bureaucratic Power and Underwriting Cycles

It will surprise no one to learn that, on the continuum of optimism and pessimism, underwriters occupy "glass half-full" territory while claims adjusters are the guardians of the "glass half-empty." Actuaries, interestingly, occupy an uneasy middle ground, professionally inclined to demand a level of statistical certainty that is anathema to the underwriter facing a premium budget, but more confident of the possibility of calculating a "correct" price that will allow the insurer to prosper notwithstanding a challenging loss environment than the perpetually embattled, and congenitally skeptical, claims adjuster.[44]

Given the range of financial perspectives discussed in the previous section, it is not surprising that representatives of the more "conservative" functions within an insurance company – claims adjusters, for example – are relatively less empowered so long as calendar year results remain good. It would take a brave claims manager indeed to cry "stop" when an insurance company is reporting excellent financial results and investors are expecting continued earnings growth (and senior managers' big bonuses are tied to those results). And those who do take the risk may lack the bureaucratic influence to carry the day. Claims adjusters are further hampered by the necessarily "anecdotal" nature of their observations; that is, their experience occurs at the level of individual cases and may be dismissed as aberrational.

As for actuaries, their institutional confidence is hampered by the fact that their profession, so scientific in its approaches and language to a

43. *See* Stewart, *supra* note 4, at 292-301 (producing actual, as opposed to apparent, economic profit).

44. There are, of course, exceptions to this simplistic categorizing. Indeed, the author acknowledges that some of his best friends are claims adjusters and actuaries.

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layperson, is at root a form of disciplined speculation—far more art than science.[45] As one actuary has observed, "[W]hile actuarial science has all the trappings of science, for example, formal classification rules and quantitative analyses, it is best seen as providing a framework for a 'guessing game' . . . You know you're going to be wrong from the start . . . You want to be least wrong."[46] Sadly, it is the essence of the "pricing problem" that an actuary cannot assess the correctness of her company's pricing with any assurance until it is too late to save a particular underwriting year's results. Thus, much like their colleagues in claims, actuaries tend to find their most confident voice, as well as their greatest bureaucratic influence, when a sustained period of under-pricing has created a crisis of profitability that cannot be obscured even by a focus on calendar year results.

C. The Influence of Insurance Brokers on Cyclicality

There is one other player whose influence on the cyclical nature of insurance markets cannot be overlooked: the insurance agent or broker.[47] It sometimes escapes notice that insurance is a product delivered almost exclusively by intermediaries who have relatively little stake in the long-term success or failure of a single provider. While in this sense insurance is no different from other "commodities" that are sold through intermediaries – think of the Green Giant peas you buy at the Stop & Shop – insurance is unique in having to balance intense downward pricing pressure imposed by intermediaries with a level of pricing uncertainty very different from that faced by the denizens of the Valley of the Jolly Green Giant.

The first priority of an independent insurance agency or brokerage is to obtain the "best deal" for their customer. Whatever an agent's or broker's legal relation to the underwriting carrier they are motivated, in practical terms, by the fear that they will lose their customer to another agent or broker who can deliver the same coverage at a lower price.[48] Thus, the

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45. *See* RICHARD V. ERICSON ET. AL., INSURANCE AS GOVERNANCE 157-65 (Univ. of Toronto Press 2003).

46. *Id.* at 158.

47. Some insurance intermediaries in the property-casualty industry are denominated as "agents" of the underwriting company, while others are denominated as "brokers" who represent the insured. As a practical matter, the line between the two is extremely blurry and insurance intermediaries of all kinds face substantial competitive pressure to seek adequate coverage for their customers at the lowest price available. For purposes of this analysis, the terms may be considered interchangeable.

48. Although insurers seek to motivate agents and brokers to place business with them through incentive compensation agreements of various kinds, these do not (and should not)

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influence of brokers in the insurance marketplace almost guarantees that underwriters will err on the side of under-pricing their products, increasing the severity of pricing spikes when the real cost of the coverage is ultimately determined.[49] Brokers also effectively play insurance carriers against one another – indeed, they may be described as the true victors in the auction market they maintain, while only the Winner's Curse awaits the "successful" insuring bidder.[50]

D. Alpha and Beta: An Insurance Fable

Let us imagine a scenario that captures the dynamics described above. Alpha Insurance Underwriters is a newly-formed venture that is looking to capitalize on opportunities in a hard medical malpractice market, having viewed rates climb stratospherically during the past 12 months. It has developed a proprietary underwriting model that its founders, and their financial backers, believe will permit Alpha to outperform traditional medical malpractice underwriters and generate substantial underwriting profits, even at rates slightly below those currently available in the market. It hires a staff of underwriters and sends them out into the marketplace. Alpha also hires a chief actuary and chief claims officer, who have proven track records in other professional liability lines, but does not immediately

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overcome the fundamental identification of the intermediary with his customer. In addition, all insurance intermediaries, whether denominated as "agents" or "brokers," are concerned with the potential for professional liability claims by their customers, another factor which supports a pro-insured orientation.

49. *See* Bill Rigby, *Directors' Insurance Costs Soar for U.S. Firms* (Mar. 14, 2003), *available at* http://www.insurance-portal.com/031903directors.htm (last visited Feb. 15, 2004) (in the context of the recent hard market in D&O insurance, a representative of a major international broker recently observed without irony that "[t]here's no intense competition in terms of price. We're having difficulty filling out capacity." That the absence of current insurance capacity is a direct result of "intense competition in terms of price" in prior years is not addressed).

50. Indeed, so great is the interest of brokers in maintaining multiple sources of insurance capacity to leverage against one another that the larger brokerage firms have repeatedly led efforts to capitalize new insurers when periodic hard markets reduce too greatly the number of alternative carriers available. *See, e.g.*, Bloomberg News, *Axis Capital Shares Rise on Public Offering*, N.Y. TIMES, July 2, 2003, at C10, *available at* 2003 WL 58985883 (reporting on initial public offering of a Bermuda insurance company capitalized after 9/11 by Marsh & MacLennan Cos., the world's largest insurance brokerage firm); Beth Healy, *Reinsurer Files for IPO*, BOSTON GLOBE, Dec. 21, 2002, at C1, *available at* 2002 WL 101990209 (reporting on initial public offering of a Bermuda reinsurance company capitalized after 9/11 by Aon Corp., the world's second-largest insurance brokerage firm). *See also* Wilt, *supra* note 6, at 2 ("In the final analysis, we believe brokers' interests favor a robust market where power is not unduly concentrated in the hands of a few (witness the number of start-ups with significant broker backing)").

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staff up these functions. Alpha's underwriters are compensated according to production goals – the company believes that the rates derived from its underwriting model will take care of profitability over the long term.

All goes well for Alpha in the early years – premium writings grow substantially and IBNR reserves are booked according to the actuarial expectations built into the underwriting model. Brokers are eager to cultivate a new market, and so steer choice accounts to Alpha. Because Alpha entered the market while it remained "hard," it is able to offer a restrictive coverage form at the outset, although it grants a few minor coverage enhancements to bolster the company's competitive edge. Alpha's claim department slowly grows and case reserves are set as deemed appropriate, but few cases have yet reached the decisive stage. Even if interest rates remain low, Alpha's solid reported underwriting results generate better than average returns on equity. If interest rates rise, Alpha's returns only get better.

Meanwhile, across town, long-time medical malpractice insurer Beta Assurance Managers watches Alpha's progress with concern. Beta's entire management team was fired a year previously because of bad results in the medical malpractice line and only the extremely high prices now available in the market have convinced Beta's board of directors to allow its new management to continue writing the line. Beta's actuarial data indicates that in current marketplace conditions it can meet Alpha's prices and terms and hold its renewals with a bit of profit to spare, but there is little margin for error. Accordingly, Beta adopts a short-term strategy of meeting competition from Alpha, but the board insists on quarterly reports from Beta's chief actuary confirming that adequate margins are still available. Beta had already implemented a system of strict home-office control of underwriting authority when profit problems came to light last year, and it continues to require each of its branch operations to report weekly on renewal pricing movement.

Both Alpha and Beta benefit in the short term from tort reform efforts in several key states, which reduce average claims pay-outs in those jurisdictions. Alpha's management also takes comfort in the fact that Beta, a market leader with access to decades worth of claims data, has matched its rate and coverage concessions in the market. Beta, for its part, gradually loosens restrictions on its underwriters based on actuarial reports indicating that tort reform will relieve pressure on its underwriting margins. Over time, Alpha becomes emboldened by its positive profitability forecasts and – followed by Beta and other markets – begins to offer broader coverage and even, on occasion, to participate in subscription placements for larger clients written on a broad new wording created by a leading insurance

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broker. This allows Alpha to continue its impressive quarterly growth in the medical malpractice market.

A few years later, several developments occur. First, a number of Alpha's early claims have proceeded to trial and verdicts have been higher than anticipated. In a few of these cases, appeals to state supreme courts have yielded decisions effectively expanding the physician's standard of care to require consideration of new pharmaceutical treatments until recently considered experimental. Alpha's actuaries report that this new claims information will require them to revise their accident year projections for the past several years; it now appears that Alpha has lost money in all of the accident years since it entered the market. Fortunately, from a financial perspective, continuing strong growth in earned premium will generate acceptable calendar year results this year from the standpoint of Alpha's investors, so the company has time to fix the problem.

But Alpha's senior managers aren't taking any chances. They immediately reduce the underwriting authority of field underwriters and require a greater number of underwriting decisions to be made in the home office. They institute mandatory rate increases and limits reductions on all renewals – based on the calculations of the company's actuaries. Alpha scraps the coverage enhancement endorsements it had added over the past several years and categorically refuses to offer capacity on "broker forms." Compensation formulas for underwriters are adjusted to add a substantial profitability component. Alpha's claim department is expanded and a number of senior medical malpractice adjusters are recruited from Beta, to increase the level of experience in the department. Insured warranties in policy applications are subjected to intensive scrutiny to determine whether claims being filed with Alpha were in fact known of at the time coverage was bound, and so should be covered – if at all – by the prior insurance carrier. Given the fact that other markets are being impacted by the same legal developments, Alpha hopes to be able to recoup its accident year losses through these actions without losing significant business to its competitors, and thereby continue to grow in the market.

At the same time, Beta's management decides to exit the medical malpractice business entirely, having concluded that – notwithstanding periodic opportunities to obtain adequate rates – the long term profitability prospects for the line do not meet Beta's corporate ROE targets.

Beta's announcement of its exit from the market encourages yet another insurer, Delta Insurance Company, to enter the medical malpractice line, hiring a number of underwriters from Beta. As a new entrant, Delta's first priority is achieving critical mass in terms of premium, so the

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underwriters are offered rich incentive packages for success in moving former Beta accounts to Delta. And so it goes . . ..

This simple scenario – while fictitious – captures the dynamics of underwriting cycles as they play out at the operating level.[51] Note that all parties acted rationally based on the information available to them, the incentives provided, and the expectations of the constituencies they served. No one "cooked the books" for personal gain; no one made grossly negligent business judgments. What this hypothetical demonstrates, however, is that while pricing uncertainty, interest rate fluctuations, and developments in the legal environment all contribute to the timing and depth of underwriting cycles, cycles are at root the result of personal judgments – risk assessments if you will – made each day by individuals. Should we be surprised that the congenitally optimistic – and revenue producing – underwriting sector tends to trump the more fact-bound and pessimistic claims and actuarial functions in the strategic deliberations of insurance companies so long as financial results remain positive? If one places these questions in a human context, it becomes clear that underwriting cycles are first and foremost the result of the inconvenient collision of human nature with the essential indeterminacy of risk.

CONCLUSION

As noted earlier, some underwriting cycles are unique to a single company or market segment, and never rise to general notice. Only when a critical mass of companies find themselves at similar points in the cycle does a visible "hard market" emerge. And the increasing mobility of capital, coupled with low barriers to entry, all but ensures that such market constrictions will be fleeting, as new capital flows to take advantage of the pricing opportunities created by periodic supply constrictions in the market. Moreover, the uncertain nature of predicting risk all but guarantees that some capital providers will overestimate available returns and hence under-price their capacity.

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51. Interestingly, the decidedly unprepossessing Barron's Dictionary of Insurance Terms comes closer than many more formidable treatises to capturing the dynamic just described, observing in its definition of "underwriting cycle" that "as insurers strive to write more premiums at higher levels of profitability [following a hard market], premium rates may be driven down and underwriting standards relaxed in the competition for new business. Profits may erode and then turn into losses if more lax underwriting standards generate mounting claims." Rubin, *supra* note 5, at 498. If one simply replaces Barron's careful "mays" and "ifs" with "wills" and "whens," its definition is quite serviceable.

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At root, the so-called "pricing problem" is worthy of the name because the uncertainty inherent in matching insurance prices to expected losses creates an environment in which the motivations, ambitions, and fears of a complex cast of characters can play out. Uncertainty regarding long-term results allows the players most interested in short-term gain to dominate the action most of the time, interrupted only by periodic "crunches" when past pricing proves to have been based on overly-optimistic assumptions about the future. Supply and demand does the rest, and we are left with a market cycle of particular volatility.

How would we go about changing this dynamic if our goal was to smooth the more abrupt peaks and valleys of the underwriting cycle? One way, which a leading professional liability underwriter once suggested, would be to have every underwriter carry a "baseball card" showing their career profitability statistics.[52] Such a practice would, be assured, embarrass more than a few high-ranking insurance company executives.

Others have suggested that the mutual company form of organization is more supportive of effective underwriting than the stock company form, with its short-term growth and earnings pressures.[53] But the capital limitations on mutuals have raised significant operational challenges for them in trying to compete with stock P&C companies, so this does not seem to be a practical solution.[54]

In the absence of any kind of "silver bullet," the single best means of mitigating underwriting cycles would be to tie a more substantial portion of the overall compensation of underwriters, claims analysts, and actuaries – as well as the senior managers of their companies – to profitability achieved over time frames appropriate to their class of business.[55] This

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52. I am indebted to John Keogh, President of the National Union Fire Insurance Company, for this creative solution to the "write and run" problem.

53. *See* Harrington & Danzon, *The Economics of Liability Insurance*, *supra* note 14, at 292; *See generally* David Mayers & Clifford W. Smith, Jr., *Organizational Forms Within the Insurance Industry*, *in* HANDBOOK OF INSURANCE 689 (2000) (discussing impact of structure-based incentives on insurance company performance).

54. *See* Harrington & Danzon, *The Economics of Liability Insurance*, *supra* note 14, at 292.

55. In financial markets, hope seems to spring eternal that insurers can learn from past mistakes and adjust incentives to motivate underwriters to maintain pricing discipline even in the face of increasing competition. *See, e.g.*, William Wilt, supra note 6, at 16 ("[m]oreover, since underwriting teams seem to make the rounds from company to company, one must also accept that changes in underwriting and pricing discipline are possible through effective management, proper incentives, or appropriately wielded sticks (i.e., the risk of losing one's job)"). As an underwriter, and therefore an optimist, the author respects this impulse but suggests that the investment community remember a favorite Russian aphorism of former U.S. President Ronald Reagan: "Doveryai, no proveryai"

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might mean that underwriters in long-tail lines of business would have deferred compensation vesting five to seven years after a particular underwriting year. Obviously, in order to be effective, the "upside" that can realized in the event of good results must be sufficiently substantial to offset the human tendency to prefer shorter-term rewards. It would not be necessary, of course, to tie payment of such deferred compensation to continued employment with the same company, although such an arrangement would have the added benefit of encouraging underwriters to stay in one job long enough to assess the validity of their underwriting practices.

Including claims analysts and actuaries in such a compensation program might seem heretical at first, as the assumption is generally that these disciplines should be concerned only with "the right answer" under the policy wording or "the right number" as derived from actuarial science. In fact, professionals in these disciplines need to be encouraged to play as active a role in book management in the "competition" phase of the cycle as they inevitably will in the "re-underwriting" phase. Finally, tying the compensation of insurance agents and brokers more directly to the profitability of the business they produce over time would add powerful incentives to limit the "race to the bottom" in rates that periodically gives rise to sharp constrictions in capacity.

As noted at the outset, underwriting cycles are inherent in the nature of insurance – they reflect the very risk that defines the discipline. But cycles need not be either broad or deep, and the uncertainty and disruption occasioned for consumers by the peaks of the cycle can be moderated if the correct set of incentives is created for participants in the insurance market. Insurers need to focus their employees on long-term profitability, brokers need to focus theirs on maintaining stable sources of capacity rather than on obtaining the lowest possible prices, and consumers of insurance need to be willing to forego short term price reductions in return for a more dependable and consistent market for insurance products. Only then will we tame the more disruptive extremes of the underwriting cycle.

("Trust, but verify"). Associated Press, *The President in Venice: Economics, Contra Aid and the Gulf*, N.Y. TIMES, June 12, 1987, at A12.

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GOD AND THE RED UMBRELLA: THE PLACE OF VALUES IN THE CREATION OF INSTITUTIONS OF MUTUAL ASSISTANCE

Brian J. Glenn[*]

In 1721, a "destroying angel" descended upon Boston. Reverend Cotton Mather noted in his May 26 diary entry that, "the grievous Calamity of the *Small-Pox* has now entered the Town."[1] The source seems to have come from "His Majesty's ship, *Seahorse*, and several other ships from Salternuda," according to the Boston Gazette.[2] As a precaution against bringing communicable diseases into the town, each ship seeking entrance to Boston's harbor had to report any illnesses to a station three miles away. The *Seahorse* had not reported any sick passengers on board at that time, but while at dock a member of the crew became ill with the symptoms of smallpox and was taken ashore. The town's selectmen immediately ordered the twenty-six free black citizens of the town to sweep the streets, and the town prayed the disease would remain quarantined.

It was too late, alas, for the disease had already spread, and the smallpox outbreak quickly reached epidemic proportions. Six thousand out of Boston's 11,000 residents would catch the disease that year, with 844 being sent to their graves by it.[3] The town had suffered previous outbreaks in 1690 and 1702, and many of those who had survived presumably had developed an immunity to the virus. Given the time span from the last outbreak, unfortunately, no one under the age of nineteen who had grown up in the town would have had the opportunity to develop an immunity, and children were disproportionately struck down by the illness.[4] The

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1. COTTON MATHER, DIARY OF COTTON MATHER 620 (Frederick Ungar Publishing Co., 1957) (n.d.).

2. BOSTON GAZETTE, Apr. 22, 1721.

3. OLA ELIZABETH WINSLOW, A DESTROYING ANGEL: THE CONQUEST OF SMALLPOX IN COLONIAL BOSTON 58 (1974).

4. Based on the national average, the median age of Boston would have been roughly sixteen years old. *See* 1 BUREAU OF THE CENSUS, U.S. DEP'T OF COMMERCE, HISTORICAL STATISTICS OF THE UNITED STATES: COLONIAL TIMES TO 1970, at 19 (Bicentennial ed. 1975).

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residents who were able to do so quickly fled the town, and it seems around a thousand did. But running away was not an option for most, and initially all that was done was to quarantine those who were ill. A red flag emblazoned with the words "God have mercy on this house" was posted above the door of each home containing someone who was infected, and two guards were posted to ensure no one went in or out.

On average for the rest of the year, smallpox killed just over three residents a day, and this was in addition to all the other sources of morbidity found in the early decades of the eighteenth century. Life expectancy was extremely low in early 1700s, even during years without smallpox epidemics.[5] (See Table 1) The year 1721 *was* an epidemic year however, with smallpox claiming no less than 77 out of every one thousand inhabitants, and that is not including deaths from all other causes.[6] In an average year, Bostonians would have witnessed about one funeral per day. In 1721, the epidemic alone would have caused over three. This three-per-day average masks the true effect of the virus however, since it did not appear until April, when a third of the year had already passed. A yearly average taken from just eight months fails to show the impact properly. While the average for a year was three per day, in reality the residents of Boston could witness close to two-dozen burials in just one day, caused just by smallpox alone. Referring to those who passed away from the disease in his September 23, 1721 diary entry, Mather notes, "The afflicted multiply fast enough. One Day this Week, their Condition obliged it, that my Prayers were seventeen, on another Day, twenty-two."[7] The town had a tradition of ringing the church bells to announce a funeral, and during the epidemic this practice grew to be so disconcerting to the town's leaders that they actually attempted to limit ringing to one bell at a time, and even then only during designated hours. But the citizens would have none of it. If they could not combat the disease, at least they wanted to retain the right to know of its effects.

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5. Especially so for the residents of Boston. Vinovskis notes that Boston's mortality rates were significantly higher than rural areas, and that the cohort born in 1700-1729 was subject to particularly high death rates. Maris A. Vinovskis, *Mortality Rates and Trends in Massachusetts Before 1860*, 32 J. OF ECON. HIST. 184, 195-97 (1972).

6. By contrast, the mortality rate in America for all causes in 1998 was 8.65 per 1,000 population. ECON. & STATISTICS ADMIN., BUREAU OF THE CENSUS, STATISTICAL ABSTRACT OF THE UNITED STATES 90 (120th ed. 2000).

7. MATHER, *supra* note 1, at 648.

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Table 1. Mortality Rates for Boston and Several other Communities

City	Deaths per 1,000 residents	Time Period
Boston	46.8	1720-1724
Dedham	0-23	1724-1738
Philadelphia	32.9	1722
Nottingham, England	37.2	1720-1724

What is noteworthy is that the town's citizens *did* have a method of actively combating smallpox, since the process of inoculation had been known for close to a decade to the dozen or so physicians who served Boston's community. In 1714, Emanuel Timonius, a surgeon attached to the British embassy in Constantinople noted that the Turks inoculated against smallpox with tremendous success, and published his findings in the *Philosophical Transactions of the Royal Society*.[8] Science at this time was the pursuit of gentlemen,[9] and the fact that the paper was authored by a Turk—who would have been considered a heathen in eighteenth century Christendom (and worse, a non-white one at that!)—did not help the cause any. The paper initially went largely unnoticed. This situation finally changed when Lady Mary Wortley Montagu, the wife of the British ambassador to the Persian Empire, had her own children inoculated upon arriving in 1718.[10] Lady Montagu was a socialite of the highest standing, and was widely known among Britain's medical and scientific elite.[11] A prolific writer of letters and editorials, she quickly circulated her support for the procedure among her vast circle of acquaintances, from whom Reverend Mather learned of the technique.[12]

For our purposes, the importance of this story is that when the smallpox epidemic raged through Boston in 1721, it was the community's

8. Letter from Emanual Timonius, The Royal Society of London, *An Accou8nt, or Hostory, of the Procuring the Small Pox by Incision, or Inoculation* (Dec. 1713), *in* 29 PHILOSOPHICAL TRANSACTIONS 1714-1716, at 72 (Johnson Reprint Corp., 1963).

9. THEODORE M. PORTER, TRUST IN NUMBERS: THE PURSUIT OF OBJECTIVITY IN SCIENCE AND PUBLIC LIFE 220 (Princeton University Press 1995).

10. WINSLOW, *supra* note 3, at 59-60.

11. *Id.* at 59.

12. *Id.* at 61-62.

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religious leaders, not the medical ones, who suggested that townspeople begin inoculating against the virus. Borrowing a copy of the *Transactions* from one of the town's physicians, Mather quickly became a strong supporter of the procedure, and convinced many of the other ministers to back it strongly as well.[13] He then set about attempting to convert Boston's medical community.[14] Referring to inoculation in a letter to the town's physicians dated June 6, 1721, he stated,

> Gentlemen, my request is, that you meet for a Consultation upon this occasion, and deliberate upon it (the operation) that whosoever first begins the practice (if you approve it should be done at all) may have the countenance of his worthy Brethren to fortify him in it.[15]

Much to Reverend Mather's displeasure, his words fell on deaf ears, as the physicians proved themselves to be extremely obstinate.[16] Save for 51 year-old physician/apothecary Zabdiel Boylston, the rest firmly and publicly opposed inoculation.[17] When Boylston began inoculating individuals on his own anyhow, starting with his own child and quickly doing the same for Rev. Mather's son, he was openly denounced by the town's other practitioners. Several signed a resolution stating "that the Operation of Inoculation in Boston was likely to prove of dangerous consequence."[18] Dr. William Douglass went farther. Writing in the Boston News Letter under a pseudonym of William Philanthropos (which would have fooled no one), Douglass called Boylston, "not only ignorant, but illiterate and incapable of understanding the writing of Timonius, unacquainted with the treatment for victims of smallpox . . . . [and] unfit to manage any of their Symptoms."[19] The issue of whether or not the procedure was medically sound could not be proven either way since only time would tell. However, given that the disease was killing roughly one out of every thirteen residents, time was the one thing the townspeople lacked.

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13. *Id.* at 46.
14. *Id.*
15. *Id.* at 46-47 (citation omitted).
16. Indeed, once Mather began instigating for the procedure, Dr. William Douglass demanded that Mather return the copy of *Transactions* he had loaned the minister, and refused to allow its circulation among others interested in reading it, even refusing the request of the colony's governor. WINSLOW, *supra* note 3, at 47.
17. *Id.* at 49.
18. *Id.* at 50-51.
19. *Id.* at 51.

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The process of inoculation was initially novel to the residents of Boston, and given the already high levels of fear and tension caused by the epidemic, the idea of one physician performing a heathen remedy opposed by his peers caused even more agitation among the population.[20] Citizens wrote angry letters to the papers; commotion was raised in the streets. Mather noted in his diary that Boston had turned into a "dismal Picture and Emblem of Hell; *Fire* with *Darkness* filling of it, and a *lying Spirit* reigning there."[21] Another entry decried: "[t]he Destroyer [i.e., smallpox] . . . has taken a strange Possession of the People on this Occasion. They rave, they rail, they blaspheme; they talk not only like Ideots but also like *Franticks* . . . ."[22] The pain Mather felt for the health of his flock was obviously great. "Widows multiply," he noted.[23]

While inoculation failed to gain universal approval, public concern declined after the terms of the debate were shifted from medical consequences to moral ones. The early issue of "is it safe?" was replaced by the question "what should good Christians do when faced with a plague of biblical proportions?" The first to attempt an answer was Reverend Edmund Massey of London, who published a sermon against the procedure entitled, "The Dangerous and Sinful Practice of Inoculation."[24] Massey compared the smallpox epidemic to the suffering of Job. Massey interpreted the Book of Job literally. In the story, the Devil infused poison into Job's body, causing loathsome sores,[25] remarkably similar to those of smallpox (both Job and Timonius lived in Persia, after all). God healed Job after Job kept faith even while facing terrible disaster. Why therefore should good Christians in the 1720s do otherwise, turning away from faith and the accompanying suffering it demanded, when in the past true believers put themselves into the hands of God?[26] To the Christian Bostonians of the time, this was a powerful argument. For inoculation to gain acceptance therefore, a new narrative needed to be written, countering Massey's objections and explaining how inoculation fit into the existing theology.

The individual who rose to the task was Reverend William Cooper, associate pastor of the Brattle Street Church, who published a widely-read

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20. *Id.* at 49.

21. MATHER, *supra* note 1, at 641.

22. *Id.*, at 632.

23. *Id.*, at 631.

24. Edmund Massey, A Sermon Against the Dangerous and Sinfull Practice of Inoculation: Preached at St. Andrew's Holborn (July 8, 1772).

25. Job 2:7.

26. *Id.* at 83.

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pamphlet entitled, "A Letter to a Friend in the Country."[27] The text consisted of a series of questions that were ostensibly asked by his friend (but which were remarkably similar to the ones posed by Massey), followed by Cooper's answers to them. For example, in one passage Cooper writes:

> But *the Small Pox is a Judgment of God, sent to punish and humble us for our Sins; and what shall we so evade it, and think to turn it away from us?* I fully agree to it, that it is a sore Judgment of God upon us for our Sins, which we have much deserv'd: And it is greatly to be lamented that it has no better Effect upon the hearts of Men. But is it Unlawful to use means for our Preservation from a desolating Judgment? *Especially*, if at the very time that God sends the Judgment, He shews [sic] us a way to escape the *Extremity* and Destruction at least, if not the Touch of it . . . . If this Town was to suffer an *Inundation*, that would be a more terrible Judgment than this, and we should look upon it too as a righteous Punishment for our Sins; yet would any refuse to make use of a *Boat*, or a *Plank that might providentially come in his Way*, thinking that to do it would be a criminal Evading the Judgment? *I [think] not*[.][28]

Point by point, Cooper rebutted Massey's arguments, providing the faithful with a way to justify their acceptance of inoculation. What began as a practice performed in opposition to the Will of God was reconstructed into one that followed His plan. Through their public writings and speaking from the pulpit, the community's religious leaders were able to redefine the issue of inoculation. Their first step was to convert it from one of medicine to one of morality. The second was to reconstruct it from one that ran against the Will of God into one that allowed the procedure eventually to find acceptance among the true believers.

Values and Mutual Assistance

This paper argues one simple point: the values held by the polity will influence the manner in which members take care of themselves and each other in times of need — which, for ease of use, I will term "mutual assistance practices." In the context of this paper, the term "values" refers

27. WILLIAM COOPER, A LETTER TO A FRIEND IN THE COUNTRY (1721).
28. *Id.* at 7.

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to interpretations of risk and responsibility held in the community. Values commonly held across members of a community will shape whether the polity decides to share risk privately (through commercial insurance or other forms of collective protection), publicly (through social policy), or bans risk sharing altogether — usually because the practice is understood to be immoral. Mutual assistance practices are not merely financial or economic methods of dealing with risk. Mutual assistance practices also have a social element to them. They are predicated on stories about the nature of fate in society, about who is deserving and who is not, and about the relationships and obligations individuals have to others and on occasion, to higher beings as well.[29]

The idea that values matter is far from universally accepted. Indeed, whether or not values matter in understanding American political development as it relates to the politics of mutual assistance is highly contested, especially by members of the historical institutionalist school of thought, who argue that American political development is almost entirely shaped by institutions and actors operating within them.[30] Often, the debate is simply moot, since for most of the time the institutions created by a polity should be expected to fit comfortably into the predominant interpretations of risk and responsibility. To find the influence of values — if there is one — we need to look at instances when institutions and values initially fail to coincide (see Table 2). This paper examines four cases comparatively.[31] In the first, which we just read, an exogenous shock presented the opportunity for a new method of self-help — inoculation. This created a problem in that the new practice conflicted with pre-existing interpretations of risk and responsibility. When the new practice was introduced, members of the community quite literally rioted. Inoculation was only able to find acceptance after a new narrative was written, one in

29. *See generally* EMBRACING RISK: THE CHANGING CULTURE OF INSURANCE AND RESPONSIBILITY (Tom Baker & Jonathan Simon, eds. 2002); Brian J. Glenn, *Risk, Insurance, and the Changing Nature of Mutual Obligation*, 28 LAW & SOC. INQUIRY 295 (2003); M. Kent Jennings, *Political Responses to Pain and Loss*, 93 AM. POL. SCI. REV. 1 (1999); Deborah Stone, *The Struggle for the Soul of Health Insurance*, 18 J. OF HEALTH POL., POL'Y & LAW 287 (1993).

30. The term "institutions" itself means many things to different people. For our purposes, institutions are rules, organizations, laws, or practices that inform or delimit the actions persons can take. This term does not include cultural factors such as norms, identities, mores, beliefs, narratives, or the like. The term "culture" would thus refer to the latter terms, but not the former. Thus, institutions and culture—at least for our purposes—encompass two distinct categories of variables.

31. ADAM PRZEWORSKI & HENRY TEUNE, THE LOGIC OF COMPARATIVE INQUIRY (1982).

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which the new procedure coincided with interpretations of risk and responsibility.

Table 2. Cases and Outcomes

Event	Conflict	Outcome
Small Pox Outbreak of 1721	Physicians did not want to inoculate, ministers changed issue from medical to spiritual.	Deadlock, since the epidemic ended before conflict could be resolved.
Lightning Rod Debate	Use of lightning rods became acceptable only after they were legally defined as not mitigating the Will of God.	New narrative constructed, and only then was new technique fully accepted.
Life Insurance	Christians did not purchase life insurance, since it threatened to mitigate the Will of God by removing the financial suffering of the sinner's dependents after he was gone.	First, ministers had to construct a narrative that allowed them to purchase it. Then entrepreneurs had to tell a new story about what it meant to "take no thought for the morrow."
Social Security Extended to Amish Farmers	Using public forms of insurance ran against religious interpretations of the Amish. They engaged in civil disobedience until obtaining an exemption.	New technique rejected after community refused to construct a new narrative about risk and mutual obligation.

In the next two cases that follow, we see practices accepted only after new narratives of risk and responsibility are presented that allow individuals to find them acceptable, given their beliefs. By the end of the third case we will have witnessed a reoccurring pattern. First, either an exogenous shock (such as a smallpox outbreak) or a new method of mitigating loss (such as the invention of lightning rods or the introduction of life insurance) is introduced. Second, the prevailing interpretation of

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risk and responsibility is mustered against the use of the proposed new method, leading to one form or another of conflict in the public arena—assuming the new method is not ignored entirely. Third, a new definition of risk and responsibility is constructed arguing that the new method runs not against the prevailing interpretation, but in fact is perfectly in line with it. This does not *cause* public acceptance, but it does allow for it to occur.[32] In our fourth and final case, we see a community rejecting a practice that fails to comport with their values, even at the cost of having to engage in civil disobedience in order to follow the lifestyle for which their belief system calls.

What we derive from the cases is that when a practice fails to comport with narratives of risk and responsibility, the practice will not be accepted, and indeed will often be rejected with violence and civil disobedience. While these incidents may seem quaint and antiquated from today's perspective, they were very real at the time, since they spoke to deeply-seated issues of identity for the participants involved, much as the debate over abortion does today.[33] Notably, in the case we witnessed above, Bostonians not only rejected the practice for their own children, but worked to ensure that others did not engage in it either. Private mutual assistance practices such as inoculation must still be acceptable to the other members of the community because issues of pain and loss, and how the members of a community deal with them, are both intimately personal and also public and political. The way they are dealt with are interpreted as expressions of collectively held values.[34] This is the case because many actions taken are often as symbolic as they are pragmatic, making statements about group boundaries and values in ways that speak to deeply held issues of identity. "Mind your own business" rings hollow in debates over how the polity

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32. *See generally* ROGER W. COBB & CHARLES D. ELDER, PARTICIPATION IN AMERICAN POLITICS: THE DYNAMICS OF AGENDA-BUILDING (Allyn and Bacon, Inc. 1972). One of the main routes to getting an issue discussed by political leaders is to raise interest in the mass public. A lesson learned is that citizens often first require themselves to be able to articulate a coherent explanation for their gut instincts before they are willing to mobilize on behalf of them. Thus, by providing such an explanation, issue entrepreneurs may able to convert latent groups into mobilized ones.

33. As noted by Cobb and Ross:

Cultural processes, and especially the dynamics of identification and symbolization, matter when they invoke threats and deep fears and effectively link political grievances to existing worldviews and individuals to political groups. These connections often account for the high commitment to and intensity of involvement with matters that often seem trivial to outsiders.

CULTURAL STRATEGIES OF AGENDA DENIAL 4 (Roger W. Cobb & Marc Howard Ross. eds., 1997).

34. *See* Jennings, *supra* note 29.

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treats both its dying and dead, as well as its unborn and those who are carrying them—these issues are simply part of everyone's business, or so many argue. Even such a seemingly private act as installing a lightning rod on one's house resulted in litigation in front of a nation's highest court because the act made a statement about the community's relationship to God.

Lighting Rods

Among his many other useful devices, Benjamin Franklin is to be credited with the invention of the lightning rod. Given their ability to protect property, one might suspect that lightning rods were quickly adopted around the world. However their acceptability was in fact highly contested, and was achieved only after their proponents succeeded in constructing a story about them, which made their usage acceptable to Christians.

In the middle of the eighteenth century, the nature of electricity was still poorly understood, and was considered something of a novelty and little more. Travelling performers would give members of their audience shocks and perform other tricks using charged items, and would market themselves as magicians. After an encounter with a scientist in 1743, Benjamin Franklin's interest in electricity was piqued, and he quickly went about obtaining the most modern scientific instruments available. As with many of his other endeavors, his attention to the subject quickly bore fruit on par with the greatest scientists of the day. Franklin discovered that pointed metal served as an excellent conductor of electricity. In May of 1747, he wrote a letter to Peter Collinson, a famed London botanist from whom he had purchased various pieces of scientific equipment, noting "the wonderful Effect of Points, both in *drawing* off and *throwing* off the Electrical Fire."[35] A man concerned with the utility of knowledge, he eventually realized that his discovery could be used to protect buildings from the devastation of a lightning strike.[36] Writing to Collinson again in 1750, Franklin pointed out the utility of his discovery.

I say, if these Things are so, may not the Knowledge of this Power of Points be of Use to Mankind; in preserving Houses, Churches, Ships &c. from the Stroke of Lightning; by Directing us to fix on the highest Parts of those Edifices upright Rods of Iron, made sharp as a Needle and gilt to prevent Rusting, and from the Foot of those Rods a Wire down the outside

35. Letter from Benjamin Franklin to Peter Collinson (May 25, 1747), *in* 3 THE PAPERS OF BENJAMIN FRANKLIN, at 127 (Leonard W. Labaree ed., Yale Univ. Press 1961).

36. Franklin formed America's first homeowner's insurance companies. The idea of protecting buildings from fire, therefore, was perhaps not coincidental.

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of the Building into the Ground; or down round one of the Shrouds of a Ship and down her Side, till it reach'd the Water? Would not these pointed Rods probably draw the Electrical Fire silently out of a Cloud before it came nigh enough to strike, and thereby secure us from that most sudden and terrible Mischief![37]

Franklin was the publisher of *Poor Richard's Almanac*, and he used that venue to instruct its readers how to install rods in the preface to the 1753 edition.[38] Rather than patent the idea, Franklin instead promoted it for free, and knowledge of his invention quickly disseminated around the globe. His treatise on electricity was considered the most eminent discourse on the subject of the day, reaching ten editions in four languages.[39] The fact that the utility of lightning rods was widely known, however, does not mean that they were immediately accepted and put to use. In fact, just the opposite happened.

Rather than being acknowledged as a scientific breakthrough with the potential greatly to reduce the damage caused by lightning strikes, rods met with opposition from numerous Christian leaders who argued their usage served to mitigate the Will of God. The most influential critic was the French Abbé Jean-Antoine Nollet. Nollet saw lightning rods as religiously intolerable. His *Letters on Electricity*, published in 1753, were a scathing attack on the invention.[40] Franklin appeared to be surprised by the religious opposition to his useful invention. Referring to Nollet in a letter to a friend, he noted that,

> He speaks as if he thought it Presumption in Man, to propose guarding himself against the *Thunders of Heaven!* Surely the Thunder of Heaven is no more supernatural than the Rain, Hail or Sunshine of Heaven, against the Inconveniencies of which we guard by Roofs and Shades without Scruple.[41]

Franklin's own religious beliefs allowed him the freedom to pursue knowledge unconstrained from the pre-enlightenment fetters that bound so

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37. Letter from Benjamin Franklin to Peter Collinson (July 29, 1750), *in* 4 THE PAPERS OF BENJAMIN FRANKLIN, at 19 (Leonard W. Labaree ed., Yale Univ. Press 1961).

38. Poor Richard's Almanac (1753 ed.).

39. BENJAMIN FRANKLIN, EXPERIMENTS AND OBSERVATIONS ON ELECTRICITY (London, E. Care 1751).

40. JEAN ANTOINEE NOLLET, ESSAI SUR L'ELECTRICITE DES CORPS (2d ed., 1753). For a summary of Nollet's *Letters, see* 4 THE PAPERS OF BENJAMIN FRANKLIN, at 423-28 (Leonard W. Labaree ed., Yale Univ. Press 1961).

41. Letter from Benjamin Franklin to Cadwallader Colden (Apr. 12, 1753), *in* 4 THE PAPERS OF BENJAMIN FRANKLIN, at 463 (Leonard W. Labaree ed., Yale Univ. Press 1961)

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many others. John Adams held Franklin in contempt for his frequently exhibited lack of faith, exclaiming that Franklin "belonged to the ranks of Atheists, Deists, and Libertines."[42] William Robertson, the principal of the University of Edinburgh was a bit more kind in his description of Franklin's theology, stating that "of all the Sciences [it was] the only one in which I suspect he is not perfectly sound."[43] Historian Kerry S. Walters presents Franklin as neither an atheist nor a conventional Christian, but rather "as a man intensely concerned with religious questions who borrowed from both the Christian and the Enlightenment traditions in his struggle to come to terms with his own hunger for God and self-knowledge."[44] Although Franklin's invention of the lightning rod appears to have caused him no internal conflict whatsoever, the same cannot be true for the rest of Christendom, where the acceptance of these devices "became a test of enlightenment among men," according to historian Esmond Wright.[45] For centuries, Europeans protected themselves from violent storms through the ringing of church bells to warn of approaching thunderclouds. (Franklin even made this process easier, devising a clapper suspended from insulated cords that would ring a bell automatically when the surrounding air became electrically charged).

For many devout Christians, lightning rods posed a dilemma. As we have already seen with the Boston smallpox case and will see again in the following sections on life insurance, natural disasters such as having one's house struck by lightning was considered a punishment for past sins, and lightning rods held the potential to remove this punishment from God's arsenal. Many believers initially therefore refused to use them.[46] Indeed, members of the Old Order Amish still do not, in fact, having banned them since 1862.[47] Proponents of their usage, therefore, had to construct a new, positive interpretation of how they fit into the theology of the era. One example of how the issue was contested took place in Boston between the Hollis Professor of Natural Philosophy, John Winthrop of Harvard, and

42. John Adams, Diary entry (June 23, 1779) *in* 2 JOHN ADAMS, DIARY AND AUTOBIOGRAPHY OF JOHN ADAMS 391 (L. H. Butterfield ed., Belknap Press of Harvard Univ. Press 1961) *quoted* KERRY S. WALTERS, BENJAMIN FRANKLIN AND HIS GODS 3 (1999).

43. Letter from William Robertson to William Strahan (Feb. 18, 1765), *in* 12 THE PAPERS OF BENJAMIN FRANKLIN, at 70 (Leonard W. Labaree ed., Yale Univ. Press 1968).

44. WALTERS, *supra* note 42, at 9.

45. ESMOND WRIGHT, FRANKLIN OF PHILADELPHIA 67 (1986).

46. I. Bernard Cohen, *Prejudice Against the Introduction of Lightning Rods*, 253 J. FRANKLIN INST. 393, 399 (1952).

47. JOHN A. HOSTETLER, AMISH SOCIETY 280 (4th ed. 1993).

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Reverend Thomas Prince, who was an amateur seismologist.[48] On November 18, 1755, Boston was terrorized by an earthquake, which Reverend Prince attributed to the use of lightning rods. In a published sermon,

> *EARTHQUAKES the Works of* GOD, *and Tokens of His Just Displeasure*: Being a Discourse on that Subject, Wherein is given a particular Description of this *awful Event* of Providence, And among other Things is offer'd a Brief Account of the *natural, instrumental, or secondary Causes* of these Operations in the Hands of GOD, After which, Our Thoughts are led up to HIM, as having the Highest and principal *Agency* in this stupendous WORK,

Prince argued that,

> The more *Points of Iron* are erected round the *Earth*, to draw the *Electrical Substance* out of the *Air*; the more the *Earth* must needs be charged with it. And therefore it seems worthy of Consideration, Whether *any Part* of the *Earth* being fuller of *this terrible Substance*, may not be more exposed to *more shocking Earthquakes*. In *Boston* are more erected than anywhere else in *New England*; and *Boston* seems to be more dreadfully shaken. O! there is no getting out of the mighty Hand of *God!* If we think to avoid it in the *Air*, we cannot in the *Earth*: Yea it may grow more fatal . . .[49]

In response, Professor Winthrop attempted to dismiss out of hand the idea of earthquakes being caused by lightning:

> Philosophy, like everything else, has had its fashions, and the reigning mode of late has been, to explain everything by ELECTRICITY . . . Now it seems, it is to be the cause of earthquakes . . . [t]he two cases of lightning and earthquakes are no way parallel; . . . the electric substance, when in the bowels of the earth, is in

48. For a complete recount of the debate, *see* Eleanor Tilton, *Lightning-Rods and the Earthquake of 1755*, 13 NEW ENG. Q. 85 (1940).

49. THOMAS PRINCE, EARTHQUAKES THE WORKS OF GOD, 23 (Fowle & Fowle 1755). Prince was reacting directly to the "fagacious Mr. Franklin," as Prince refers to him, in the Appendix of the sermon. *Id.* at 20.

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> circumstances essentially different from what it is, when in the clouds of the air.[50]

An attack on the science of earthquakes alone would not suffice, however. Winthrop also needed to address the theological component. Referring to Prince's quote above, Winthrop continued,

> I should think, though with the utmost deference to superior judgements [sic], that the pathetic exclamation, which comes next, might well enough have been spared. "O! there is no getting out of the might hand of GOD!" For I cannot believe, that in the whole town of *Boston*, where so many iron points are erected, there is so much as one person, who is so weak, so ignorant, so foolish, or, to say all in one word, so atheistical, as ever to have entertained a single thought, that it is possible, by the help of a few yards of wire to "get out of the might hand of GOD."[51]

In short, Winthrop challenged the idea that mankind could ever escape the Will of God—an idea appealing to those who believed in His omnipotence. While the war of words between these two eminent figures quickly died down (they were also close friends), the larger debate in which they were engaged carried on for several decades more, eventually developing into a French legal battle in the 1780s, when M. de Vissery de Bois-Valé installed a lightning rod on the top of his home in St. Omer. His neighbors took offense and tore it down, which by law they had the right to do since local laws banned their usage. When the case went to the Council of Artois, Bois-Valé was defended by a young lawyer, Maximilien Robespierre, who was appearing before the bench for his very first time. In an argument that brought him a fair amount of fame, Robespierre not only attacked the law banning lightning rods with scientific evidence, but, notably, with appeals for enlightened progress as well — all in the name of God, of course. "The Arts and Sciences are the richest gifts that God can give to mankind," he noted, "what perverse fate has then put so many obstacles in the way of their progress on earth? Do we really believe that the Almighty needs this meteor that terrifies us so much?"[52] With the suggestion that it was the greatest form of arrogance for mankind to believe

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50. JOHN WINTHROP, A LECTURE ON EARTHQUAKES, READ IN THE CHAPEL OF HARVARD-COLLEGE IN CAMBRIDGE AT 32-33 (1755).

51. *Id.* at 37. *See also* Tilton, *supra* note 48, at 89.

52. Cohen, *supra* note 46, at 436.

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that God's authority relied on His ability to strike a house with lighting, the banning of lightning rods in France quickly ended, as it had in England a decade earlier. Writing from London, Franklin was able to boast to Winthrop that, "Conductors begin to be used here. Many country seats are furnished with them, some churches, the powder magazine at Purfleet, the queen's house in the park . . . ."[53]

What might simply have been understood as the progress of science was in fact greatly influenced by the stories told of how lightning rods fit into contemporary interpretations of religion, risk, and responsibility. The acceptance of lightning rods required a new narrative to be written about them; one in which they worked *with* the Will of God, not against it. We see this, for example, in South Carolina, where the South Carolina and American General Gazette attempted to turn the issue on its head by suggesting instead that its readers raise lightning rods "to the glory of God."[54]

It is noteworthy that while few, save the Amish, refuse to make use of lightning rods to protect their property anymore, echoes of the debate still linger. When a schoolhouse under construction was burned to the ground after being struck by lightning on April 14, 1854, the Supreme Court of Connecticut referred to the event as an "Act of God."[55] The term is still found in the argot of American legal and insurance communities. That opposition to lightning rods existed a century after they were invented is revealed by the publication of a short story in 1856 by Herman Melville, who had clearly written it for a popular audience. In the story, the Devil appears as a lightning rod salesman trying to tempt a believer during a thunderstorm.[56] Given the oddity of the subject, Melville clearly believed that his readers would have understood the context.

Religious interpretations have not only influenced the development of devices and medical techniques designed to protect individuals from harm, they have influenced insurance practices as well. Nowhere is this better seen, perhaps, than in the development of life insurance, where both its very usage, and the question of who would be allowed to purchase it, were the sites of highly contested debates.

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53. WRIGHT, *supra* note 45, at 66.

54. *Id.* at 68.

55. School District No. 1 v. Dauchy, 25 Conn. 530 (1857). The phrase itself has much older origins.

56. HERMAN MELVILLE, PIAZZA TALES 141-48 (Egbert S. Oliver ed. 1923).

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The Rejection and Adoption of Life Insurance in America

There was a time in America when Christians did not purchase life insurance because it was understood as mitigating the Will of God. The reasoning went something like this: God punished some men by striking them down early and leaving their families destitute.[57] God rewarded others by giving them long lives, such as He did with Moses who lived to the age of 120.[58] If God wanted a man's family to suffer, who were mere humans to counteract that decision by purchasing life insurance? Early Americans took this question very seriously, pointing to 1 Peter 5:7, in which God spoke to his followers, "Cast all your anxieties on [me], for [I] care[] about you."[59] Despite the fact that life insurance companies were established and thriving in England and other countries by the eighteenth century, they made virtually no inroads at all in America until the middle of the 1800s. Life insurance practices simply did not fit in with the dominant narratives about risk and responsibility, and they were rejected by the overwhelming majority of the population until they did.

The problem with the idea that God punished the wicked by calling their lives short was that it held an internal contradiction: sometimes ministers also died young, often leaving their families in a very bad financial position. Despite the fact that they were expected to be well dressed and maintain a decent lifestyle, ministers were poorly compensated. Even the famous Cotton Mather was forced to sell everything he owned at one point late in his life.[60] Surely a fine upstanding minister would never sin so greatly as to warrant an early death, nor would God ever will that his family be left impoverished. Thus, ministers were presented with a dilemma. Life insurance would have solved the problem of leaving their families destitute after they died. Insurance under the old interpretation served to mitigate the Will of God, and therefore ministers could not purchase it. Yet God would never will that one of their families would be left destitute, even though in practice this happened with frightening regularity. In order to get themselves out of this paradox, the ministers were challenged to create a new interpretation of scripture as it related to risk and responsibility. This was no easy task, and the debates

57. It was never made clear in the literature if God ever punished wives by striking down their husbands early. The gender focus here reflects the literature of the era.

58. *Deuteronomy* 34:7.

59. 1 *Peter* 5:7.

60. He regretfully noted in his diary, "The glorious Lord who orders my Condition for me, has order'd me a Condition of considerable *Poverty*. What little Estate I had, has been sold, and the Money is gone to pay my Debts. I do not own a Foot of Land in all the World. My Salary is not enough to support me comfortably . . . ." Mather, *supra* note 1, at 630.

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over the question were quite earnest—at least on the part of some—since they were redefining their relationship not just to each other, but also to God. Presbyterian ministers (followed closely by the Episcopalians and Congregationalists) solved their insurance dilemma by writing a new story about risk:

> (A) God punished sinners by cutting their lives short and making their families suffer from poverty afterwards. (B) Life insurance could mitigate the Will of God by protecting the families of sinners. (C) Ministers did not live sinful lives and therefore God would never punish their surviving family members. (D) The logical conclusion is that ministers should be able to purchase life insurance, since if they did die early, it was not as a punishment for their sins.[61]

On May 22, 1761, the first American life insurance contracts were issued by the Corporation for Relief of Poor and Distressed Widows and Children of Presbyterian Ministers, now the Presbyterian Ministers Fund.[62] The story does not end here. In fact, this is just the beginning.

The above narrative applied only to ministers. Enterprising insurance salesmen still had their work cut out for them with the rest of the population who would still reject its usage for almost another entire century. Before the mass public of America would find purchasing life insurance acceptable, they too would require a new narrative; something the struggling American life insurance contracts finally started to provide in the 1840s.

Providing for One's Own House

For our purposes, one of the most prevalent themes for Christians in America has been concern for the soul's eternal salvation. The temptations of greed and selfishness, which lead away from the true path of spirituality, have been seen as impediments blocking the path to heaven.[63] Much like the rich man whose chances of getting into heaven were slimmer than the chance of a camel passing through the eye of the needle,[64] individuals who tried to protect their financial interests with insurance were thought to be too concerned with earthly wealth and too lacking in faith that God would

61. Myles A. Tracy, *Insurance and Theology*, 33 J. RISK & INS. 85, 87 (1966).

62. *Id.*

63. *Matthew* 12:35 warns, "[t]he good man out of his good treasure brings forth good, and the evil man out of his evil treasure brings forth evil."

64. *Luke* 18:25.

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provide what was truly necessary. "[W]e brought nothing into the world, and we cannot take anything out of the world . . ."[65] The solution, therefore, is to "seek first his kingdom and his righteousness,"[66] for "what will it profit a man, if he gains the whole world and forfeits his life?"[67] For the true believer these are powerful messages, and it is certainly easy to understand how they could have been used to justify opposition to insurance. Taken literally, "[c]ast all your anxieties on him, for he cares about you[,]"[68] leaves little room for the need to insure. The idea of putting oneself into the hands of God reached beyond the individual of course, and extended to concerns about one's family after the breadwinner passed away. Throughout the Bible the heads of household are admonished to trust their loved ones into the care of God's tender mercies. "Leave [thy] fatherless children [to me, and] I will keep them alive; and let your widows trust in me."[69] Imagine the poor insurance salesman going up against this!

The challenge for those who wanted to spread the usage of life insurance was to convince the faithful that it fulfilled a Godly purpose. Advocates did this by appealing to the Christian morals of their audience, in an attempt to convince them that the purpose of insurance was not financial but rather spiritual. There were two major arguments. First, that life insurance rested on principles of divine law. Second, that it was the religious duty of the father to take care of his family. By studying the dynamics of how proponents altered the terms of the debate from financial to spiritual concerns, we see an account of how insurance was expanded to take on new risks.

A key first task for insurance salesmen was to convince their target audience that life and death were not contingent upon living a good or a sinful life, but rather that there were regularities to human mortality. One of the earliest writers to address the subject of religion and life insurance was Elias Heiner. Writing in 1857, he stated that:

> *Life Insurance should be encouraged on the ground that it is a* GREAT MORAL BENEFIT. Let no one be surprised at this assertion. We feel persuaded that it can easily be made good. If we can show that Life Insurance has a benign influence in holding the fragments of a broken family together—that it shapes in small measure the

65. 1 *Timothy* 6:7 (footnote omitted).
66. *Matthew* 6:33.
67. *Matthew* 16:26.
68. 1 *Peter* 5:7.
69. *Jeremiah* 49:11.

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> destiny of children—that it prevents crime and promotes virtue, and that it hallows the widow's efforts, and brings down upon the orphan's head incalculably great blessings—we say if we make all this appear, we shall have succeeded, doubtless, in our efforts to prove that Life Insurance is a very good thing in a moral point of view.[70]

On the last page of his point-by-point argument, Heiner arrives at the last and most significant hurdle that needed to be overcome: Does life insurance go against the will of God? "In our humble judgment," he writes, "it is no more interfering with Providence for a man to insure his life, than it is for him to provide himself against the cold blasts of winter . . . ."[71] It is noteworthy that Heiner's long article on the justification for the usage of life insurance failed to mention money—something quite shocking if insurance is little more than a financial tool. Instead, Heiner's article focused on values such as holding families together, protecting orphans, preventing crime and promoting virtue. According to this argument, insurance was not so much a financial instrument as it was a Christian method of living, much as the original believers lived. As Heiner explains:

To us these seem to be just views, and in sweet harmony with the tender yearnings of a mind and heart rightly educated. And in this connection, we desire to call particular attention to the fact, that the principle of Life Insurance is substantially the same as that adopted by the early Christians, when they sold off their individual possessions, and held every thing in common; for *insurance is but an agreement of a community to consider the goods of its individual members as common property.* And no one will doubt, it is presumed, that the principle here adopted by the early followers of our Lord, received the sanction of the Divine approbation.[72]

Heiner's article appeared in the *United States Insurance Gazette and Magazine of Useful Knowledge*, a periodical for insurance agents. The idea was that insurance agents would read the article, and then apply its arguments to their sales pitches. Similar arguments were also found in publications aimed directly at the consumer, such as this excerpt from a pamphlet published by the Mutual Life Insurance Company of New York:

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70. Elias Heiner, *An Examination and Defense of Life Insurance*, 5 U.S. INS. GAZETTE & MAG. OF USEFUL KNOWLEDGE 144 (1857).

71. *Id.* at 152.

72. *Id.* at 143.

"Life Assurance, then, rests on Divine Law, as its only true basis; and the assured, in so doing, at once places himself under the protection of this law. Hence, it banishes speculation from society, and brings all things in subjection to Divine government and will."[73]

The second key task for the life insurance industry was to convince the public that it was the breadwinner's duty to support his family even beyond the grave. To accomplish this, salesmen relied on several scriptural passages, notably, 1 Timothy 5:8, which reads, "[i]f anyone does not provide for his relatives, and especially for his own family, he has disavowed the faith and is worse than an unbeliever."[74] Reading over insurance treatises and advertisements from the 1840's up to a century later, one repeatedly sees this verse cited over and over. Such arguments did not fade away in the twentieth century. C. C. Spaulding, then president of the North Carolina Mutual Insurance Company, made reference to it in a speech given at Howard University in 1943.[75] Also, Jehovah's Witnesses struggled with the issue as late as the 1960's. Their magazine, *The Watchtower*, used the following argument:

> Life insurance and other forms of insurance cannot be condemned as gambling but are rather a form of investment. One is not trying to insure that one will not have an accident or will not die, but is only seeking to provide in the case of an emergency. It is Scriptural *for a man to provide for those that are his own*, and if he wishes to make such provision in this way, that is entirely up to him.[76]

Once the idea took hold that the father was responsible for his family even after his death, it was an easy step to justify life insurance based on the financial security it provided. The magazine *The Catholic World* similarly reasoned:

> If we have responsibilities for the past, we may have anticipated duties towards the future. Because the acts of to-day entail responsibilities in the future, there is created

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73. Alexander Welsh, *The Religion of Life Insurance I; Assurance of Immortality*, THE CHRISTIAN CENTURY 1963, at 1541.

74. 1 *Timothy* 5:8.

75. WALTER B. WEARE, BLACK BUSINESS IN THE NEW SOUTH: A SOCIAL HISTORY OF THE NORTH CAROLINA MUTUAL LIFE INSURANCE COMPANY 185 (1973).

76. THE WATCHTOWER, Sept 15, 1960, at 576 (emphasis added).

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> an ethical relationship which cannot be ignored. Life insurance is the modern method of fulfilling the duties that belong to what which is to be. The ethical side alone concerns us.[77]

In summary, the new story of insurance completely reversed the old one, and it did so in two steps. First, the idea of providence was replaced by one of divine regularity. People died or lived long lives not because they were sinners or virtuous, but because some happened to die early and some did not. The Creator still remained in the picture, of course, but in a post-Enlightenment version that made room for scientific accounts of the way the world worked. Second, the good Christian was converted to one who took care of his family's finances, even after his death.

Take no Thought for the Morrow

Life insurance came to be accepted by the lay public after they were able to tell a story that did not conflict with the dominant narratives about risk and responsibility. For this to happen, life insurance salesmen had to provide a new biblical interpretation of the nature of fate and how the provident individual responded to it. The old story of insurance was one of putting faith in God for the care of dependents after the breadwinner passed away. Individuals enjoyed long lives or suffered short ones depending on how well they served God and were faithful to His commandments. One needed only to look to Matthew 6:34, which instructs the faithful to, "take no thought for the morrow."[78] Under this story, the true believer did not need to, since God was merciful to those who followed His word. "Put not your trust in princes, nor in the son of man, in whom there is no help . . . . The Lord . . . . relieveth the fatherless and the widow . . . ."[79] Under the new version, individuals were responsible for their own and took care of them through life insurance. Thus it was that the Presbyterian Annuity and Life Insurance Company could inform the readers of its sales pamphlet that its policies used sound actuarial principles based on the laws of "Christ the Creator." Moreover, the advertisement boasted, if they purchased insurance today they would be following Christ's command to "not be anxious about tomorrow."[80]

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77. *The Ethics of Insurance*, THE CATHOLIC WORLD, Mar., 1867, at 816; *Social Security Coverage of Amish Workers: Hearing on H.R. 2259 Before the Subcomm. on Social Security of the Comm. on Ways and Means*, 100th Cong. 16 (1987) (statement of Jesse Neuenschwander, Bishop, Eastern Pennsylvania Mennonite Church).

78. *Matthew* 6:34.

79. *Psalms* 146:3,9.

80. TRACY, *supra* note 61, at 86.

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In 1840, there were fifteen life insurance companies in America, holding an estimated $5 million worth of coverage.[81] By 1860, the number of companies had risen to forty-three, holding an astonishing $205 million in coverage.[82] The rise could not simply have been due to the Civil War that would shortly follow. After all, the nation had already witnessed two significant military conflicts in 1812 and 1832. The key variable was neither war nor changes in cost and benefit analyses. I have argued that the key variable, instead, was that a new narrative allowing the faithful to purchase life insurance without it being in conflict with deeply held religious values had been systematically and comprehensively introduced across the nation. We need to approach this claim with apprehension, as it is a difficult one to test. Still, in the absence of a better explanation, the data do appear to support this argument nicely.

Bear Ye One Another's Burdens

When communities break with long-standing practices, social scientists should take notice. One such example is the reaction of the Old Order Amish to the introduction of Social Security for self-employed farmers. This case, while not exactly representative of mainstream American society, is still instructive for the lessons it reveals about culture and institutions.

The Old Order Amish consciously attempt to preserve their culture and shape their society through a clear set of rules upon which all must agree. These rules, in large part, are predicated on stories of who they are; and just as importantly, who they are not. Perhaps more than any other American sub-culture, the "Plain People" (as the Amish call themselves) actively define who they are. They actively and consciously write their own stories. To those who see the Amish as a highly traditional people, this may come as a bit of a surprise. In reality, the Amish are a highly "modern" society in the sense of taking control of their own destiny.[83] Social structures, rules, financial dealings, and rituals are all designed to protect and preserve their culture.[84]

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81. VIVIANA A. ROTMAN ZELIZER, MORALS AND MARKETS: THE DEVELOPMENT OF LIFE INSURANCE IN THE UNITED STATES 6 (1979).

82. *Id.*

83. *See* DONALD B. KRAYBILL & MARC A. OLSHAN, THE AMISH STRUGGLE WITH MODERNITY 33 (Univ. Press of New England 1994). *See generally* CHARLES P. LOOMIS, SOCIAL SYSTEMS: ESSAYS ON THEIR PERSISTENCE AND CHANGE 212 (1960).

84. *See* Robert L. Kidder & John A. Hostetler, *Managing Ideologies: Harmony as Ideology in Amish and Japanese Societies,* 24. LAW & SOC'Y REV. 895 (1990).

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Amish individuals study the Bible extensively and predicate their lives on a relatively strict interpretation, which, among other things, calls for separation from the outside world and a system of helping those in need. The two are related in that separation from the outside world necessarily implies mutual assistance. Having cut themselves off from the outside world, they leave no one else to whom they can turn. Conversely, mutual reliance helps strengthen the ties that bind them to each other.[85] Quilting parties, barn raisings, and helping each other with farm work during times of illness enriches the lives of the participants, allowing them to express friendship and enjoy each other's company.

The Amish draw from the bible in deciding to separate themselves from the outside world. II *Corinthians* 6:14 instructs the follower, "Be ye not unequally yoked together with unbelievers: for what fellowship hath righteousness with unrighteousness? and what communion hath light with darkness?"[86] Two verses later, the believers are instructed, "Wherefore come out from among them, and be ye separate, saith the Lord, and touch not the unclean thing . . . ."[87] Fear of the outside extends beyond biblical teaching. News of crime, divorce, violence and atomistic lifestyles devoid of the richness provided by community strike fear into the hearts of many Plain People, bringing them even closer together and pushing them away from the outside world.[88] The Amish use a wide variety of cues to mark themselves as distinct from the non-Amish.[89] The simple dress, German dialect, and use of horse and buggy help distinguish the "us" from the "them." Following the exhortations found in Romans 12:2 "[d]o not be conformed to this world[,]"[90] the Amish attempt to remove themselves both in culture and in society from outsiders. While they readily engage in trade, they are reluctant to connect their lives in many other ways, such as using insurance, out of fear of being "unequally yoked."

While commercial insurance policies that link them to the outside world are avoided, formal and informal mutual welfare programs between members of the community are part of the very fiber of Amish society. Following Galatians 6:2 "Bear one another's burdens, and so fulfill the law

85. IRA D. LANDIS. *The Social Security-Amish Issue*, 3 MENNONITE RES. J. 14 (1962).

86. 2 *Corinthians* 6:14.

87. 2 *Corinthians* 6:17.

88. *See* HOSTETLER, *supra* note 47, at 130-31, 234-35. *See also Social Security Coverage of Amish Workers: Hearing on H.R. 2259 Before the Subcomm. on Social Security of the Comm. on Ways and Means*, 100th Cong. 16 (1987) (statement of Jesse Neuenschwander, Bishop, Eastern Pennsylvania Mennonite Church).

89. *See* DONALD B. KRAYBILL, THE RIDDLE OF AMISH CULTURE 18-19, 50-58 (1989).

90. *Romans* 12:2 (footnote omitted).

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of Christ,"[91] the Plain People strive to ensure that none of their brethren fall into dire need. The large communal gatherings to make quilts and raise barns are perhaps the more famous examples of helping one another, but assistance can be found in numerous other ways as well. When a farmer falls ill, his neighbors will organize and tend the crops and animals.[92] The tiresome chore of canning preserves falls on the mother, who will also receive help with this and the other endless household duties when she is sick.

Even the burden of coping with death is shared in a highly communal manner. Three couples are selected to make the burial arrangements, including sending out notices, preparing food, and dealing with the hundreds of visitors who will come to the house over the next few days to pay their last respects and attend the funeral. Friends and family will attend to all the chores of the house and farm, with one close female relative or friend often moving in to take care of the children. By taking care of all the details and chores, the community allows the loved ones time to mourn and be together.[93] When a motorist killed several small children in Fredericksburg, Ohio in 1993, for example, hundreds of Amish swarmed to the village from as far as several states away in order to express their sympathy and tend the farms of the grieving families.[94]

Mutual aid among the Amish is based on two pillars. Immediate and extended families form the first pillar. The typical Amish household has seven children, with nearly fifty percent of the total population aged younger than eighteen.[95] In terms of extended family, a child may have two dozen aunts and uncles and seventy-five first cousins, all living within a day's travel.[96] Divorce does not exist and grandparents usually live in a smaller building next to the main house. The individual is rarely alone, constantly interacting with relatives. Families that farm will usually eat three meals a day together, spending many of their off hours huddled

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91. *Galatians* 6:2.

92. Jane Getz, *The Economic Organization and Practices of the Old Order Amish of Lancaster County, Pennsylvania*, 20 THE MENNONITE Q. R. 98, 98-127 (1946).

93. *See* Kathleen B. Bryer, *The Amish Way of Death: A Study of Family Support Systems*, 34 THE AM. PSYCHOL. 255, 255-57 (1979). *See also* LUCIAN NIEMEYER & DONALD B. KRAYBILL, OLD ORDER AMISH: THEIR ENDURING WAY OF LIFE 157-58 (The Johns Hopkins Univ. Press 1993).

94. Don Terry, *A Drawing Together in Grief for 5 Amish Children*, N.Y. TIMES, May 17, 1993, at A12.

95. Donald B. Kraybill, *Negotiating with Caesar*, *in* THE AMISH & THE STATE 7 (Donald Kraybill ed., 1993).

96. KRAYBILL, THE RIDDLE OF AMISH CULTURE, *supra* note 89, at 76.

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together around a single space heater in the living room during the winter months, or performing some common activity during the warmer ones.

The second main pillar of assistance is the church district. A church district averages around 163 members from an average of twenty families.[97] Districts are geographically based, with the closest households congregating together every other Sunday in the home or barn of one of the families for a service. Hosting duties rotate between all the families, guaranteeing that all the other district members will visit one's home at least twice a year.

Each district has an explicit set of rules known as the *Ordnung*.[98] The *Ordnung* is not a formal written list, but is known to all in no uncertain terms. It defines the rules and behavior that each member must follow. The *Ordnung* is best conceived of as a consciously developed and propagated body of understandings, allowing individuals to place new situations into a pre-existing framework. In other words, it is a collection of narratives about life in the world and the place of the Amish in it. Like the other debates we have witnessed in this chapter, the *Ordnung* speaks to what members owe each other. Unlike the other debates however, which for the most part arose in an *ad hoc* manner in response to exogenous shocks or new inventions, the *Ordnung* is formally discussed and agreed upon by all adult members of the district twice a year, before they take semi-annual communion, and agreement must be unanimous. Families that cannot abide by the *Ordnung* will leave the district, sometimes actually physically packing up and moving elsewhere.

> One effect of routinely and consciously debating issues of risk and responsibility is that the Amish have a strong awareness of the relationship between identity and institutions of mutual assistance. Since identity is always one of the criteria by which they make decisions, they are able to explicitly assess both the impacts of various policies, in terms of their financial effects, and in regards to what that says about who they are as a community. We see how this works by examining the case of the introduction of Social Security to self-employed farmers.

In 1955 President Eisenhower's administration announced that the Old-Age, Survivors, and Disability Insurance program, commonly known as Social Security, was being extended to self-employed farmers. This

97. *Id.* at 76.

98. Pronounced "Ott-ning."

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mandatory program would allow self-employed farmers (which most of the Amish were then) the assurance of a steady, albeit small, income after they entered their retirement years. While many farmers might have found comfort in knowing that they would hence be covered by America's social safety net, the Amish saw things differently. The U.S. Social Security program would have linked them to the outside world via an insurance scheme, something prohibited by their religion. Just as important, I argue, is that the government benefit plan would have mitigated the need for mutual reliance, one of the very cornerstones of Amish society.[99]

From a religious perspective, Social Security was an affront to the Amish in two ways. First, it was unveiled to the public as an insurance program. Peter Ferrara notes that when the Amish explained to the Internal Revenue Service (IRS) that their religious beliefs forbade them from engaging in insurance programs, IRS agents stated that the Social Security payments were not insurance contributions but rather a tax. The brethren disagreed, pointing not just to the program's title "Old-Age, Survivors, and Disability *Insurance,*" but also to numerous publications put out by the government to sell the new idea as a form of insurance for the retired.[100] Secondly, it was a governmental program linking the Amish to the outside world for assistance. "Woe to those who go down to Egypt for help"[101] warns Isaiah 31:1, and the Plain People interpreted this to mean that they should not go to the government for assistance. The Amish are in a constant struggle to keep their society removed from outside influence, even as they interact with the non-Amish through trade and other means. Social Security would have made them uncomfortably close to outsiders, yoking them unequally to the "unclean" world.

One can tell the tale of the Amish community's opposition to Social Security as being based on religion, and this has been the prevailing interpretation.[102] Yet religion is only one component of the opposition, since Social Security was threatening to the Amish in a different, more subtle manner as well. I have argued that Amish society is held together in part by the institutions of mutual welfare. Social connections and mutual welfare are intimately linked for the Amish. If the mutual welfare component of their society began to break down, the result very well could

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99. *See generally* Brian J. Glenn, *Collective Precommitment From Temptation: The Amish and Social Security*, 13 RATIONALITY & SOC'Y 185 (2001).

100. PETER J. FERARA, *Social Security and Taxes, in* THE AMISH & THE STATE 130-31 (Donald Kraybill ed., 1993) (emphasis added).

101. *Isaiah* 31:1.

102. Landis, *supra* note 84; Clarence W. Hall, *The Revolt of the 'Plain People'*, 81 READERS DIGEST 74-78 (Nov. 1962).

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be an unwinding of the numerous other links that keep the community together. It would have changed who they were as a people.

The Search for an Exemption from Social Security

From the very introduction of Social Security, many Amish simply refused to pay the contributions. Being self-employed, the burden fell upon them to make the payments themselves. Since the *Ordnung* of different districts varied, there was a variety of responses to the dilemma. While some brethren refused to make payments but left money in accounts where they knew the IRS could seize it, others closed their accounts "and otherwise arrange[d] their affairs so no funds were vulnerable to IRS collection procedures."[103]

The IRS began seizing funds and even farm animals from the Amish to sell off in lieu of contributions. This elicited a few editorials and angry letters by friends of the Amish. The Plain People try to live a life that is "[r]ejoice in your hope, be patient in tribulation, be constant in prayer[;]"[104] but even they have a boiling point. That point was breached with the case of Valentine Y. Byler. Byler was an Amish farmer living in Wilmington, Pennsylvania. In 1959 the IRS filed legal action against Byler for failure to pay his Social Security taxes, and he was arrested in August of 1960 on contempt charges. The judge was so moved by Byler's religious convictions that he let Byler out on bail. During the spring planting of April 1961, Byler was out in his fields with three of his horses. IRS agents pulled up in a truck, presented him with legal papers, and carted off his horses, which were later sold at auction. The excess funds of $37.89 were returned to Byler by check. Public outcry was quick and severe. The idea of big government seizing an Amish farmer's horses while he was in the field with his spring planting enraged politicians, journalists and citizens alike. The story of the case reached into both the elite media and popular publications, placing the issue on the public agenda across the nation.[105]

The tide of sympathy and support led the Amish to consider a political appeal to Congress for an exemption from the tax. Abraham Ribicoff, President Kennedy's Secretary for Health, Education and Welfare (HEW) met with Amish representatives in 1961, but the two sides could not reach an agreement. The following year, eighty representatives from the Amish communities traveled to Capitol Hill in their simple garb and met face-to-face with over four hundred members of Congress. HEW and the Social

103. FERRARA, *supra* note 100, at 131.
104. *Romans* 12:12.
105. Hall, *supra* note 102.

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Security administration argued against an exemption, claiming that if the hundred thousand or so Amish members were allowed to opt out of the system, it would threaten the actuarial stability for the remaining 200 million Americans still in it. Congress found this argument less than convincing, and eventually sided with the Amish. In 1965 an exemption was attached to a Medicare bill, and exacted into law. Henceforth the Amish were allowed to request exemptions on an individual basis from the Social Security system as long as they remain self-employed and are certified as members in good standing in their church district.[106] The exemption was later extended to brethren working for Amish employers.

Being a people who give great thought to the nature of their communities and how new factors will affect them, the Amish were quick to realize the temptation that Social Security benefits posed for dismantling their careful net of mutual obligation and assistance. Once they began paying into the system, it would be hard to resist cashing the checks they received after retiring — the very time when members were expected to become reliant on the next generation for support. If the law forced members to pay into the Social Security system, there was a concern over the ethics of then mandating that members could not tap into such funds later in life, even though doing so ran directly against the Amish way of life regarding insurance.[107] Testifying before Congress in an appeal for a further exemption three decades later, Mennonite Bishop Jesse Neuenschwander explained that "[b]eing involved in insurances including Social Security brings a conditioning effect upon our people that undermines our trust in God and consequently our faith . . . [t]o receive Social Security payments, welfare payments, and similar programs is *a threat to the continuation of our way of life and faith.*"[108] The eighteenth century Bostonians reconstructed their narratives of risk and responsibility before they were able to accept inoculation. For this procedure to be allowed, pre-existing values had to be re-interpreted. In the case of the Amish, however, we see an example of a community realizing that their cherished cultural beliefs were so valued that they were willing to forego the opportunity to receive Social Security in order to protect them. It was only because of their awareness of the influence that insurance schemes

106. The Amish actually have their own IRS exemption form, IRS Form 4029.

107. FERRARA, *supra* note 100, at 130-31; WAYNE L. FISHER, THE AMISH IN COURT 133 (1993).

108. *Social Security Coverage of Amish Workers: Hearing on H.R. 2259 Before the Subcomm. on Social Security of the Comm. on Ways and Means*, 100th Cong. 16 (1987) (statement of Jesse Neuenschwander, Bishop, Eastern Pennsylvania Mennonite Church) at 16 [emphasis added].

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had on their definition of who they were as a people that they were able to do this. By clearly acknowledging that how a community takes care of their own has an impact both on the recipients of the aid financially and on the community as a whole, the Amish are able to define who they are and what they value. Just as important, they are able to protect their system from unwanted change. As a 105 year-old Amish explained, "[t]imes change, and styles and ways of doing things change for us Amish. But the thing that has never changed is the way we help and care for each other. That never changes."[109]

Conclusion: Who We Are Shapes How We Take Care of Each Other

Tucked in between the massive corporate headquarters of some of America's largest insurance companies sits the stately Center Church of Hartford, Connecticut. It is literally a stone's throw from the imposing tower of the Travelers Insurance Company, whose corporate logo is the red umbrella. In 1964, the Reverend William L. Bradley gave a sermon at the church entitled, "God and the Red Umbrella," in which he noted that even though the body is now protected by commercial insurers, only the Church can care for the soul.[110]

What Rev. Bradley failed to understand is that even the care for the body was an issue of religion. The extent to which members of the polity take care of each other is contingent upon the stories they tell themselves—and which are told to them—about who they are and how they got here. There is no one single identity, of course. It is a shifting concept. At different times, individuals will define themselves in terms of their job, their location, their ethnicity and religious heritage, their ancestors, and their nation. Not only does each one of us have multiple identities, but the different identities themselves are constantly evolving. We acquire new experiences in the present and rewrite our histories of the past, and one of the forces in shaping these stories, as we have seen in this article, are the institutions of mutual assistance whose form and extent need to be justified in order to find acceptance.

In this study we examined four cases in which communities were faced with the opportunity to protect themselves from risk through the introduction of inoculation on the one hand, and public old-age insurance, on the other. All four of these methods for mitigating loss challenged deeply held beliefs, and as we have seen, each required a new interpretation

109. BRYER, *supra* note 93, at 260-61.

110. WILLIAM L. BRADLEY, *God and the Red Umbrella, in* 5 THE HARTFORD Q. (1964).

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of the community's values to be constructed before being able to find acceptance. These cases reveal two important points.

The first major lesson we learn from studying these cases is that forms of mutual assistance created by a polity are profoundly and intimately related to the very definition of who they are as a people. Viewed as a whole, the process is dynamic. Culture helps structure the shape of the institutions through which members of a community take care of those in need. These institutions in turn also force the community to justify why they help members in one way and not another, which can at times result in the alteration of values.

Values and institutions simply must correspond, and when they don't, we see instability and change in one or the other. Before Cotton Mather, William Cooper and the other Boston ministers were able to provide the town's residents with a justification for inoculating themselves against the smallpox epidemic, there were quite literally riots in the streets. Neighbors tore lightning rods off each others' houses. The normally passive Amish engaged in massive (by their standards) forms of civil disobedience rather than fall under a form of mutual assistance that was unable to fit into their existing narratives pertaining to risk and responsibility.

The second major point that cannot be stressed enough is that the debates over the acceptability of the new methods and the reconstruction of the definitions of risk and responsibility they entailed were distinctly *political* events, and as such are vital to accounts of the development of the American institutions of mutual assistance. David Easton has described politics as "the authoritative allocation of values for a society."[111] Proclaimed as one of the most influential and useful definitions of the field,[112] it has been frequently ignored of late by scholars of American political development, many of whom largely consider politics as little more than the activity of legislatures, courts, and lobbying groups. Prior to the New Deal especially, what has been omitted has perhaps been the most important part of the story of all: the debates discussed in the cases above would not have been picked by institutionalist scholars not interested in cultural issues, and this is unfortunate, for to the members of those communities engaged in them, *the debates themselves were politics.*

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111. This definition has informed much of Easton's massive and impressive scholarship. DAVID EASTON, THE POLITICAL SYSTEM: AN INQUIRY INTO THE STATE OF POLITICAL SCIENCE (1953); DAVID EASTON, A FRAMEWORK FOR POLITICAL ANALYSIS (1965); DAVID EASTON, A SYSTEMS ANALYSIS OF POLITICAL LIFE (1965); David Easton, *Political Science, in* 12 INT'L ENCYCLOPEDIA OF THE SOC. SCIENCES (David L. Sills ed., 1968).

112. DWIGHT WALDO, *Political Science: Tradition, Disciplines, Professions, Science, Enterprise, in* 1 HANDBOOK OF POL. SCI. 1 (Fred I. Greenstein & Nelson Polsby eds., 1975).

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To understand why members of a polity protect themselves and others the way they do via institutions of mutual assistance, we first need to understand the narratives of risk and responsibility that inform the debates. Of course, specific details of a program will be influenced by far more than cultural arguments, but the broad outlines of a program will be bounded by conceptions both of what is feasible, and also of what is desirable.

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THE LEGAL STANDING OF AN INSURANCE INSOLVENCY RECEIVER: WHEN THE SHOE DOESN'T FIT

Karl L. Rubinstein

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INTRODUCTION

The issue presented in this article is whether an insurance receiver "stands in the shoes" of the pre-receivership company and, thus, may be held to stand *in pari delicto*[1] with the company or be subject to estoppel principles based on pre-receivership misconduct by the company's management. The thesis of this article is that, as the embodiment of the state's police power and as the representative of innocent policyholders and creditors, an insurance receiver is neither *in pari delicto* nor subject to such estoppel.

The need for the regulatory take-over of financially impaired large insurance companies has been all too frequent. The collapses of companies such as the Baldwin-United Insurance subsidiaries, the Mission Insurance Companies, Integrity Insurance Company, Executive Life Insurance Company, First Capital Life Insurance Company, Mutual Benefit Insurance Company, Fidelity Mutual Insurance Company, Confederated Life Insurance Company, Golden Eagle Insurance Company, Reliance

1. Literally, "in equal fault." The full phrase is: *in pari delicto, potior est conditio defendentis,* meaning "[i]n a case of equal or mutual fault, [between two parties] the condition of the party in possession [or defending] is the better one." *See* BLACK'S LAW DICTIONARY 791 (6th ed. 1990).

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Insurance Company and many others have left a wake of litigation, regulatory burden, policyholder loss, as well as substantial public financial burden and disillusionment.

Many of these complex insolvencies involved insurers that were part of a holding company system owning several affiliated non-insurance companies. Often, the non-insurance companies have become embroiled in related federal bankruptcy proceedings.[2]

The business contexts in which these insolvencies occur have become extremely complex and courts often have difficulty in resolving the legal issues presented by competing claims and equities.

On many occasions courts fail fully to focus upon the fact that insurance and reinsurance companies operate in a highly regulated environment very different from that of other companies, and that there are key differences between ordinary commercial contracts and insurance related contracts such as insurance policies and reinsurance agreements, which support obligations to innocent policyholders.

Importantly, it is at the time of an insurer's financial collapse that the efficacy of its insurance policies and related contracts becomes most crucial to its policyholders, its creditors, and the public at large. Insurance or reinsurance contracts, though technically between only the particular parties thereto, also affect the vital interests of third parties.[3] Moreover, the enforcement of these contracts by a state's Insurance Commissioner or equivalent,[4] acting as an insurance receiver, is an exercise of the police power of the state and implements the vital public purpose of regulating the insurance industry and protecting those affected by its transactions.

The very essence of insurance regulation is to protect the public's interest in efficacious insurance products and to insure that policyholder rights will be protected. All states have detailed statutory schemes for regulating insurance companies. These statutory schemes, among other things, also specify a claim filing process and a priority scheme for the payment of claims in the event of insolvency.[5] Under the statutory

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2. Insurance companies may not be debtors under federal bankruptcy law. *See* 11 U.S.C. § 109 (2003). Accordingly, insurer insolvencies are handled in state court proceedings under state laws while the non-insurers proceed in federal bankruptcy courts.

3. For example, third persons injured by drivers with auto policies, individuals covered by workers' compensation policies, or beneficiaries of annuities or life insurance policies.

4. For ease of reference, this paper will usually not attempt to distinguish between titles such as "Commissioner," "Superintendent" or " Director" of Insurance, but will refer to all such officials as "Commissioner."

5. *See, e.g.*, CONN. GEN. STAT. §§ 38a-937 -962j (2003); OHIO REV. CODE ANN. §§ 3903.35-3903.49 (West 2004).

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priorities, policyholders are preferred over general creditors and general creditors are preferred over shareholders.[6] Thus, the claims of policyholders must be fully paid or adequate provision made for their full payment before general creditors may be paid. Shareholders cannot be paid unless creditors are first satisfied. The insurance receiver has the discretion to approve or disapprove claims. If a claim is disapproved, the claimant must, within a certain time, file an action in the receivership court seeking to overturn the receiver's decision.[7]

The state insurance statutes normally vest the Commissioner, as receiver, with title to all of the assets of the insolvent company and, by statute, the Commissioner becomes the "successor" to the company with respect to its assets and the enforcement of its contracts and other pre-receivership rights.[8] Because of this, courts sometimes say that the receiver "stands in the shoes" of the insolvent company.

Some courts have not only used this phrase, but upon its authority, have imputed the wrongdoing of pre-receivership management to the receiver so as to place the receiver *in pari delicto*.[9] On this basis some courts have held the insurance receiver barred or estopped from recovering damages or other relief from these guilty third parties, thus diminishing the pool of assets available to pay policyholder and other creditor claims.

The doctrines of *pari delicto* and various forms of estoppel are founded in equity and are based on the concept that one ought not benefit from one's own wrong. Where the court finds two parties "in equal fault," the court will leave them where they are. Where one has unclean hands, one

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6. In this way, among many others, state insurance insolvency differs from federal bankruptcy. In the context of bankruptcy, the primary division between classes of claims is that of "secured claimants" and that of "unsecured claimants." Under state insurance insolvency laws, there are strict priorities under which policyholders are *always* preferred over general creditors and shareholders. Due to the requirement that insurers have unencumbered reserves to support policy obligations, there are usually few secured claimants in an insurance insolvency context.

7. Under some statutes, for example TEX. INS. CODE ANN., art. 21.28 § 3(h) (Vernon Supp. 2004), the claim hearing is *de novo*. Under others, the burden is upon the claimant to show cause why the receiver should be reversed. *See, e.g.*, CAL. INS. CODE § 1032 (West 1993). In either event, the claimant will obtain court review. One may expect that officers, directors, shareholders and third parties with unclean hands would find it difficult to obtain approval of their claims, particularly where policyholders and other creditors with higher statutory claims priority have not been paid first.

8. *See, e.g.*, TEX. INS. CODE ANN. art. 21.28 § 2 (Vernon Supp. 2004).

9. *See, e.g.*, Seidman & Seidman v. Gee, 625 So. 2d 1, 3 (Fla. Dist. Ct. App. 1992).

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may be estopped from recovery.[10] Accordingly, if, for instance, the management of an insurance company enters into a contract with a third party, which is illegal under applicable law, then outside of the insurance receivership context, neither the insurer nor the third party may enforce the contract. Or, if insurance company management conspires with third parties in some way to injure the property of the insurer, then, pre-receivership, it may well be that the parties would be in equal fault and, absent the advent of a receivership, the insurance company would not be able to recover damages from the co-conspiring third parties. Such non-receivership results, however, cannot properly occur after an insurer is placed into statutory receivership under state insurance statutes, because any recoveries would be for the benefit of innocent policyholders and other creditors; not the guilty company, its management, or its owners.

The purpose of this article is to show that an Insurance Commissioner who, acting as the statutory insurance receiver, seizes control of the company can never properly be held *in pari delicto* with former management. This is so because the insurance receiver is not the same as the company and he or she is not the mere "successor" to the insurance company. Instead, an insurance regulator, as receiver, is the manifestation of the state's police power and is asserting the sovereign authority and interest of the state in seizing the delinquent insurer and dealing with its assets and liabilities to protect the interests of the innocent policyholders and other creditors of the insurer.

Accordingly, the insurance receiver does not stand precisely in the shoes of the company. Instead, the insurance receiver acts as the agent of the sovereign state in its efforts to promote and protect the public welfare. Under the statutory claims priorities, recoveries by the receiver are for the benefit of innocent policyholders and creditors; not for guilty shareholders. Because of this the insurance receiver is not acting on behalf of the company *per se*, and the equitable notions that might estop the company from recovering on the basis of acts in which it has been made to participate do not apply to the insurance receiver.

Because of the insurance receiver's unique position, it is not correct simply to say that the insurance receiver "stands in the shoes" of the company, as some courts have done. This is not a correct statement of the law because it fails to give effect to the special standing of an Insurance Commissioner acting as the receiver on behalf of the state and the public

10. For example, in the case of Vaszauskas v. Vaszauskas, 115 Conn. 418, 423 (1932), the Connecticut Supreme Court of Errors held "[I]f both parties are in [sic] *pari delicto*, the law will leave them where it finds them[.]" *Id.* at 423.

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welfare, and it fails adequately to take into account the nature of insurance and reinsurance relationships as they affect the public welfare.[11]

This article will discuss the nature of the police power and the manner in which it affects and permeates insurance regulation. The thrust of the article is to show that as the embodiment of the state in the exercise of its police power, the insurance receiver cannot legitimately be held to stand in the shoes of the insurer in the sense of being *in pari delicto* with the company and any third parties that have helped engineer its demise.

The thesis of this paper is that an insurance receiver presents an exception to the general rule that a company's successor stands in the shoes of the company. As the *statutory* successor to the company, put in place to implement the police power of the state for the purpose of enforcing the laws of the state, the insurance receiver acts in his or her own name as an officer of the state, and not in the name of the company. The receiver does not stand in the shoes of the company in the sense that equitable estoppel principles or *in pari delicto* principles can be applied against the receiver because to do so would be applying these principles to the state itself and against the innocent policyholders and creditors whom the statutory insurance regulatory scheme is designed to protect.

There are a number of case decisions that have properly stated and applied the thesis of this article. The article will discuss several of these cases, but it does not attempt to cite and discuss every case. The article will also discuss several of the cases that hold the receiver does stand in the shoes of the company, again without attempting to discuss every case.[12]

In *English Freight Co. v. Knox*,[13] the court had it right when it held that "[t]he receiver not only represents the insolvent insurance company, but he also represents its policyholders, the beneficiaries under the policies, the creditors, and is the representative of the public interest in the enforcement of the insurance laws as applicable to the policies of an insolvent insurance company."[14]

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11. State statutes place strict requirements on the financial status of insurers. Insurers must have sufficient "admitted assets" as "reserves" to support obligations to policyholders and others claiming through the policies. *See, e.g.*, CONN. GEN. STAT. §§ 38a-69-89 (2003). Thus, it is proper to view the reserves as belonging to the policyholders and only the surplus over reserves as being available to creditors and shareholders in the priority established by the state statutes.

12. There are certain unique situations, such as disputes over offsets and disputes over an agent's balances that this article does not address other than in passing.

13. 180 S.W.2d 633 (Tex. App. 1944).

14. *Id.* at 640.

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Likewise, the Texas Supreme Court was correct in *Shaw v. Borchers*[15] when it held:

> It is true the general rule is that the receiver of an insolvent corporation has no greater rights than those possessed by the corporation itself. There is, however, a well-defined exception to such rule. A receiver of such a corporation acts in a dual capacity. He is a trustee both for the stockholders and the creditors. As trustee for the creditors, he is permitted to maintain and defend actions involving acts done in fraud of creditors, even though the corporation would not be permitted to do so.[16]

This article will seek to show why these and similar case decisions reach the just, equitable and legally correct result.

I. THE STATE'S POLICE POWER AND ITS RELATIONSHIP TO INSURANCE

The sovereignty of a state includes the right and the duty to exercise a police power to promote the peace, security, safety, health and general welfare of its citizens.[17] A state cannot surrender, abdicate or abridge its police power and, as a general proposition, a state cannot be estopped from exercising its police power.[18] An act is within the state's police power if it reasonably relates to legitimate governmental interest.[19]

The court system has long recognized the significant public role of insurance. The United States Supreme Court, for example, said in *German Alliance Insurance Co. v. Lewis*[20] that:

> The effect of insurance -- indeed, it has been said to be its fundamental object -- is to distribute the loss over as wide an area as possible. In other words, the loss is spread over the country, the disaster to an individual is shared by many, the disaster to a community shared by other communities; great catastrophes are thereby lessened, and, it may be, repaired . . .. [Insurers'] efficiency, therefore, and solvency are of great concern. The other objects, direct and indirect, of insurance we need not mention.

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15. 46 S.W.2d 967 (Tex. App. 1932).

16. *Id.* at 968-69. *See also* Farmers State Bank v. Largent, 132 S.W.2d 482, 484 (Tex. Civ. App. 1939).

17. 16A AM. JUR. 2D *Constitutional Law* § 313 (1998).

18. *Id.*

19. *Id.*

20. 233 U.S. 389 (1914).

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> Indeed, it may be enough to say, without stating other effects of insurance, that a large part of the country's wealth, subject to uncertainty of loss[,] . . . is protected by insurance. This demonstrates the interest of the public in it . . . .[21]

It is for these reasons that the law considers insurance to be a public asset.[22] The solvency of insurers is, accordingly, a matter of vital public concern both in regard to preventing insurer insolvencies and in regard to handling them when they do occur. Clearly, the financial collapse of an insurance company is a problem of many facets and ramifications. The injury to policyholders, third party claimants, general creditors, shareholders and the general public is very serious even in the smallest of cases. When the carrier is a huge company with policyholders in all 50 states and a financial impairment running in the hundreds of millions, or even into multi-billions, the situation is tragic. It is, therefore, crucial that courts apply the correct legal and equitable principles to these situations.

Insurer insolvencies most frequently result from acts or omissions that either overstate its assets, understate its liabilities, or both. These acts or omissions sometimes result from ineptness, sometimes from fraud or other misconduct and sometimes from a combination of these factors. Whether inept or intentional, the fault is often that of corporate management, but sometimes a substantial share of the fault is upon third parties who have acted in concert with management.

Insurers are regulated by the states and when an insurer becomes financially troubled, it is the job of the Insurance Commissioner to step in and deal with the situation. Normally, the Commissioner places the insurer under some form of regulatory control. In all but the least serious of situations this control involves a court-supervised receivership.[23]

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21. *Id.* at 412-13.

22. *See, e.g.*, Cal. State Auto. Ass'n. Inter-Ins. Bureau v. Maloney, 341 U.S. 105, 109 (1951) (holding that the rule that the police power "extends to all the great public needs" is "peculiarly apt when the business of insurance is involved - a business to which the government has long had a 'special relation.'"); Osborn v. Ozlin, 310 U.S. 53, 65 (1940) ("Government has always had a special relation to insurance. The ways of safeguarding against the untoward manifestations of nature and other vicissitudes of life have long been withdrawn from the benefits and caprices of free competition."); German Alliance Ins. Co. v. Lewis, 233 U.S. 389, 414-15 (1914) (the insurance business is "of the greatest public concern.").

23. The term "receiver" as used herein is meant to include the Commissioner in any of the roles as conservator, rehabilitator or liquidator.

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A. STATE INSOLVENCY LAWS IN GENERAL

Important issues of states rights and principles of federalism have confronted our nation since its very beginnings and it is certainly outside the scope of this article to delve into that subject in any depth. It is, however, important to note that it has been accepted historically that the states should regulate insurers as an adjunct of their police power. Naturally, in the fullness of time, the interests of the federal government and that of the state governments clashed over this issue and state regulation of the industry was brought very much into question by the case of *United States v. South-Eastern Underwriters Ass'n*,[24] which held that insurance companies were subject to federal regulation under the Commerce Clause of the Constitution.

There was a vigorous backlash from the industry and the state regulators as a result of *South-Eastern Underwriters* and, in 1945, Congress was persuaded to pass the McCarran-Ferguson Act.,[25] of which states, in pertinent part:

> (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, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance . . . .[26]

McCarran-Ferguson has been held to grant the several states the authority to control existing and future state systems for the regulation and taxation of the business of insurance.[27] While it is true that the federal government probably has the power to regulate insurance companies under the Commerce Clause as held in *South-Eastern Underwriters*, the congress has expressly declined to exercise that power by virtue of McCarran-Ferguson.[28]

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24. 322 U.S. 533 (1944).

25. 15 U.S.C. §§ 1011-15 (2003).

26. 15 U.S.C. § 1012 (2003).

27. *See* SEC v. Nat'l Sec., Inc., 393 U.S. 453 (1969); Wilburn Boat Co. v. Fireman's Fund Ins. Co., 348 U.S. 310 (1955); Prudential Ins. Co. v. Benjamin, 328 U.S. 408 (1946); Allstate Ins. Co. v. Lanier, 361 F.2d 870 (4th Cir.), *cert. denied*, 385 U.S. 930 (1966).

28. There is a series of cases that debate the extent to which the actual liquidation of an insurer is the "business of insurance" under McCarran-Ferguson, particularly with respect to federal tax claims, but that debate is outside the scope of this article. *See* Idaho v. United States, 858 F.2d 445, 452 (9th Cir. 1988), *cert. denied*, 490 U.S. 1065 (1989); Gordon v. U.S. Dep't of Treasury, 846 F.2d 272, 273-74 (4th Cir. 1988), *cert. denied*, 488 U.S. 954

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McCarran-Ferguson, therefore, permits the states to determine the rules of insurance regulation and one, accordingly, looks to state legal principles for interpretation of those rules.

Each state has its own legislative scheme. Attempts at uniform acts have resulted in the Uniform Insurer's Liquidation Act (1939) and, later, the Insurers Rehabilitation and Liquidation Model Act. These were efforts by the National Association of Insurance Commissioners ("NAIC") to sponsor uniform legislation, and a number of states have adopted versions of these models.

Although the precise provisions of the insurance statutes of the several states vary, they are more alike than they are different. Insofar as the points made in this article are concerned, the fundamental sense of the legislative schemes is the same, and the state statues selected for discussion in this article are typical unless otherwise noted.

The various state statutes all require that the Commissioner be appointed conservator or liquidator of insolvent insurers.[29] Accordingly, only an elected or appointed officer of the state acting in his or her official capacity may be appointed an insurance receiver.

In that capacity, the Commissioner acts as receiver and trustee.[30] As receiver, the Commissioner is not simply an equity or common law receiver, but acts in his official capacity as an officer of the state. The Commissioner is the embodiment of the state's police power in the insurance insolvency context. In *Mitchell v. Taylor*[31] and *Garris v. Carpenter*,[32] the courts stated: "[t]he Commissioner acts for the benefit of the policyholders, creditors and general public. The Commissioner as liquidator of the insolvent insurance company is a state officer, performing

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(1988); Baldwin-United Corp. v. Garner, 678 S.W.2d 754, 757-58 (Ark. 1984), *cert. denied* 471 U.S. 1111 (1985); *see also* Fabe v. U.S. Dep't of Treasury, 939 F.2d 341, 343 (6th Cir. 1991). The United States Supreme Court went a long way towards putting this issue to rest in U.S. Dep't of Treasury v. Fabe, 508 U.S. 491 (1993) when it held the Ohio Insurance Code insolvency statues were laws relating to the "business of insurance" to the extent they sought to "carry out the enforcement of insurance contracts by ensuring the payment of policyholders' claims despite the insurance company's intervening bankruptcy . . . . Ohio's law is one 'enacted by any State for the purpose of regulating the business of insurance.'" *Id.* at 504. Of course, the same ruling applies to the laws of all the states.

29. *See, e.g.*, CAL. INS. CODE §§ 1011, 1016 (West 2004); CONN. GEN. STATE. § 38a-906 (a) (2003); OHIO REV. CODE ANN. § 3903.04 (West 2004); TEX. INS. CODE ANN. art. 21.28 § 2(a) (Vernon 2003).

30. *See, e.g.*, CAL. INS. CODE § 1057 (West 2004); Anderson v. Great Republic Life Ins. Co., 106 P.2d 75, 79 (Cal. Ct. App. 1940).

31. 43 P.2d 803 (Cal. 1935).

32. 92 P.2d 688 (Cal. 1939).

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duties enjoined upon him by the state, and in their performance he acts in behalf of the state."[33]

At the commencement of a receivership, title to all assets of the insurer, including all accounts receivable, is vested, by operation of law, in the Commissioner in his official capacity.[34]

The receiver has the right to sue to recover assets of the insurer or for damages caused to the insurer and in that sense represents policyholders and other creditors even though the receiver may not sue on behalf of creditors to recover for damages or injuries that are personal to a particular creditor.[35]

In summary, an insurance receiver is a statutory successor to the pre-receivership entity, but that succession is not for the purpose of continuing the company's operations as such, but to subject the insurance company to a comprehensive statutory scheme designed to protect the public as well as the policyholders and other creditors of the insurer.[36] The event of a receivership is a police action, not a sale. The receiver is not the mere successor to the company, but is the embodiment of the state's intervening hand controlling the assets and liabilities of the insolvent on behalf of the public interest.

B. THE FUNCTION OF THE INSURANCE RECEIVER

The job of the Commissioner, as receiver, includes receiving and determining the claims filed in the receivership proceedings.[37] The commissioner also protects, marshals[38] and eventually liquidates (or

33. *Id.* at 692; *Mitchell,* 43 P.2d at 804. *See also* 20th Century Ins. Co. v. Garamendi, 878 P.2d 566, 580 (Cal. 1994), *cert. denied,* 513 U.S. 1153 (1995); Carpenter v. Pacific Mut. Life Ins. Co., 74 P.2d 761, 774-75 (Cal. 1937), *aff'd sub nom.* Neblett v. Carpenter, 305 U.S. 297 (1938).

34. *See, e.g., Carpenter,* 74 P.2d at 774-75; Commercial Nat'l Bank v. Superior Court, 17 Cal. Rptr. 2d 884, 886 (Cal. App. 1993), *reh'g denied,* Nos. B069188, B069205, B069220, B069282, 1993 Cal. App. LEXIS 399 (1993); CAL. INS. CODE §§ 1011, 1064.2(b). The underlying proceedings are *in rem* or, alternatively, *quasi in rem.* Princess Lida of Thurn & Taxis v. Thompson, 305 U.S. 456 (1939); United States v. Bank of New York & Trust Co., 296 U.S. 463 (1936); Penn Gen. Cas. Co. v. Pennsylvania, 294 U.S. 189 (1935); Lion Bonding & Sur. Co. v. Karatz, 262 U.S. 77, *modification denied,* 262 U.S. 640 (1923).

35. *See, e.g.*, Cotten v. Republic Nat'l Bank of Dallas, 395 S.W.2d 930, 941 (Tex. Civ. App. 1965); *In Re* Rehabilitation of Centaur Ins. Co., 606 N.E.2d 291, 294 (Ill. App. Ct. 1992).

36. The relevant statutes in each state set out the manner in which claims against the company will be made and handled. There is a priority scheme in all states by which the rights under policies are preferred over claims of general creditors and shareholders. Thus, the rights of innocent parties claiming under polices are paid first.

37. *See, e.g.,* CAL. INS. CODE §§ 1021, 1032, 1037(c) (West 1993).

38. Some courts use "marshal" and some use "marshall." This article will use marshal.

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disposes through rehabilitation plans) the assets of the insolvent company. The Commissioner has wide discretion and authority in these regards.[39] As discussed above, the insurance business is affected "with the vital public interest" and is subject to the regulation by the states through their police powers.[40] Consequently, when the Insurance Commissioner functions as statutory receiver of a financially impaired or otherwise delinquent insurer, he or she acts as a regulator and enforcer of the laws of the state and not only as a functionary of the appointing court. However, courts sometimes fail to focus upon the precise nature of an insurance insolvency receiver and, thus, ignore the differences between an insurance Commissioner acting in a regulatory capacity versus a mere "equity" or "common law" receiver.

When the receiver sues to recover assets or damages, these recoveries are for the benefit of those claiming under the statutory claims priorities in the order provided in the statutes. In other words, the recoveries are not for the benefit of the company, *qua* company, but on behalf of the innocent policyholders, beneficiaries and other creditors.[41]

If these significant differences are not appreciated, then courts fail adequately to distinguish between the standing of the insurance Commissioner, post-receivership, as a statutory and regulatory receiver versus the pre-receivership postures of the insurance company and its directors or shareholders.

The term "mere," as related to an equity or common law receiver is not intended as derogatory. However, at equity or common law a receiver did not act as the manifestation of the state's police power. Instead, such a receiver's only purpose was to provide a presumably neutral party to carry out a particular task or set of tasks pursuant to the supervision of a court. Such a receiver was not performing a regulatory function on behalf of the sovereign state, but acted only on behalf of the particular court that

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39. *See, e.g.*, CAL. INS. CODE § 1037 (West 1993); *Garris*, 92 P.2d at 692; *In re* Executive Life Ins. Co., 38 Cal. Rptr. 2d 453 (Cal. App. 1995), *modified reh'g. denied*, 33 Cal. 4th 505 (1995).

40. *See, e.g., Carpenter*, 74 P.2d. at 761; *German Alliance Ins. Co.*, 233 U.S. at 389; *Osborn*, 310 U.S. at 53; *Cal. State Auto. Ass'n Inter-Ins. Bureau*, 341 U.S. at 105.

41. One might posit some scenario by which a guilty shareholder might ultimately benefit from a recovery by the receiver, but, given the statutory priority scheme, this could only occur if all others with claims have been paid fully. This would mean the company had been rendered solvent. Denying recovery from wrongdoers based upon this remote possibility seems akin to burning down the house with the family in it so as to get at the rats. Let the wrongdoers sort out these matters between themselves in their own actions when and if such an event occurs. In the meantime, the wrongdoers should be required to account to the receiver on behalf of the innocent parties reliant upon the insolvent estate.

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appointed him or her. Thus, the term "mere" simply distinguishes an equity receiver who functions as a servant of a court from the insurance receiver who operates as an officer of the state, on behalf of the state and for the benefit of its citizenry at large, as well as all policyholders and other creditors.

As an insurance receiver, the state Insurance Commissioner acts in a dual capacity. That is to say that he or she acts both as an officer of the state enforcing its police power and as the representative of the policyholders and other creditors of the insurer. The very duality of the receiver's position can give rise to certain complexities. For example, in *Corcoran v. National Union Fire Insurance Co.*,[42] the New York Superintendent of Insurance, acting as receiver sued to enforce a certain contract of the insolvent insurer. The defendants claimed that, acting in his regulatory capacity as New York Superintendent, the receiver had been guilty of regulatory negligence and was therefore barred from recovering on the contract in his capacity as receiver.[43] The court rejected this defense theory, holding that as the representative of the creditors and policyholders, the Superintendent could not be estopped based on actions in his capacity as regulator.[44]

As this paper seeks to show, the fact that the Superintendent represented innocent creditors and policyholders was quite enough reason to reject the defense theories in *Corcoran*. This point is the very essence of the basis for holding that an insurance receiver cannot be estopped by reason of the misconduct of former management of the insurance company. Because he or she represents the innocent, an insurance receiver's action to recover assets for the insolvency estate cannot be barred either by the former misconduct of management nor, to turn the coin over, by any hypothetical pre-receivership regulatory misconduct of the Superintendent or Commissioner as regulator.[45]

The *Corcoran* court also said that "[t]he plaintiff Superintendent of Insurance as Liquidator of Ideal acts in a separate and distinct capacity from his role as regulator of the insurance industry."[46] But this is plainly incorrect in the broad sense. As an officer of the state, the insurance regulator has the official duty to enforce the interest of the state and wield

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42. 532 N.Y.S.2d 376 (1988).

43. *Id.* at 377-78.

44. *Id.* at 378.

45. Indeed, as touched upon below, one must doubt that an Insurance Commissioner could ever be estopped from enforcing insurance laws except in the most outlandish of circumstances.

46. *Corcoran*, 143 A.2d at 310-11.

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its police power to enforce its insurance laws. But for this official duty, the insurance regulator would not even *be* the receiver. The whole point of McCarran-Ferguson, *supra*, for example, was that insurance regulation was a matter of the exercise of state power.

Other cases make the point better. For example, in *El Paso Electric Co. v. Texas Department of Insurance*,[47] the court held that the receiver for an insolvent insurer performs a public, regulatory function and is a state officer performing duties placed upon that office by state statues and that, in performing these duties, the insurance receiver acts in behalf of the state.[48]

Similarly, in the case of *In the Matter of the Liquidation of Integrity Insurance Co.*,[49] the New Jersey Supreme Court held that the insurance receiver had a "hybrid role," with fiduciary responsibility to the creditors of the insolvent as opposed to the public at large, but at the same time acting in a public role.[50]

Other cases mandate that the receivership court not substitute its own judgment for that of the insurance receiver, basically because the insurance receiver is functioning as an adjunct of the state pursuant to state statutes. Accordingly, these cases say judicial discretion may not be substituted for administrative discretion.

For instance, in *Kueckelhan v. Federal Old Line Insurance Co.*[51] the Washington Supreme Court held:

> [I]n this instance, [the court] is reviewing the Insurance Commissioner who is acting like a receiver or trustee and as an officer of the state.[52] Moreover, the Insurance Commissioner is not acting as an agent of the courts. He holds his position as rehabilitator by force of legislative enactment, confirmed by court appointment. Consequently, the court's power of Discretion, vis-à-vis the Insurance Commissioner, is curtailed by the Commissioner's statutory powers and the statutes governing the

47. 937 S.W.2d 432 (Tex. 1996).
48. *Id.* at 436.
49. 165 N.J. 75 (2000).
50. *Id.* at 90-91.
51. 418 P.2d 443 (Wash. 1966).
52. *Citing* COUCH, INSURANCE § 22:16 (Lee R. Russ & Thomas F. Segalla, eds. 1959); *Anderson*, 106 P.2d at 75.

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> management of insurance companies and rehabilitation proceedings.[53]

One can further mince this issue, particularly in discovery disputes where the insurance receiver claims deliberative privilege in connection with discovery motions seeking pre-receivership information,[54] but to do so would needlessly un-track the discussion herein. An insurance Commissioner or equivalent is plainly a state official.[55] In some states, such as California, the Commissioner is elected. In others, he or she is appointed by the governor, or a state board.

The Texas Insurance Code provides:

> (a) The commissioner is the department's chief executive and administrative officer. The commissioner shall administer and enforce this code, other insurance laws of this state, and other laws granting jurisdiction or applicable to the department or the commissioner.
>
> (b) The commissioner has the powers and duties vested in the department by this code and other insurance laws of this state.[56]

The Connecticut Insurance Code provides:

> The commissioner shall see that all laws respecting insurance companies and health care centers are faithfully executed and shall administer and enforce the provisions of this title. The commissioner has all powers specifically

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53. *Kueckelhan,* 418 P.2d at 453 (emphasis added). *See also* Foster v. Mut. Fire Ins. Co., 614 A.2d 1086 (1992) (giving deference to insurance receiver because, "courts will not review the actions of governmental bodies or administrative tribunals ... judicial discretion may not be substituted for administrative discretion"); *Carpenter,* 74 P.2d at 776, *aff'd sub nom Neblett,* 305 U.S. at 297 (under statutory plans of Insurance Code *"the state, acting under and within its police power,* has provided that the commissioner" shall be appointed as conservator.) (emphasis added); Commercial Nat'l Bank in Shreveport v. Superior Court, 17 Cal. Rptr. 2d 884, 886 (Cal. App. 1993) ("In accordance with this public policy, the Commissioner has undertaken to rehabilitate the business of ELIC. The statutory authority he exercises in that effort is an aspect of the *police power of the state.*") (emphasis added).

54. Sometimes insurance receivers seek to bar discovery of pre-receivership deliberative processes based on the concept that he or she was wearing his or her pure regulatory hat as a government official at the time.

55. Some states have expressed this statutorily. *See, e.g.,* CAL. INS. CODE § 1059 (West 1993) ("The commissioner, in the performance of any of his duties under this article, shall be deemed to be a public officer acting in his official capacity on behalf of the State . . . .") *Id.*

56. TEX. INS. CODE ANN. § 31.021 (Vernon 2004).

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> granted, and all further powers that are reasonable and necessary to enable the commissioner to protect the public interest in accordance with the duties imposed by this title.[57]

The California Insurance Code states that "[t]he commissioner shall perform all duties imposed upon him by provisions of this code and other laws regulating the business of insurance in this State, and shall enforce the execution of such provisions and laws."[58]

All states have similar statutory provisions. Connecticut, for example, has adopted the Model Act. In the Connecticut Insurers Rehabilitation and Liquidation Act it is stated that the purposes of the act include:

> Providing for a comprehensive scheme for the rehabilitation and liquidation of insurance companies and those subject to sections 38a-903 to 38a-961, inclusive, as part of the regulation of the business of insurance in the state. Proceedings in cases of insurer insolvency and delinquency[59] are deemed an integral aspect of the business of insurance and are of vital public interest and concern.[60]

This language is identical to the Model Act other than the citations to Connecticut statutes. These provisions are designed to make it clear that the provisions relate to the "business of insurance," and accordingly come within McCarran-Ferguson. They also manifest the intent of the state to apply its police power through the insurance receiver to insurer insolvencies.

C. *IN PARI DELICTO* AND ESTOPPEL

The doctrines of *in pari delicto* and *estoppel* rest upon equity principles which themselves arise out of the concept that one ought not benefit from one's own wrong or misconduct. Several "maxims" of equity developed, including that "whoever seeks equity must do equity" and "whoever comes into equity must come with clean hands,"[61] The doctrine of *in pari delicto* is closely related to the clean hands doctrine:

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57. CONN. GEN. STAT. § 38a-8(a) (2003).

58. CAL. INS. CODE ANN. § 12921 (West 1993).

59. "Delinquency" occurs when an insurer may be solvent, but has violated the insurance laws in some other manner that makes it subject to a form of receivership or similar regulatory action. *See, e.g.*, OHIO REV. CODE ANN. § 3903.12 (2002).

60. CONN. GEN. STAT. § 38a-903(7) (2003).

61. *See, e.g.*, 27A AM. JUR. 2D *Equity* §§ 121-126 (1996).

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> As to parties in pari delicto, the principles cognate with the clean hands maxim include: equity will not relieve one party against another when both are in pari delicto; where both are equally in the wrong defendant holds the stronger ground; where the fault is mutual the law will leave the case as it finds it.[62]

It could be said that one alone may have unclean hands, but like the Tango, it takes two to be *in pari delicto*. In the one instance, equity will not permit the dirty to prevail over the clean. In the second, equity will not aid either of two guilty parties.

Similar notions give rise to equitable estoppel. The terms "estoppel in pais" and "equitable estoppel" are now generally used interchangeably. In its broadest sense equitable estoppel prevents a party from asserting rights when his own conduct renders that assertion contrary to equity and good conscience.

In order to apply these principles to an insurance receiver who intervenes to assert the sovereign power of the state on behalf of innocent creditors and for the general public welfare, one would be forced first to decide that the receiver has unclean hands or is in equal fault with the wrongdoers. But to do this, one must first ignore reality and, in effect, hold the intervening regulator as guilty as those he regulates.

How ironic it would be to permit the guilty to escape and the innocent to suffer loss based upon misplaced notions of equity. "A court of equity seeks to do justice, and not injustice. Nothing unconscionable will be permitted within the jurisdiction of a court of equity . . . . nor will a court of equity do inequity in the name of equity."[63] A full discussion of the principles of equity is beyond the scope of this article, but no matter how full a study of equity is made, the basic principles discussed above remain the same.

Fundamentally, equity is supposed to be a source of justice, not injustice. To apply the equitable principles of *in pari delicto* or equitable estoppel against an insurance receiver, a court must first logically and reasonably determine that he or she has acted with the defendants in some misconduct so as to be equally guilty or must have gotten unclean hands in some other manner.

In terms of reality, it would be only in the most rare and improbable of circumstances that the insurance regulator will have *actually* engaged in misconduct, yet the only means of holding the insurance receiver *in pari*

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62. 30A C.J.S. *Equity* §103 (1992).
63. 27A Am. Jur. 2D *Equity* § 110 (1996).

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delicto or equitably estopped is to *deem* him or her as being equally guilty with the wrongdoers. But the underpinning of this *deeming* is the notion that the receiver stands exactly in the shoes of the insolvent insurer.

The thesis here is that a court cannot logically and reasonably make any such determination. It is indisputable that in all usual cases the insurance receiver *intervenes after* the misconduct has occurred so as to enforce the laws and protect innocent parties. Under normal circumstances, this intervention, being based upon statutory mandate, cannot be deemed wrongful.[64] The only way a court can make the receiver "dirty" is to engage in the erroneous fiction that he or she is the exact same entity as the former company and therefore stands exactly in that entity's shoes and then apply equity to prevent the insurance receiver's recovery on behalf on innocent creditors.

To do this, however, the court must stand equity upon its head by punishing the innocent and rewarding the guilty; it must use concepts of equity to produce inequity. Not only would such result make a mockery of equity itself, but it would violate other equitable principles. Indeed, "[e]quitable estoppel cannot arise against a party except when justice to the rights of others demands it and when to refuse it would be inequitable."[65] Further, "estoppel generally cannot be invoked against a governmental agency to prevent it from discharging its statutory duties."[66]

As a general proposition, concepts of estoppel cannot act against the government acting in its sovereign capacity. "A litigant asserting estoppel against the government bears a heavy burden, particularly when the government acts in a sovereign or governmental role rather than a proprietary role. In fact, it has been held that estoppel may not be applied against the government acting in its sovereign capacity."[67] Estoppel is generally unavailable against a sovereign body performing in a public or governmental capacity.[68] "The insurance commissioner acts as an officer of the state in the public interest regardless of the fact that his duties as conservator are in the nature of those of a receiver or trustee."[69]

In light of well-established equitable considerations, it seems very difficult to find a true equitable rationale to bar an insurance receiver from

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64. *Cf.* Bishop v. Bailey, 48 So. 2d 588, 590 (Miss. 1950) ("hands do not become unclean when exercising lawful authority and power").

65. 28 AM. JUR. 2D *Estoppel & Waiver* § 30 (2003).

66. Shelton v. Wing, 684 N.Y.S.2d 726, 727 (N.Y. App. Div. 1998) (interal quotations omitted).

67. 28 AM. JUR. 2D *Estoppel and Waiver* § 139 (2003) (citing numerous cases).

68. 31 C.J.S. *Estoppel and Waiver* § 171 (1996).

69. GEORGE J. COUCH, COUCH ENCYCLOPEDIA OF INSURANCE LAW § 22:17 (1982).

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making recoveries from wrongdoers. If one asks whether it is fair to employ the name of equity to bar the insurance regulator from making recoveries on behalf of the innocent simply because former management acted in concert with the wrongdoers, it is difficult to find a reasonable justification for an affirmative answer.

II. THE WRONG PATH

As stated above, the key point in this analysis is that, under modern statutes, the Insurance Commissioner, as receiver, represents the interest of policyholders and general creditors. This was not always so, and prior to the enactment of the insurance codes of the various states, receivers were appointed by the courts and acted on behalf of the insolvent company as an arm of the court.

Equity or common law receivers were a product of English Common Law and grew out of the need of the King, and later, the equity courts to appoint an individual to carry out functions necessary to effect the court's equity decrees. Thus, receivers were appointed to take charge of rents or to take charge of property to avoid its waste or destruction and, thus, to preserve its existence and the ability of the court to deal with it.[70] A discussion of the transplantation of the common law to the colonies and its evolution thereafter is well beyond this article, but the earliest receivers appointed in this country were equity receivers; there were no unique insurance receivers because there were no statutory schemes making provisions for them.[71]

Judges are normally bound by the legal precedent in their jurisdictions. Therefore, once insurance insolvency statutes were in place and disputes arose over the powers of the insurance receivers, the courts looked for legal precedent. In the beginning, the only legal precedents relating to receivers were the earlier cases that related not to insurance receivers, but to equity receivers.

In order to fully understand the applicable law today, it is necessary to go back to earlier cases because that is where this trail begins. To understand how the "stands in the shoes" concept began is to understand how and why some more recent courts have followed the path laid by pre-insurance code cases and have come to the wrong destination. *People ex*

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70. *See, e.g.*, RALPH E. CLARK, THE LAW AND PRACTICE OF RECEIVERS §§ 1-10, at 1-10 (1959).

71. For instance, California did not enact its Insurance Code until 1935. Stanley v. Columbia Cas. Co., 147 P.2d 627, 630 (Cal. Ct. App. 1944). The codification of the Insurance Code was an attempt to secure clarification of earlier decisions and to delete superseded provisions. *See generally* Sobey v. Molony, 104 P.2d 868 (Cal. App. 1940).

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rel. Barrett v. Bank of Peoria[72] is a good example of an early case which followed the wrong trail. The earlier case of *Republic Life Insurance Co. v. Swigert*,[73] had held that the receiver of an insurance company had no greater powers than the company. In *Bank of Peoria,* the receiver argued that *Republic Life Insurance* was no longer good law because of the enactment of Illinois' insurance laws in 1925, pursuant to which the Illinois director of insurance would become the statutory receiver of insolvent insurance companies, and such receivers were no longer to be appointed by the courts.[74] The receiver asserted that he no longer represented only the company, but all creditors as well.[75] The court seemed to concede that *if* the receiver did represent all creditors, then he *would* be in a different posture than the company. However, that court decided that the statutes did not make the receiver the representative of all the creditors, which was the linchpin for the result in the case.[76]

In *Republic Life,* the court itself conceded that, even at that time, there was a conflict in the authorities, but that:

> [w]e think the decided weight of authority sustains the rule in respect to the powers of receivers, where there has been no enlargement of their powers by legislative enactment, that they have such rights of action only as were possessed by the persons or corporations upon whose estates they administer.
>
> A receiver is the right hand and creature of the court of equity, and he has such powers as are conferred upon him by the order appointing him, and the course and practice of the court.[77]

The basis for the result in *Republic Life* and *Bank of Peoria* is the phrase "where there has been no enlargement of [the receivers'] powers by legislative enactment . . .." If one asks the question "what if their powers *were* enlarged by legislative enactment?" the answer seems clear. That is, once the insurance laws were enacted by the state legislatures and made the receiver a statutory receiver representing the rights of policyholders and other creditors, then cases such as *Republic Life* and *Bank of Peoria*, by the

72. 15 N.E.2d 333 (Ill. App. Ct. 1938).
73. 25 N.E. 680 (Ill. 1890).
74. *Bank of Peoria*, 15 N.E.2d at 335-36.
75. *Id.* at 336.
76. *Id.*
77. *Republic Life,* 25 N.E. at 687.

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logic in the latter case, appear to have reached the wrong result given the enactment of the Illinois insurance statutes.

After so many years, whether these courts were right or wrong on their reading of the then current Illinois statutes is not important, but what is important is that the result in the case depended upon whether the receiver was only a creature of the court (and therefore the representative of *only* the company) or whether he represented all creditors *in addition* to the company. As it happens, later Illinois statutes make it very clear that the Director of Insurance, as insurance receiver *does* represent all policyholders and other creditors.[78] Most, if not all state statutes, have similar provisions.

The courts in these early Illinois cases certainly understood that the key issue was whether the receiver represented *only* the interests of the company or whether the receiver represented the interests of policyholders and other creditors. It seems clear that if those courts had accepted the notion that the receiver *did* represent policyholders and creditors in addition to the company, then these early cases would have had the opposite result and the courts would have held that the insurance receiver does *not* stand in the shoes of the insolvent insurer.

As discussed below, various later cases have not always understood the key point and have failed to understand that under modern statutes, the receiver *does* represent the rights of the policyholders and creditors.

The State of New York led the way in revising insurance laws to enact comprehensive statutory plans for insurance insolvencies.[79] In cases such as *People by Van Schaick v. Title & Mortgage Guarantee Co.*[80] and *In re Kinney*,[81] the courts of New York understood from an early point that, once there were statutory provisions which mandated that the insurance Commissioner or equivalent be appointed receiver of an insolvent carrier, then the receiver was no longer a creature of the court, but was a statutory receiver drawing his or her powers from the legislature. The receiver held title to the insolvent's assets for the benefit of the policyholders and other creditors.

Where the receiver is *not* the minion of a court, but is a statutory receiver representing the interests of the state, the policyholders and the other creditors, there is an entirely different situation. In this latter

78. 215 ILL. COMP. STAT. 5/192 (2004).

79. JOSEPH A. JOYCE, LAW OF INSURANCE OF EVERY KIND § 336(f) (2d ed. 1917) (refers to the New York Insurance law of 1892). New York later codified an early version of its Insurance Code in 1913.

80. 190 N.E. 153 (N.Y. 1934).

81. 14 N.Y.S.2d 11 (N.Y. App. Div. 1939).

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circumstance, the receiver is the representative of the state and takes his or her powers from the statutory scheme, not as they might have been delegated by a particular court. In this capacity, the receiver represents the company plus all of its policyholders, all of its other creditors and the people of the entire state. In this circumstance, it is flatly wrong to restrict the rights of receiver to those of the company. To do so would ignore the interests of all the policyholders, creditors and the citizens of the state whom the receiver also represents.

More modern cases which state that an insurance receiver "stands in the shoes" of the party or company for which he or she acts do not always perform the same degree of analysis as the earlier cases. Instead, they simply quote the earlier cases without necessarily appreciating the key reasons for the results in those cases. A good example of this is the Wisconsin case of *McNamee v. APS Insurance Agency, Inc.*.[82]

In *McNamee,* the court devoted only a little over thirteen lines to the issue, all of which consisted of flat, non-analytical statements followed with a citation. Specifically, the court said the liquidator "stands in the shoes of the company and takes only its interests."[83] "The liquidator's authority does not extend beyond that of the property, contracts and rights of action of the company as of the date of the order directing liquidation."[84] In citing Appleman, however, the court demonstrated the problem of lifting language out of context because the court ignored section 10673 of the very same volume that plainly states:

> The receiver of an insolvent insurance company is the statutory successor of the company for the purpose of winding up its affairs, and, as such represents the company at all times and places in all matters connected with the trust and he is also an officer of the state and as such represents the state in its sovereignty while performing public duties connected to winding up the affairs of one of its insolvent corporations...his rights and powers are not limited to those possessed by the company....but he represents also the creditors of the insolvent company and as such representative is vested with powers and may do

82. 332 N.W.2d 828 (Wis. Ct. App. 1983).

83. *Id.* at 830, *citing* Commonwealth ex rel. Kelly v. Commonwealth Mut. Ins. Co., 299 A.2d 604, 606 (Pa. 1973) (examining the limited circumstances in which the Commissioner wanted to expand the contractual limitation period on imposing assessments on policyholders).

84. *McNamee*, 332 N.W.2d at 830, *citing* 19 J. APPLEMAN, INSURANCE LAW AND PRACTICE, § 10682 at 121 (1982).

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> acts that could not be done by a mere representative of the company.[85]

Similarly, Couch says: "[t]he insurance commissioner acts as an officer of the state in the public interest regardless of the fact that his duties as conservator are in the nature of those of a receiver or trustee."[86] In *McNamee,* the court was dealing with litigation over agent's balances due to the company. These particular kinds of cases have their peculiar complexities, a full discussion of which is outside the scope of this article,[87] however, they almost always revolve around situations where the agent has either retained premiums and/or commissions and has retained and/or diverted the premiums to another, solvent, carrier. The issue is whether the premiums and commissions collected by the agent must be remitted to the receiver of the insolvent carrier. Different cases involving the special area of agents' balances have had different results, usually distinguishing between earned and unearned premiums and commissions that are still in the hands of the agent post-receivership.[88] Some of these cases, such as *McNamee,* hold that the receiver is not entitled to certain premiums or commissions and resort to the "stands in the shoes" language.[89]

Concededly, where the policies have been canceled and unearned premiums remain un-remitted by an agent, it may be a legitimate regulatory result to permit these unearned premiums to be used to purchase new coverage.[90]

Accordingly, one might suggest that this is a circumstance in which the insurance receiver does stand in the shoes of the insurer as a matter of *contract*, but the essence of the agent's balance cases is a dispute over

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85. APPLEMAN, *supra* note 84, at § 10673 (emphasis added).

86. COUCH; *supra* note 52, at 22:17.

87. *See* Downey v. Humphreys, 227 P.2d 484 (Cal. Ct. App. 1951); Langdeau v. Bouknight, 344 S.W.2d 435 (Tex. 1961); Bard v. Charles R. Myers Ins. Agency, 811 S.W.2d 251 (Tex. App. 1991).

88. For example, sometimes courts have held that the company's policies are canceled or breached by the insolvency. *See, e.g., Downey*, 227 P.2d at 490. In other states, such as Texas, the policies may or may not be canceled by court order after insolvency. TEX. INS. CODE ANN. § 21.11-2 (Vernon 2004). When cancellation results in a portion of the premiums being unearned, then it is sometimes held these must be paid over to the receiver for distribution under the claims statutes. *But see id.*

89. *McNamee,* 332 N.W.2d at 830. *See also Downey,* 227 P.2d at 492-93 (another agent's balance case).

90. One could say that *may* be a proper result because cases come down on both sides of this issue, depending upon individual circumstances. Agents' balances present a unique situation and a full discussion of this issue as it relates solely to agents balances is outside the scope of this article.

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whether the funds *are* the property of the insurer and where recovery is denied to the receiver that is because the assets are held to not belong to the estate. The recovery is not denied on the notion that the receiver is *in pari delicto*. Thus, in some limited senses the insurance receiver does assume the company's pre-receivership contract posture,[91] but in the greater sense it is incorrect to say that the receiver stands precisely "in the shoes" of the company. As demonstrated below, the case decisions that have fully appreciated and directed their attention to the precise issue have almost always distinguished between the insurance receiver and an equity receiver.

These more thoughtful cases sometimes accept as *a general rule* the insurance receiver "stands in the shoes" of the company. Indeed, this may adequately serve as a *general rule*, but if it is the general rule, it is subject to some well-considered exceptions as was held in *Shaw v. Borchers*.[92] Nevertheless, the better *general* rule would be that an insurance receiver does *not* stand in the shoes of the insolvent, although he or she may do so in excepted situations. Rather than quibble over the semantics of it, however, the point of this article is that it is incorrect to say that the insurance receiver always stands in the shoes of the insolvent because this carryover from old and no longer pertinent cases which deal with the posture of mere equity receivers fails to take into account the very real differences between the company, pre-receivership, and the Insurance Commissioner as receiver, post-receivership.

It is inappropriate to adhere to a rigid position that the Insurance Commissioner, as statutory receiver, stands in exactly the same position of the insurer because to do so would subvert the very purpose of insurance insolvency laws.

This can be demonstrated in many ways. For example, one might consider the illogic of forcing the regulator, who has taken over the company *because* of the improper conduct of the company, to wear the company's dirty shoes. If, for example, the Insurance Commissioner takes over the company *because* it is engaging in improper reinsurance arrangements with reinsurers who are in *pari delicto* with the company, it is completely illogical to hold that the police power of the state is nullified because, having become the receiver of the company in order to enforce the laws of the state, the state's regulatory officer is now in exactly the same posture the company had been in. This would effectively thrust the state's

91. One of the most common of such situations relates to the permissibility of setoffs. Whether a pre-receivership setoff is good against the receiver post-receivership is normally governed by statute. *See, e.g.*, CAL. INS. CODE § 1031 (Deering 2004). *See also* Prudential Reinsurance Co. v. Superior Court, 842 P.2d 48, 50-51 (Cal. 1992).

92. 46 S.W.2d 967, 968 (Tex. App. 1932).

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regulatory official into the standing of a co-conspirator and deny recovery for the policyholders whom the statutes are designed to protect. The absurdity seems obvious.

It is easy for a court to follow this hypothetical syllogism: i. the receiver stands in the shoes of the company; ii. the company was engaged in the wrongdoing complained of; therefore, iii. the receiver is in *pari delicto* and estopped in the same way the company would have been. But the first premise is false; the receiver does not stand in the shoes of the company.

The California case of *Downey v. Humphreys*[93] presents an example of a case that held that the insurance receiver "stands in the shoes" of the company. *Downey* has been cited many times for this proposition. An examination of *Downey*, however, shows that it is not correct law even under prior and subsequent cases applying California law.

Although *Downey* was decided in 1951, the underlying facts occurred in 1933, prior to the enactment of the California Insurance Code in 1935. The case involved an insurance agent that did not remit unearned premiums to the receiver.[94] Thus, it presented the questions of whether the agent held the premiums in trust or whether there was a debtor/creditor relationship.[95] Further, since the premiums were unearned, there was an issue of whether the company was entitled to possess them at all.[96] The court held that the relationship was debtor/creditor and that neither the company nor the receiver had a right to recover the unearned premiums.[97] As already noted above, the agent's balances cases present a unique circumstance as to whether the unearned premiums are the property of the company at all. Thus, if the court views unearned premium as not being an asset of the company at all, then one can understand why a court would deny their recovery by the receiver.

Unfortunately, the *Downey* Court dealt with the issue with too broad a brush by saying:

> A receiver occupies no better position than that which was occupied by the party for whom he acts. "He takes the property and rights of the one for whom he was appointed precisely in the same condition and subject to

93. 227 P.2d 484 (Cal. Ct. App. 1951).

94. *Id.* at 489. An "unearned premium" is that portion of the premium, which is not earned by the insurer due to cancellation of the policy. *Id.* at 488.

95. *Id.* at 490.

96. *Id.*

97. *Id.* at 493.

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> the same equities as existed before his appointment, and any defense, good against the original party, is good against the receiver." . . . . [o]n April 19, 1933, defendant had a legal right to set off unearned premiums against the amount he owed International. The fact that a receiver of International had been appointed did not affect that right. The unearned premiums belonged to the policyholders. Neither the receiver nor the liquidator had any better right than International, upon its adjudication as insolvent, to the unearned premiums, and International had none. The domiciliary receivers approved the action of defendant in replacing the insurance. Replacing the insurance and the setoff had been effected before plaintiff's appointment as liquidator. Plaintiff had no rights until the date of his appointment, June 28, 1933.[98]

The authority cited by Downey for the foregoing proposition is *People v. California Safe Deposit & Trust Co.*,[99] in which case the California Supreme Court did not quite say what the *Downey* court suggests. Instead, the California Supreme Court stated: "The *general rule* is that a receiver acquires no greater interest in an estate than the one from whom he takes, and it follows that chooses in action pass to him subject to any right of set-off existing at the time of his appointment."[100] Thus, the rule that had actually been stated was only a general rule, not a universal one. Accordingly, Downey's rendition seems to set a bright line that does not exist under California law.

One might also keep in mind that both *Downey* and *California Safe Deposit* involved the issue of whether the insurance receiver was bound by a pre-receivership offset. Certain types of offsets are permitted under the relevant provisions of the insurance laws of the several states, but some types are not permitted. Thus, the offset issue is now largely controlled by statute.[101] Even so, offsets present far different equities than those involved in determining whether a receiver ought to be held *in pari delicto*.

Boiled down to its essence, the *Downey* decision held that (i) an offset made prior to insolvency bound the receiver; (ii) that unearned premiums are not the property of the insolvent carrier, but belong to the insureds; and

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98. *Id.* at 492-93.

99. 141 P. 1181 (Cal. 1914).

100. *Id.* at 1183 (emphasis added, internal quotation marks omitted).

101. *See, e.g.*, CAL. INS. CODE, *supra* note 54, at § 1031 (a typical example of such provisions).

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(iii) the agent was not a fiduciary to the insurer and did not hold the unearned premiums in trust for the insurer.[102] It is also significant that the domiciliary receivers in Delaware, the state of domicile of the insurer had approved the use of the unearned premium in the manner it was handled by the agent.

It should also be noted that in *Downey* the court was writing prior to the enactment of the California Insurance Code, which was enacted to clarify earlier decisions and to delete superseded provisions.[103] Under California Insurance Code section 1037, the Commissioner, as liquidator, is deemed to be a trustee for the benefit of all creditors and other personas interested in the estate of the insurer.[104] Many state insurance codes have similar provisions. Even if they do not have express statutes, the effect is the same. The U.S. Supreme Court long ago recognized this status in *Relfe v. Rundle*.[105] Relfe was the insurance superintendent of Missouri and, by statute, became the insurance receiver of the Life Association of America.[106] The Supreme Court characterized Relfe as follows:

> Relfe is not an officer of the Missouri State court, but the person designated by law to take the property of any dissolved life insurance corporation of that State, and hold and dispose of it in trust for the use and benefit of creditors, and other parties interested . . .. He is the trustee of an express trust, ... He is an officer of the State, and as such represents the State in its sovereignty while performing its public duties connected with the winding up of the affairs of one of its insolvent and dissolved corporations.[107]

One sees that there is a very strong line of cases supporting the position that an insurance receiver does not simply stand in the shoes of the insolvent. *Downey* and similar cases that seem to set a firm rule that the receiver always stands in the shoes of the insolvent company, themselves stand on unsound ground.

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102. *Downey*, 227 P.2d at 493. *But see* Maloney v. Rhode Island Co., 251 P. 2d. 1027 (Cal. Ct. App. 1953) (agent *was* held to be the fiduciary to the insurer as to collected premiums).

103. *See, e.g.*, Sobey v. Molony, 104 P.2d 868 (Cal. App. 1940).

104. CAL. INS. CODE, *supra* note 55, at § 1037.

105. 103 U.S. 222 (1880).

106. *Id.* at 222-23.

107. *Id.* at 225.

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A fairly recent application of the "stands in the shoes" concept is the case of *Seidman & Seidman v. Gee*,[108] in which the court, relying largely upon *Cenco, Inc. v. Seidman & Seidman*,[109] imputed the wrongdoing of the insurer to estop the insurance liquidator in a suit against the insurer's accountants who had allegedly cooperated with the insurer in fraudulently prolonging the corporation's life.

Although *Seidman* seems contrary to the thesis of this article, the case is easily distinguishable because, as that court stated on rehearing, the insurance receiver *stipulated* in the trial court that "the Liquidator brings *only* the claims of Universal itself . . . and is *not* seeking to bring the creditors[']claims himself."[110] Having made this concession, the liquidator prevented the court from applying the thesis advanced herein. One suspects that what the liquidator was attempting to accomplish by this stipulation was to avoid being accused of seeking to recover upon causes of action personal to creditors and running afoul of the principles of *Cotten*.[111] The stipulation was ill-advised because it may have avoided the frying pan, but it plunged him into a fire. As the Florida Insurance Department made plain in its *amicus* pleadings, the liquidator did represent innocent creditors, but by then the prior stipulation had already procedurally bound the liquidator to the erroneous position. Having been procedurally prevented from adopting the thesis of this article, the court cannot be faulted from not doing so, nor should the decision be considered contrary to the thesis.[112]

The *Seidman* court relied upon *Cenco* for the proposition that although an employee's fraud is not always imputed to the corporation, but will be so imputed when the fraud is committed *on behalf of* the corporation.[113] In other words, *Seidman* and *Cenco* hinged upon the notion that a statutory insurance receiver is merely a successor to the pre-receivership company.

The *Seidman* court also relied upon *F.D.I.C. v. Ernst & Young*,[114] where that court held the corporation "had knowledge of and benefited from the fraud" allegedly covered up by the auditors, and, therefore, could

108. 625 So. 2d 1 (Fla. Dist. Ct. App. 1992).

109. 686 F.2d 449 (7th Cir.), *cert. denied*, 459 U.S. 880 (1982).

110. *Seidman*, 625 So. 2d at 4 (emphasis in original, internal quotation marks omitted).

111. *Cotten*, 395 S.W.2d at 941.

112. The court made so much of the stipulation and the procedural posture that it went to the trouble of making the problem plain in a second opinion. One *might* take this as a signal that things could have turned out differently if the liquidator had urged that he does not stand in the shoes of the corporation and was seeking to recover for innocent policyholders and creditors.

113. *See Seidman*, 625 So. 2d at 2.

114. No. 3-90-0490-H, 1991 U.S. Dist. LEXIS 13955 (N.D. Tex. Sept. 30, 1991).

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not assert that it had relied upon the fraud.[115] It also cited *In re Investors Funding Corp.*[116] for the proposition that the knowledge of the corporate agent is imputed to his principal, except where the agent is acting adversely to the principal.[117]

The fundamental assumption in these cases is that the receiver is acting on behalf of the corporation and not on behalf of innocent policyholders and creditors. While a given court might permit recovery on the theory that the looting was not done on behalf of, but was done to the insurance entity, such a court would nevertheless still be starting from the assumption that the insurance receiver is like any other receiver and that pre-insolvency legal concepts still apply. The idea that it is important in an insurance insolvency whether the insurer was *being looted* as opposed to *doing the looting* is incorrect. Once one accepts the principle that the insurance receiver is the manifestation of the state's sovereignty, and is, therefore, not just another hand on the same throttle, then it is manifest that it does not matter whether the former management looted the corporation or whether management turned the corporation into an "engine of theft." That distinction makes no difference when one considers the rights and equities of innocent policyholders and other creditors, particularly where there is a comprehensive statutory scheme that governs. This point is discussed further below.

Close analysis demonstrates that the *Seidman* type cases simply, but incompletely, take one back to the early cases such as *Bank of Peoria*, in which the court reached a similar result based on the same assumption. That is to say that all similar cases from *Bank of Peoria* to *Seidman* assume that the insurance receiver is only the old company carrying on under court supervision and that the receiver is suing only on behalf of the corporation. The newer cases, however, fail to state what has long been stated since *Bank of Peoria*-- that the rule would be different if the insurance receiver were suing on behalf of creditors in addition to the old company.

Because it is crystal clear that under current state insurance codes, the insurance receiver *is not just the old company, but is suing on behalf of policyholders and other creditors*, then *Seidman*, and its ilk are incompletely reasoned and do not state the proper rule to be applied to State insurance regulators acting as receivers under statutory schemes.

Consider the statement of the Ninth Circuit's opinion in *F.D.I.C. v. O'Melveny & Myers*:[118]

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115. *Seidman*, 625 So. 2d at 2.
116. 523 F.Supp. 533 (S.D.N.Y. 1980).
117. *Seidman*, 625 So. 2d, at 3.
118. 61 F.3d 17 (9th Cir. 1995).

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> Also significant is the fact that the receiver becomes the bank's successor as part of an intricate regulatory scheme designed to protect the interests of third parties who also were not privy to the bank's inequitable conduct. That scheme would be frustrated by imputing the bank's inequitable conduct to the receiver, thereby diminishing the value of the asset pool held . . . .[119]

There are enough similarities between insurance receivers and F.D.I.C. receivers that this statement is equally applicable to insurance insolvency receivers.[120]

III. THE RIGHT PATH

A. CASES CONTRA TO *DOWNEY*, *SEIDMAN*, AND OTHER SIMILAR RULINGS

In the insurance context, it seems impossible to accept that sound legal analysis would hold that innocent policyholders and creditors stand in the same shoes as the insurer where those shoes are dirty due to no fault or involvement of these innocent parties. As discussed below, there is substantial good legal authority and analysis to the contrary.

One can do little better in defining the correct rule than re-quoting the Texas Supreme Court's language in *Shaw*:

> It is true the general rule is that that the receiver of an insolvent corporation has no greater rights than those possessed by the corporation itself. There is, however, a well-defined exception to such rule. A receiver of such a corporation acts in a dual capacity. He is a trustee both for the stockholders and the creditors. As trustee for the creditors, he is permitted to maintain and defend actions involving acts done in fraud of creditors even though the corporation would not be permitted to do so.[121]

The opinion in *F.D.I.C. v. O'Melveny* rests on this same foundation. Like insurance companies, banks and savings and loans are exempt from being debtors in bankruptcy and are liquidated with the aim or protecting

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119. *Id.* at 19.

120. This is because, like insurance companies, banks and savings and loans (jointly "banks" herein) are exempt from being debtors under the Bankruptcy Code by § 109 of that Code. Bank depositors are to be preferred over general creditors, just as policyholders are. Bank receivers serve pursuant to the state's police power, the same as insurance receivers.

121. *Shaw*, 46 S.W.2d at 968-69.

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innocent depositors. As noted immediately above the legal precepts of *O'Melveny* are quite applicable to insurance insolvency law as to the issue now under discussion. In that case, the court held:

> We recognize that, in general, "[a] receiver occupies no better position than that which was occupied by the person or party for whom he acts . . . and any defense good against the original party is good against the receiver." However, this rule is subject to exceptions; defenses based on a party's unclean hands or inequitable conduct do not generally apply against that party's receiver. While a party may itself be denied a right or defense on account of its misdeeds, there is little reason to impose the same punishment on a trustee, receiver or similar innocent entity that steps into the party's shoes pursuant to court order or operation of law.[122]

In *Camerer v. California Sav. & Commercial Bank*, cited in *O'Melveny,* the California Supreme Court acknowledged the general rule that:

> [A] liquidating receiver represents the interests of depositors and creditors. It is equally fundamental that as a general rule, the receiver takes the insolvent's property subject to all liens, defenses, and equities to which it is subject in the hands of the insolvent, and that he administers on behalf of creditors no greater title or estate than the debtor had. Without denying the validity of this general rule, there are certain situations where the receiver is permitted to assert rights and defenses not available to the insolvent. Thus, it is held that although the insolvent debtor cannot set aside a transfer in fraud of his creditors, as he is *in pari delicto*, the receiver acting for the creditors may attack it.[123]

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122. *O'Melveny,* 61 F.3d at 19 (internal citations omitted). This was not the first time the Ninth Circuit, relying upon California law, reached the same conclusion. In Cecil B. De Mille Productions, Inc. v. Woolery, 61 F.2d 45, 49 (9th Cir. 1932), that court said of a receiver that "[a]s trustee for creditors he represents them in following the assets of the corporation, and can assert their rights in cases where the corporation could not have been heard." *See also* Scholes v. Lehmann, 56 F.3d 750, 754-55 (7th Cir. 1995), where the Seventh Circuit held that the defense of *in pari delicto* could not be used against a receiver.

123. *Camerer*, 48 P.2d 39, 44-45 (Cal. 1935) (emphasis added, internal citations omitted).

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The Court went on to hold that, even though the bank was the receiver, the bank could enforce a promissory note executed without consideration in order to make a fictitious showing of assets to the bank examiner.[124]

In *Verder v. American Loan Society*,[125] which dealt with the insolvency of a savings and loan association, which like banks and insurance companies are liquidated under state law, the California Supreme Court held:

> [W]hile an operating receiver takes the assets of a corporation subject to all equities outstanding against it, a liquidating receiver acts in the dual capacity of representing the corporation, as such, and also its creditors, and that in the latter capacity he may claim rights and advance defenses not available to the corporation . . . . the dealings of the insolvent were in fraud of the creditor's rights, or where the dealings in question were had directly between the third party claimant and the insolvent corporation.[126]

One would find it quite difficult to explain why the Supreme Court's positions in *Camerer* and *Verder* would not be controlling over the lower Court of Appeals decision in *Downey* on this issue. Although *Downey* involved an insurance company and *Camerer* and *Verder* involved a bank and an S&L, these are distinctions without a difference as to this issue; particularly where *Downy* was not applying the California Insurance Code, but was applying its concept of general California case law.

Further, if *Downey* really meant to set a bright line to the effect that an insurance receiver, even prior to the enactment of the insurance code, *always* stands in the shoes or the prior entity, it was out of step with the controlling California Supreme Court cases cited above. In addition, subsequent California cases have reached a different result.

In *Arthur Anderson v. Superior Court*[127] the Insurance Commissioner acting as an insurance receiver sued the accounting firm of Arthur Anderson for negligence. That court rejected application of *Downey* and also rejected an argument that the insurance receiver was only an ordinary receiver. It stated:

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124. *Id.* at 45. In doing so the court cited a number of cases, including Bank of Orland v. Harlan, 206 P.75 (Cal. 1922) and First Nat'l Bank v. Reed, 244 P. 368 (Cal. 1926).

125. Verder v. Am Loan Soc., 32 P.2d 1081 (Cal. 1935).

126. *Id.* at 44-45 (internal cites omitted, emphasis added).

127. *Arthur Andersen v. Superior Court*, 67 Cal. App. 4th 1481, 79 Cal. Rptr. 2d 879 (1998).

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> Nor can AA's argument that the Insurance Commissioner acts only as an ordinary receiver exonerate AA from liability for negligent misrepresentations in an audit report. When carrying out his statutory regulatory duty of monitoring the claims-paying ability of an insurer, the Insurance Commissioner is not acting to protect the investment of the insurance company's owners, but instead to protect the policy-buying public. The Insurance Commissioner hence represents far broader interests than those typically represented by an ordinary receiver, whose potential claims are limited to those of the company in receivership.
>
> We will therefore hold that the Insurance Commissioner, in his capacity as liquidator of Cal-American's estate, may recover from AA on behalf of the liquidation estate (for the benefit of policyholders and others having claims against the liquidation estate) for damage caused to the liquidation estate by negligent misrepresentations in AA's audit report.[128]

The *Arthur Andersen* court cited several cases to the same effect, all of which support the thesis of this article.[129]

As discussed above, the insurance receiver is the representative of the state's police power and has important purposes that are significantly different from those of the corporation prior to insolvency. Before receivership, the insurer was the regulated entity and the Commissioner was the regulator who regulated for the welfare of the public in general and the policyholders and creditors in particular. After receivership, the previously separate functions of the regulated entity and its regulator become merged in the receiver through the police power of the state and the intervention of the Commissioner. The role of the receiver is to enforce the laws of the State and further its public policy. The receivership itself is designed to cause adherence by the insurer to the laws of the state.

Although the receiver becomes vested, by operation of the law, with all assets and rights of the insolvent, the receiver does not act *as* the company, instead he or she acts *as* the state. Furthermore, the receiver does not act

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128. *Id.* at 882.

129. In re Liquidation of Am. Mut. Liab. Ins. Co., 63 N.E.2d 1029 (Mass. 1994); Foster v. Peat Marwick Main & Co., 587 A.2d 382 (Pa. Commw. Ct. 1991); In re Integrity Ins. Co., 573 A.2d 928 (N.J. Super. 1990); Corcoran v. Frank B. Hall & Co., 149 A.D.2d 165 (N.Y. 1989).

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on behalf of the company; he or she acts *on behalf* of the policyholders and other creditors as well as on behalf of the public interest.[130]

In *LeBlanc v. Bernard*,[131] a Louisiana Court held:

> The trial court placed defendant in the exact shoes of First Republic. He erred here as a matter of law. The Commissioner of Insurance as rehabilitator or liquidator owes an overriding duty to the people of the State of Louisiana. The *raison d'etre* of his office is because the insurance industry is "affected with the public interest." Any duties imposed upon that office, therefore, must be performed with the public interest foremost in mind. The Commissioner's responsibilities as rehabilitator or liquidator include, additionally, protection of the policyholders, creditors, and the insurer itself. This court has previously held that defendant, as rehabilitator, "does not stand precisely in the shoes of First Republic."[132]

In summary, these cases state the correct rule; that the insurance receiver or other statutory receiver does not stand in the same position as an equity receiver. An insurance receiver does represent creditors in addition to the rights of the old company. Thus, the statutory receiver is not to be estopped by the same equitable rules that might estop a mere equity receiver.

B. ADVERSE DOMINATION DOCTRINE

The so-called "adverse domination doctrine" has sometimes been brought into play in insurance receivership cases. This doctrine holds that when there has been misconduct by corporate insiders, the statute of limitations is tolled until an uninterested party gains knowledge of the wrong and then takes appropriate action.[133]

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130. The rights of the policyholders, other creditors and shareholders are governed by the state's statutory scheme. In the event of liquidation, these innocent parties are entitled to share the available assets in the order of their statutory priorities. As a practical matter, if the insurer has insufficient funds fully to pay policyholder claims, then the only real parties in interest are the policyholders and all others have only a remote and contingent interest. Likewise, if there are sufficient funds to pay policyholder claims in full, but not fully pay general creditors, then the real parties in interest are policyholders and general creditors.

131. 554 So. 2d 1378 (La. Ct. App. 1989).

132. *Id.* at 1381 (internal citation omitted).

133. Clark v. Milam, 872 F. Supp. 307, 310 (S.D. W. Va. 1994).

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For example, In *Clark v. Milam*[134] the court held:

> The peculiar facts of the case now before us make this case a particularly apt candidate for application of the adverse domination doctrine. When the Commissioner is appointed Receiver for an insolvent insurance company, he is charged with marshalling the assets of the company for the benefit of its policyholders and creditors . . .. After all, much more is at stake in this litigation than simply a loss to shareholder investors: we have here an insurance Company that was allegedly victimized and that was allegedly looted of monies that should have been used to pay the claims of totally innocent policyholders.[135]

The *Milam* court permitted the Commissioner to recover for injury to the insolvent company and also adhered to the concept that the Commissioner was acting on behalf of policyholders and other creditors.[136] The Commissioner's special status was key in the court's application of the adverse domination doctrine.[137] It would be hard to argue successfully that the state insurance regulator was not the ultimate "uninterested party."

Basically the same rationale was used in *Schacht v. Brown*[138] in which the Insurance Commissioner as receiver was permitted to pursue a RICO action against the former officers, directors, parent corporation and third parties.[139]

While the adverse domination doctrine could be a valid justification for permitting the insurance receiver to sue former officers and directors, one does not even reach the doctrine unless one has traveled the wrong road. The right road is to conclude that the state insurance regulator acts under the statute as the state in the exercise of its police power. Of course the insurance receiver is an uninterested party, acting as he does pursuant to statute and as the arm of the state.

The issue of the insurance receiver's standing should begin with the premise that he acts under statute for the state. [140] Though the insurance

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134. 452 S.E.2d 714 (W. Va. 1994).

135. *Id.* at 720. To the same effect, *see Clark,* 872 F. Supp. at 307.

136. *Clark*, 452 S.E.2d at 720.

137. *Id.*at 716.

138. 711 F.2d 1343 (7th Cir. 1983).

139. *Id.* at 1351.

140. Bankruptcy cases, which have some similarities, however, do not present the same considerations as insurance cases, or even banking cases. The bankruptcy trustee may be able to use the adverse domination doctrine (*See, e.g.,* In re Greenberg, Inc., 212 B.R. 76 (Bankr. E.D. Pa. 1997) and In re Greenberg, Inc. 240 B.R. 486 (Bankr. E.D. Pa. 1999)), but

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receiver should certainly be considered as the quintessential uninterested party and, accordingly, the right party to pursue the adverse domination doctrine, that doctrine carries inappropriate baggage with it. "Inappropriate baggage" means the view of the *Schacht*[141] court that it was necessary to demonstrate that wrongs complained of were done *to* the corporation and not *by* the corporation as an "engine of theft against outsiders."[142] This puts too fine a point on it.

To adopt the rationale of *Schach* forces the court to distinguish every case from *Cenco* and decide if the wrongs giving rise to the litigation were done *to* or done *by* the corporation. One must ask how such an analysis sheds any light at all upon the equities presented in an insurance insolvency being conducted under a comprehensive statutory scheme. The only reason non-insurance cases make such a distinction is to avoid permitting guilty shareholders or others from profiting by having manipulated the insolvent into an "engine of fraud." But with an insurance insolvency, the recoveries are for innocent creditors by an agent of the state.

It would be ironic, indeed, to deny recovery for the benefit of innocent policyholders and creditors on the theory that they were victimized by an "engine of fraud," as opposed to individual officers and directors acting improperly and causing the corporation to act in certain ways. Despite legal fictions that corporations are "persons," it nevertheless remains that a corporation is not sentient. Like the operator of an automobile, the operators of a corporation may act with malice, but in real life, the corporation has no more malice than the car. The malice lies with the operators.

Are rights of policyholders to be terminated because a court has engaged in a kind of "Is this a dagger I see before me," analysis to determine whether the corporation was the weapon or one of the victims? Where the corporation in question is an insurer, one must struggle mightily

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is not in a position similar to the insurance receiver who acts as the state on behalf of the state as part of the police power of the state. Thus, the bankruptcy trustee, who is a creature of the court and is a successor to the corporation, is much more susceptible to being placed *in pari delicto* or estopped. *See* Official Committee v. R.R. Lafferty Co., 267 F.3d 340, 358 (3d Cir. 2001).

141. The *Schacht* court had to distinguish its earlier decision in Cenco, Inc. v. Seidman & Seidman, 686 F.2d 449 (7th Cir. 1982) in which it reached the opposite result. In *Cenco* there were directors and shareholders that would recover directly from the suit and there had been large corporate shareholders who could have policed the corporate officers. *Id.* at 455. These factors were held not to be present in *Schacht*, 711 F.2d at 1347-48. These considerations make sense in a non-insurance context but they are inapposite in an insurance insolvency contest where the state has intervened on behalf of innocent third parties.

142. *Id.* at 1347, *quoting Cenco*, 686 F.2d at 454.

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to conceive a situation in which (for example) the looting of an insurer by management does not also involve the perpetuation of false financial statements and other wrongs that injure third parties and could be argued to have turned the insurer into an "engine of deceit." There are *always* innocent third parties injured by the serious financial misconduct of the management of an insurer. It is because of this fundamental nature of insurance and the public's vital interest in it that the industry is "vested with the public interest" and subject to regulation by the state.

Accordingly, while the adverse domination doctrine arises out of the same kinds of equitable and legal concepts as the thesis of this article, it is a rule for non-insurers. The same is true of the "independent action" doctrine under which the company is not estopped by misconduct done by an officer or agent outside the scope of employment and on an independent course of his or her own.[143]

To be sure, these doctrines may be applied in an insurance insolvency case, but they are not the prime reason an insurance receiver is not estopped by the misconduct of former management. When an insurance company is involved, the rule should be an insurance receiver is the agent of the state and the manifestation of its police power as it relates to insurance regulation. In this capacity the insurance receiver represents the policyholders and other creditors of the insurer and the insurance receiver is not *in pari delicto* with former management and cannot be estopped based upon their former actions.

To hold that the receiver stands in the shoes of the insolvent and to say no more, would be to ignore the fundamental point of insurance regulation. The ultimate ability of the Commissioner as regulator to enforce his regulatory powers is to take over the company and, as receiver, to mandate and carry out the proper conduct. If, upon the advent of receivership, the law were to treat the regulator *exactly* as it would treat the company prior to receivership, the result would be to ignore the difference between the regulator and the company and also to ignore the rights of the innocent policyholders, creditors and shareholders.

If, for example, the pre-receivership company were to become involved in a conspiracy to defraud its policyholders and creditors, the general rule blindly applied would prevent the receiver from putting aside such fraudulent acts. One can envision any number of things that a desperate, insolvent carrier might do prior to receivership. For instance, it could enter into contracts by which it grants liens or priorities to favored third parties that have the effect of subordinating the rights of policyholders. The

143. *See, e.g.*, In re Investors Funding Corp., 523 F. Supp. 533 (S.D.N.Y. 1980).

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insurer could commit fraudulent transfers. The insurer could enter into reinsurance contracts by which it transfers the lion's share of its premiums out as reinsurance premiums and then grants special concessions to the reinsurers under the contracts. In these kinds of situations, the contracts might be enforceable as against the insurer. However, they certainly should not be enforceable against the state or against the innocent policyholders and creditors who are the real parties in interest.

It is also well-settled that private parties cannot evade the force of the law and that private contracts cannot write around the law.[144] Thus, it would seem to follow that any contract entered into by the insurer prior to receivership which is in derogation of the law should not be enforceable against the regulator as the arm of the law. Just as it would be senseless to stain the receiver with the unclean hands of the insurer, it would also be senseless to force the enforcer of the law to be bound by the illegal acts of the regulated entity. Thus, the exception to the general rule exists where the receiver, in the interest of the policyholders and other creditors, seeks to disaffirm transactions of the insolvent which were done in violation of the law and in fraud of creditors. In *Schacht* the court held that the receiver was entitled to recover damages alleged to have resulted from the artificial prolongation of an insolvent corporation's life.[145] The Court rejected the contention that a corporation's receiver could not sue for the fraudulent prolongation of the insolvent's life, stating: "[t]his premise collides with common sense, for the corporate body is ineluctably damaged by the deepening of its insolvency, through increased exposure to creditor liability."[146]

In rejecting the contention that the receiver should be barred by reason of the defalcations of the shareholders, the Court noted that:

> [A]ny recovery by the Director from the instant suit will inure to Reserve's estate. And under the distribution provisions of the governing liquidation statute, it is the policyholders and creditors who have first claim (after administrative costs and wages owed) to the assets of the estate . . . . Thus, the claims of these entirely innocent parties must be satisfied in full before Reserve's shareholders, last in line for recovery, receive anything.[147]

144. Wildman v. Government Employees' Ins. Co., 307 P.2d 359, 367 (Cal. 1957); Malmgren v. Southwestern Auto. Ins. Co., 255 P. 512, 516 (Cal. 1927).

145. *Schacht*, 711 F.2d at 1350.

146. *Id.*

147. *Id.* at 1348.

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These principles are entirely consistent with the decision of the California Supreme Court in *Camerer*, which was one of the cases relied upon by the Ninth Circuit in *O'Melveny*.[148]

In *Battles v. Braniff Airways, Inc.*,[149] the Fifth Circuit refused to hold an insurance receiver seeking to recover premiums due on a policy to be in *pari delicto* with the company where the company had agreed to receive less premium than that statutorily mandated. Thus, while the company could not have recovered the correct premium, the receiver was in a different position.[150] In its holding, the Fifth Circuit relying upon *English Freight Co. v. Knox*,[151] recognized that the insurance receiver:

[N]ot only represents the insolvent insurance company, but he also represents its policyholders, the beneficiaries under the policies, the creditors, and is the representative of the public interest in the enforcement of the insurance laws as applicable to the policies of an insolvent insurance company.[152]

The court in *Shaw* said the same thing:

> It is true the general rule is that the receiver of an insolvent corporation has no greater rights that those possessed by the corporation itself. There is, however, a well-defined exception to such rule. A receiver of such a corporation acts in a dual capacity. He is a trustee both for the stockholders and the creditors. As trustee for the creditors, he is permitted to maintain and defend actions involving acts done in fraud of creditors, even though the corporation would not be permitted to do so.[153]

CONCLUSION

Courts are not always careful in their selection of language. Sometimes they make statements in the course of their reasoning in a

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148. 61 F.3d at 19.

149. 146 F.2d 336 (5th Cir. 1944), *cert. denied*, 325 U.S. 871 (1945).

150. *Id.* at 339. The Court did hold the receiver was barred by the running of a four year statute of limitations, but

that is a different issue. *Id.*

151. 180 S.W.2d 633 (Tex. Civ. App. 1944). This is another case where the insurance receiver was attempting to collect the proper premiums despite an illegal agreement between the company and its agent that less would be paid.

152. *Id.* at 640. That court quoted from *Shaw* to the same effect. *Shaw*, 46 S.W.2d at 968.

153. *Shaw*, 40 S.W. 2d at 968; *see also* A.B. Leach & Co v. Grant, 54 F.2d. 731 (6th Cir. 1932).

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particular case which need no elucidation in that particular case's context, but which statements are not portable to other cases with different contexts. Accordingly, pulling language out of one case to support a court's desired result in another case, can often distort the rule. Such distortion has occurred with regard to the "stands in the shoes" language.

There is a danger of misconstruction if one lifts language out of a prior case without a thoughtful consideration of the particular context of that case and the facts of that case. Further, courts dealing with insolvent insurance companies should to be mindful of the overall public purpose of the insurance insolvency statutes and the purpose of insurance receivers who are implementing the public policy and enforcing the police power of the state.

An insurance receiver should not be held to "stand in the shoes" of the insurer for all purposes even assuming, *arguendo,* that he or she does stand in those shoes for some purposes. Actually, the receiver stands in the state's shoes. One might even say that, if the receiver stands in the company's shoes for any purpose, he or she always wears the galoshes of government over those shoes and is normally prevented from being estopped or held *in pari delicto* because of pre-receivership misconduct of former management or owners.

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TRAVELING OUTSIDE THE INSURANCE CONTRACT; THE PROBLEMS WITH MAXIMIZING VICTIM COMPENSATION: *KOIKOS V. TRAVELERS INSURANCE COMPANY*

*Sharon Abidor**

In *Koikos v. Travelers Ins. Co.*[1] ("*Koikos*") the Florida Supreme Court certified a question of first impression that asked:

> When the Insured is sued based on negligent failure to provide adequate security arising from separate shootings of multiple victims, are there multiple occurrences under the terms of an insurance policy that defines occurrence as "an accident, including continuous or repeated exposure to substantially the same general harmful conditions"?[2]

The court concluded that each shot fired at each separate victim constituted a separate occurrence, for which Travelers Insurance Company (Travelers) is obligated to indemnify the insured, up to the policy limit.[3] The number of occurrences determined how much money was paid to the policyholder; for example, a single occurrence would be indemnified only once. The court's decision is important as it misapplied causation theory, and it failed to take into account the reasonable expectations of contracting parties.

This note will argue that *Koikos* was incorrectly decided by misapplying the causation theory. I will argue that in a standard form insurance contract covering occurrences, coverage arises based upon the acts or omissions over which the policyholder has control. In this case, it

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1. 849 So. 2d 263 (Fla. 2003).
2. *Koikos*, 849 So. 2d at 264.
3. *Id.*

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was Mr. Koikos's negligent security that acted as the underlying impetus which allowed the accident to occur, and it was this single event for which Traveler's should have indemnified Mr. Koikos with a single payment of $500,000. Part I of this note will discuss the history of *Koikos*. Part II of this note will discuss two theories used to determine coverage liability: first, the effect theory, and second, the causation theory, which this note advocates applying. Part II will also discuss the relationship between proper causation analysis and its support of traditional insurance law practice, which includes honoring the reasonable expectations of the insured. Finally, Part III will discuss why *Koikos* was decided incorrectly, the possible reason the court reached the outcome it did, and the potential implications of this decision.[4]

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4. This note will discuss liability and occurrence insurance, which I believe differs from property insurance. For this reason, the most prominent occurrence case as of late, World Trade Center Properties, L.L.C. v. Hartford Fire Insurance Co., 345 F.3d 154 (2d Cir. 2003) (holding that the attack was a single occurrence under the language of certain insurance policies), will not be discussed within this note.

> There are at least two fundamental differences between liability and property insurance that suggest caution in using liability insurance precedents to determine the number of occurrences in the property insurance context.
>
> First, unlike a property insurance risk, there is no natural limit on a liability insurance risk. In the property insurance context, the worst that can happen is the total destruction of the property and, thus, the amount the insurance company has at stake in a total destruction places a natural limit on the total risk assumed by the company; . . . [t]hus, in a complex, layered property insurance program, occurrence limits and deductibles function in relation to the natural limit by dividing up who takes what piece of that "natural" whole . . . .
>
> In the liability insurance context, in contrast, there is no natural limit on the worst case.
>
> Policyholders can cause harm that is vastly disproportionate to the value of their assets, and they can do so repeatedly during a single policy period.
>
> Second, unlike property insurance benefits, liability insurance benefits go to victims who had no choice over the amount or kind of insurance purchased by the person or entity that harmed them. That difference helps to explain the coverage-maximizing approach that many courts have taken with regard to the meaning of accident and occurrence in liability insurance policies. Most tort victims had no opportunity to require the policyholder to purchase enough insurance and, thus, courts may be motivated to expand coverage to protect them, sometimes even in inconsistent ways, in order to provide the compensation that tort law declares they are entitled to receive.

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I. *KOIKOS V. TRAVELERS INSURANCE COMPANY*

On April 26, 1997, George M. Koikos rented his restaurant Sparta Bar & Grill to the Florida A&M chapter of the Alpha Kappa Psi Fraternity.[5] After refusing to pay admission to the party, two men, Charles Bell and Antonio Anderson, were turned away from the restaurant, only to return armed shortly thereafter. Bell fired two separate, but nearly concurrent rounds of fire, injuring five people, two of whom brought suit against Koikos, alleging negligent failure to provide adequate security.[6] Brian Armstrong and Dejuan Harris, the plaintiffs, were each hit by a separate bullet. Mr. Koikos in turn filed a suit for declaratory action against Travelers Insurance Company in state court, which was removed to the United States District Court for the Northern District of Florida.[7] The District Court ruled in favor of Travelers, holding that while the Florida courts have not addressed the specific issue before the court, other jurisdictions have defined the "'cause of an occurrence' [to be an] act or event that results in the insured becoming legally obligated to pay damages for bodily injury or property damage."[8] The District Court believed that the insurance company would only be responsible for the events that the insured is legally responsible, which in the present case would be negligent security.[9]

After the Court of Appeals for the Eleventh Circuit certified the question for the Florida Supreme Court (Supreme Court), an entirely new holding was adopted for this case.[10] The Supreme Court felt that the definition of 'occurrence' was ambiguous under the terms of the commercial general liability policy that was issued by Travelers to Koikos.[11] The policy provided that:

> Property insurance beneficiaries, in contrast, do have the opportunity to influence the amount of insurance that is purchased.

TOM BAKER, INSURANCE LAW AND POLICY, CASES, MATERIALS, AND PROBLEMS: TEACHER'S MANUAL 104-05 (2003).

5. *Koikos v. Travelers Ins. Co.*, No. 4:99CV57-WS, 2000 WL 33993303, at *1 (N.D. Fla. Mar. 1, 2000).

6. *Id.* at *1.

7. *Koikos*, 849 So. 2d at 265.

8. *Koikos*, 2000 WL 33993303, at *3.

9. *Id.* at *3.

10. *Koikos*, 849 So. 2d at 265-66.

11. *Id.* at 266.

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> a. We will pay those sums that the insured becomes legally obligated to pay as damages because of the "bodily injury" or "property damage" to which this insurance applies.
>
> b. This insurance applies to "bodily injury" and "property damage" only if:
>
> (1) The "bodily injury" or "property damage" is caused by an occurrence that takes place in the coverage territory."
>
> (2) The "bodily injury" or "property damage" occurs during the policy period.
>
> The Policy Declarations provide that "Each Occurrence Limit" is $500,000.
>
> The policy explains that the "Each Occurrence Limit is the most we will pay for damages and medical expenses because of 'bodily injury' or 'property damage' arising out of any one occurrence. There is also a 'General Aggregate Limit of $1,000,000 that is the limit of insurance for each annual twelve month period.
>
> "Occurrence" is defined in the policy as "an accident including continuous or repeated exposure to substantially the same general harmful conditions."[12]

As the term "accident" was not defined within the policy, the Supreme Court adopted the view that the policy language was ambiguous, and when "policy language is subject to differing interpretations, the term should be construed liberally in favor of the insured and strictly against the insurer."[13] Once the policy was determined to be ambiguous, the Court attempted to determine causation, an often tricky issue when dealing with the term "occurrence."[14] The court used the cause theory because "absent explicit

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12. *Id.*

13. *Id.* at 266-67.

14. *See* Home Indem. Co. v. City of Mobile, 749 F.2d 659 (11th Cir. 1984) (finding that the cause of an occurrence refers to the events or incidents for which the insured is liable); American Indem. Co. v. McQuaig, 435 So. 2d 414 (Fla. Dist. Ct. App. 1983) (using cause theory to determine that multiple gunshots gave rise to multiple occurrences); Maurice Pincoffs Co. v. St. Paul Fire & Marine Ins. Co., 447 F.2d 204, 206 (5th Cir. 1971) (the "occurrence" to which an insurance policy referred must have referred to "the occurrence of the events of incidents for which the [insured] [was] liable"); Philips v. Ostrer, 481 So. 2d 1241, 1247 (Fla. Dist. Ct. App. 1985) ("the act which causes the damage constitutes the occurrence"); New Hampshire Ins. Co. v. RLI Ins. Co., 807 So. 2d 171 (Fla. Dist. Ct. App. 2002) (court focused on shots fired, as cause for policy trigger).

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policy language, most jurisdictions apply the 'cause theory,' which looks to the cause of the injuries, rather than the 'effect theory,' which looks to the number of injured plaintiffs."[15]

The Florida Supreme Court was ultimately persuaded by Mr. Koikos's argument: "the event that was neither expected nor intended from his standpoint was the shooting and not his own negligent failure to provide security . . . thus there were two occurrences because there were two shootings resulting in separate injuries to the two victims."[16] The Court concluded that under the cause theory it was the shots fired, and not the underlying negligence of the policyholder (the restaurant owner) that triggered the policy, thus multiple gun shots equated to multiple occurrences.[17] The Court acknowledged other jurisdictions have differing views on what constitutes a cause in occurrence actions, yet it opted to rule in favor of Koikos, requiring Travelers to indemnify Mr. Koikos twice, meeting the aggregate payout limit on the policy of one million dollars.[18]

II. CAUSATION THEORY & INSURANCE COVERAGE

Within standard commercial general liability (CGL) insurance contracts (standard form contracts), such as the one in *Koikos*, courts have had to resolve the issue of causation in relation to the policy language in the contract. This determination is important as it controls the amount of money the insurance company must indemnify the policyholder. Two basic theories have evolved over the years when dealing with causation and occurrences: the effect theory and the cause theory.[19]

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15. *Koikos*, 849 So. 2d at 269 (citing *McQuaig*, 435 So. 2d at 415). For further explanation of why the court opted to use causation theory, *see Koikos*, 2000 WL 3393303, at *2. "It is also agreed that Florida courts apply the 'cause theory' when assessing whether conduct giving rise to liability constitutes more than one 'occurrence.'" *Id.* (citing *McQuaig*, 435 So. 2d 414 (Fla. Dist. Ct. App. 1983)). Under the cause theory, as opposed to the 'effect' or 'result' theory, the inquiry is whether "there was but one proximate, uninterrupted, and continuing cause which resulted in all of the injuries and damages." *McQuaig*, 435 So. 2d at 415 (quoting Bartholomew v. Ins. Co. of North America, 502 F. Supp. 246 (D.R.I. 1980)), *aff'd*, 655 F.2d 27 (1st Cir. 1981).

16. *Koikos*, 849 So. 2d at 267.

17. *Id.* at 271.

18. *See id.* at 271-72. "We recognize that other jurisdictions have differing views on this issue . . . We respectfully disagree that the term 'occurrence' unambiguously refers to the underlying negligence of the insured." *Id.*

19. Tung Yin, *Nailing Jello to a Wall: A Uniform Approach for Adjudicating Insurance Coverage Disputes in Products Liability Cases With Delayed Manifestation Injuries and Damages*, 83 CAL. L. REV. 1243, 1249, 1253 (1995) [hereinafter *A Uniform Approach for Adjudicating Insurance Coverage*].

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A minority of jurisdictions apply the effect theory which looks to the number of injuries that result (i.e. the 'effects'), rather than the cause of such injuries to determine liability.[20] Choosing between the effect and cause theory, a majority of jurisdictions opt for the former. [21] The reason for this preference is linked to the history of standard form contracts and the reasonable expectations of the insured.[22] The majority of jurisdictions apply the causation theory or causation test, which uses the proximate cause of the damages to determine the policyholder's liability.[23] Determining liability is important because it triggers insurance coverage (based upon the number of occurrences) for the policyholder. On its face, this approach may seem easy for the courts to determine; however, as demonstrated in *Koikos* and other occurrence related cases, courts applying the causation test have difficulty determining the proximate cause. The problem for the courts is determining where they should focus, either on the immediate cause of harm (which can be argued was an accident or unexpected occurrence from the standpoint of the insured), or on the underlying cause of harm (the cause for which the policyholder was legally responsible). By focusing on the underlying cause, the policyholder's reasonable expectations to receive coverage are honored, since this analysis focuses on the tortuous omission of the policyholder as opposed to the intentional harm and damage done by a third party, not covered by the insurance policy.[24] Before explaining the cause theory, and why I believe this is the theory that courts should adopt to analyze insurance contracts, I will discuss the effect theory, and the reason why this theory is not as helpful resolving occurrence related issues.

a. The Effect Theory

The effect theory looks to the effect of a tortuous event or the number of injuries sustained to determine the number of occurrences. It is adopted by a minority of jurisdictions in interpreting insurance liability contracts.[25] In terms of the key word "accident," the effect theory determines the

20. Yin, *supra* note 19, at 1253.

21. *Koikos,* 849 So. 2d at 271-72 (other jurisdictions have differing views on this issue, determining the number of occurrences under the cause theory).

22. *See* discussion on history of standard form contracts, *infra* Part II.b.

23. Yin, *supra* note 19, at 1249.

24. *See, e.g., Koikos*, 849 So. 2d at 266 ("Koikos asserts that under the policy there were two occurrences because there were shootings resulting in separate injuries to the two victims . . . . Travelers contends that the occurrence was Koikos's negligence and, therefore, . . . there was but a single occurrence).

25. *Koikos*, 849 So. 2d at 269.

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number of accidents from the perspective of the injured plaintiffs. The main appeal of the effect theory is generally to compensate victims,[26] especially in situations where the activity covered is one that society generally feels more empathy for the victim (i.e. gunshot victims, child molestation victims). Instead of having to determine what the real or proximate cause that triggered coverage is, this theory allows the court to look at the damage done, and then determine coverage after the fact. This theory does not really concern itself with the reasonable expectations of the insured prior to making the contract, which can be a difficult and time-consuming task. In essence, it may be more judicially efficient to count the number of bodies rather than delving into the complicated issue of causation. Compensating innocent victims and reserving judicial resources are certainly important public policy goals, yet most courts do not choose to employ the effect theory.

b. The Causation Theory

The causation theory looks to the underlying legal cause of the injury or damage, rather than looking to the number of resulting injuries or damage claims (the effects).[27] The causation theory is the test that most courts use in determining occurrence liability.[28] Under proper causation test analysis, a single proximate, uninterrupted cause results in a finding of a single occurrence.[29] The causation test is useful in that it looks to the policyholder's actions and expectations in relation to the event that causes injury. Most courts deciding cases that have an insurance policy at issue

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26. Of course there are situations in which a 'single occurrence' rather than a 'multiple occurrence' result will maximize the insurance coverage (*e.g.*, in a very high limit corporate insurance policy with a high deductible). *Cf.*, Owens-Illinois, Inc. v. United Ins. Co., 650 A.2d 974 (N.J. 1994).

27. *See, e.g.*, Appalachian Ins. Co. v. Liberty Mut. Ins. Co., 676 F.2d 56 (3d Cir. 1982).

28. RLI Ins. Co. v. Simon's Rock Early College, 765 N.E.2d 247, 250 (Mass. App. Ct. 2002) ("[A]s in the majority of jurisdictions having decided the issue, the number of occurrences is determined by the 'cause' theory, which construes occurrence 'by reference to the cause or causes of the injury or damage rather than the number of claims.") (citing Doria v. Ins. Co. of N. America, 509 A.2d 220, 223-24 (N.J. Super Ct. 1986)). *See also* Yin, *supra* note 19, at 1249 (applying the causation view: "[t]he majority of courts apply the general proposition that an occurrence is tied to the underlying cause of damages" (citing Michael P. Sullivan, Annotation, *What Constitutes Single Accident or Occurrence Within Liability Policy Limiting Insurer's Liability to a Specified Amount Per Accident or Occurrence?*, 64 A.L.R. 4th 668, 673 (1988)). *See also* Hyer v. Inter-Ins. Exch. of the Auto. Club of So. Cal., 246 P. 1055 (Cal. Ct. App. 1926).

29. *See, e.g.*, Michigan Chemical Corp. v. American Home Assur. Co., 728 F.2d 374 (6th Cir. 1984).

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with an identical or very similar definition to the contract in *Koikos* (an occurrence is an accident, including continuous or repeated exposure to substantially the same general harmful condition) use a proximate-cause approach to determine coverage.[30] The reason this approach is so popular is because it takes into account the fact that these standard form policies were written to embody the reasonable expectations of the insured. This is important in relation to the history of the standard form CGL policies.

Starting in the 1960's standard form insurance contracts began taking into account the reasonable expectations of the policyholder.[31] Courts adjudicating coverage disputes regularly construed policies to provide the insured with its reasonable expectation of coverage.[32] Policyholders should reasonably expect that their underlying negligence or action is the 'occurrence' that will be covered under the standard form contracts. "The 1966 version of the standard CGL policy, which used the term 'accident' instead of 'occurrence,' determined whether an accident took place from the point of view of the insured."[33] Prior to 1966, an effect theory interpretation was given weight by the courts, because coverage was being determined by "'[v]iewing the incident from the viewpoint of the victim [which] would almost always lead to a conclusion that the loss in question was an accident and therefore covered, since victims rarely foresee, intend, or expect the loss caused by the insured.'"[34] By looking to the underlying cause, and apply causation theory analysis, the courts are following the CGL policy language changes faithfully.

Applying pure causation analysis not only takes into account the history of the standard form policy, but it also makes policyholders responsible for their role in an accident or occurrence that causes harm. The idea of making the individual who "set the stage for the suffering that unfolded"[35] to take responsibility for victim compensation is an idea that has developed throughout the twentieth century.[36] This individual's, or "the Enabler's"[37] role in the harm is the cause which the courts should

30. Yin, *supra* note 19, at 1249 (citing Appalachian Ins. Co. v. Liberty Mut. Ins. Co., 676 F.2d 56, 61 (3d Cir. 1982); Champion Int'l Corp. v. Continental Cas. Co., 546 F.2d 502, 505-06 (2d Cir. 1976), *cert. denied*, 434 U.S. 819 (1977)).

31. Yin, *supra* note 19, at 1256.

32. *Id.*

33. *Id.* at 1257.

34. *Id.* (citing ROBERT H. JERRY, II, UNDERSTANDING INSURANCE LAW 97, 99 (1987).

35. Robert L. Rabin, *Enabling Torts*, 49 DEPAUL L. REV. 435, 438. (Winter 1999).

36. *See id.* at 437.

37. "Beyond the immediate perpetrator of harm, the victim perceives the individual, or more often, the enterprise, that set the stage for the suffering that unfolded. The Enabler." *Id.* at 437-38.

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focus upon in determining insurance coverage liability within standard form contracts. A modern trend of imposing duty upon a party who enables a third party to cause direct harm has emerged. For example, negligent entrustment cases,[38] negligent security cases,[39] and social-host responsibility cases.[40] In order to impose this duty, the courts must look at how the policyholder caused the injury, and not at the direct cause of harm. If judges truly wish to force enablers into securing their property, then the analysis that should occur links the underlying cause with indemnification. Thus, if the action which enhanced the likelihood of harm to occur was negligent security, and the immediate harm was a multiple shooting scenario, the court should find the policyholder's negligent action to be the 'occurrence' for which indemnification should occur. Analyzing causation this way places responsibility on the policyholder for his wrongdoing, and it also faithfully honors the policyholder's expectations for coverage.

c. Problems With Punishing the Policyholder

While it is advantageous for an enabler to take some responsibility in the harm caused by a malevolent third party, courts are taking the enabling principle too far. Instead of looking at the enabler's role in causing harm, which is generally a single act of negligent behavior, courts are deciding that the immediate harm is the cause for which the enabler/policyholder should be responsible. By switching this focus, insurance companies have to indemnify policyholders for occurrences that were not really bargained for. As stated previously, courts want to impose a duty to "protect against third party violence."[41] Yet courts have expanded policy coverage beyond the single negligent act. Courts are doing this because "implicitly, of course, the main 'deterrence gap' is the inability to effectively reach the putative wrongdoer himself, either through criminal or tort sanctions,"[42] thus the burden of paying for the victims falls to the insured policyholder. The only way for victims to receive insurance money is to misconstrue causation theory analysis, by switching the focus to the immediate harm done by the third party, and by assuming the policyholder should be liable

38. *Id.* at 438 n.15 (discussing negligent entrustment of a vehicle to an unlicensed or unsafe driver).

39. *Id.* at 446 n.55 (discussing negligent parking lot security).

40. *Id.* at 441 n.34 (discussing generic 'enabling' in social host liability duty for alcohol related injury).

41. Rabin, *supra* note 35, at 444 n.46.

42. *Id.* at 444.

for these actions. This switch in focus in a multiple shooting case, for example, produces multiple coverage, and it allows judges to "adopt extremely flexible constructions of 'cause' in order to maximize the available coverage."[43] While victim compensation is an admirable goal, imposing liability upon the policyholder for the acts of a third party detract from recognizing their real duty and role in the harm, and it also ignores the reasonable expectations of coverage.

d. Reasonable Expectations & Causation Theory

The reasonable expectation doctrine was first developed in the 1970's in a two part law review article written by Professor (and now Judge) Keeton.[44] He defined the reasonable expectation theory as "the objectively reasonable expectations of applicants and intended beneficiaries regarding the terms of insurance contracts will be honored even though painstaking study of the policy provisions would have negated those expectations."[45] In its ideal form, the doctrine was to encourage insurance contracts to be written for a layman's understanding, as opposed to a sophisticated underwriter's.[46] The doctrine was meant to protect the policyholder's expectations "as long as they are objectively reasonable from the layman's point of view."[47] This doctrine assumes that resolving any and all ambiguities against the insurer is best for the community as a whole.[48]

The link between reasonable expectations and causation predated the actual articulation of the principle in Professor Keeton's article, and it has

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43. Michael F. Ayward, *Multiple 'Occurrences' — A Divisive Issue*, 5.1 COVERAGE 39 (Jan./Feb. 1995).

44. Robert E. Keeton, *Insurance Law Rights at Variance with Policy Provisions*, 83 HARV. L. REV. 961 (Mar. 1970).

45. *Id.* at 967.

46. *Id.*

47. *Id.*

48. *Id.* at 969.

> [A]mong the decisions that can be explained in this way are most, at least, of the decisions resolving genuine ambiguities against the policy draftsman. To this proposition it might be objected that resolving ambiguities against the insurer would sometimes be more favorable to the insured than would honoring reasonable expectations. For example, even though the contractual language was ambiguous, there might be no expectation at all, or the expectation might be unreasonable, thus defeating a claimed expansion of coverage beyond the letter of the contract . . . there has always been an implicit understanding that ambiguities . . . would be resolved favorably to the insured's claim . . . .

Id.

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continued ever since.[49] A case that recognized the natural link between determining causation and an insured's reasonable expectations is *Bird v. St. Paul Fire & Marine Insurance*.[50] The key issue in that case was whether or not the fire that occurred was the proximate cause of loss.[51] In order to determine causation, Justice Cardozo utilized the reasonable expectations of the insured prior to the accident to determine the scope of coverage. In the opinion he stated:

> Our guide is the reasonable expectation and purpose of the ordinary business man when making an ordinary business contract. It is his intention, expressed or fairly to be inferred, that counts. There are times when the law permits us to go far back in tracing events to causes. The inquiry for us is how far the parties to this contract intended us to go. The causes within their contemplation are the only causes that concern us.[52]

When analyzed properly, the reasonable expectations doctrine compliments pure causation theory analysis. However, the reasonable expectation doctrine is imperfect, and it is in these imperfections that courts justify the improper application of causation theory.

e. Problems in Applying Reasonable Expectations & Causation Theory

One of the main problems with the reasonable expectation doctrine is that courts have relied on the principle to extend coverage to all losses, claiming that a policyholder expected to be covered for any and all

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49. The *Bird* decision is discussed and/or cited in approximately 250 other opinions, primarily for its view on the relationship between causation and reasonable expectations. *See, e.g.*, Ins. Co. of N. Am. v. Dayton Tool & Die Works, Inc., 443 N.E.2d 457, 462 (N.Y. 1982) (dissent); Burr v. Commercial Travelers Mut. Accident Ass'n of Am., 67 N.E.2d 248, 251 (N.Y. 1946); New York Dock Co. v. Aetna Cas. & Sur. Co., 46 N.Y.S.2d 307, 309 (N.Y. 1943); Pan Am. World Airways, Inc. v. Aetna Cas. & Sur. Co., 368 F. Supp. 1098, 1133 (S.D.N.Y. 1973).

50. 120 N.E. 86 (N.Y. 1918).

51. The case decided by Justice Cardozo in 1918 resolved the question of "whether a policy of fire insurance covered damage to a vessel, which was located about 1,000 feet away from fire which never reached the vessel, in circumstances where the loss resulted from a concussion accompanying an explosion that resulted from the fire." *Bird*, 120 N.E. at 86-87.

52. *Id.* at 87.

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situations. The general expectation that all incidents are covered just because insurance was purchased should not be sufficient to create a reasonable expectation of coverage.[53] However, many courts come to this very conclusion;[54] if not expressly stating it as such, the courts implicitly adopt reasoning that covers situations outside the scope of what the insured could have reasonably bargained. "DRE [doctrine of reasonable expectations] provides doctrinal justification for a court's intuitive sense of what constitutes a right and just decision."[55]

Therefore, when courts have to determine difficult issues, like causation, the reasonable expectation doctrine provides courts with a framework to choose a cause that will amount to the 'best' result. Instead of using reasonable expectations "to set the parameters for causation under an insurance policy,"[56] the doctrine is often used to support the "judges' perceptions of fairness,"[57] which many times runs counter to setting boundaries on causation and reasonable expectations. Judges understandably want to compensate innocent victims, thus they use the doctrine in relation to causation as a "policy base for altering and modifying contract obligations."[58] This tilt toward favoring the individual policyholder and providing the greatest amount of coverage possible, seems to run counter to the purposes of having a standard form contract,[59] which benefits both insured and insurer.

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53. James M. Fisher, *The Doctrine of Reasonable Expectations is Indespensible, If We Only Knew What For?*, 5 CONN. INS. L.J. 151, 162-63 (1998-99) [hereinafter *The Doctrine is Indespensible*] (citing State Farm & Cas. Co. v. Bongen, 925 P.2d 1042, 1047 (Ala. 1996) (noting that "most insureds develop an expectation that every loss will be covered . . . .")). This is not to suggest that this expectation standing alone is sufficient. *See*, Darner Motor Sales, Inc. v. Univ. Underwriters Ins. Co., 682 P.2d 388, 395 (Ariz. 1984) (stating that the policyholder's reasonable expectations must be filled by "something more than the fervent hope usually engender by a loss").

54. *See* Fisher, *supra* note 53, at 162-63 (citing Haber v. St. Paul Guardian Ins. Co., 137 F.3d 691 (2d Cir. 1998) (applying New York Law)). In *Haber*, uncommunicated insurance needs were covered in a worker's compensations suit. *Id.* at 163. Also, in *Koikos*, extending coverage to include the intentional acts of third parties as incidents covered by the policy extends the insurance coverage into a realm where Mr. Koikos appeared to be covered for all occurrences, grounding this in the reasonable expectation doctrine. *Koikos*, 849 So. 2d at 269 (referring to Keeton, *supra* note 44).

55. Fisher, *supra* note 53, at 153.

56. Robert H. Jerry, II, *Insurance, Contract and the Doctrine of Reasonable Expectation*, 5 CONN. INS. L.J. 21, 49 (1998-99).

57. Fisher, *supra* note 53, at 164.

58. *Id.* at 165.

59. *Id.* at 153 (citing KENNETH ABRAHAM, DISTRIBUTING RISK 31-36 (1986), which discusses issues of efficiency and equity in interpreting insurance contracts).

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f. Resolving the Causation Issue

Perhaps the answer to the problem of misapplication of the causation theory is for courts to make more of an effort to use pure causation theory analysis, as opposed to a test that maximizes coverage for victims. When properly applied, true causation analysis uses the 'per occurrence' language under a general liability insurance contract to ensure that the occurrence for which coverage is provided relates to the underlying cause or source of injury.[60] The doctrine of reasonable expectations is useful in determining causation, if properly applied.

If this doctrine is used to determine what the insured reasonably bargained for when purchasing insurance, courts could rely on the doctrine to deny coverage in cases where the insured attempts to collect on any incident that occurred, even those beyond the scope of his reasonable expectation. By combining these two principles, the reasonable expectations doctrine provides boundaries for what the insured can expect coverage for, and the causation theory provides a framework for analyzing the underlying event that determines the amount of coverage received. Ideally this will prevent the "invoca[tion] [of the] doctrine of reasonable expectations [to] support . . . any decision a court wishes to make in the specific coverage dispute at hand."[61]

III. REVISITING KOIKOS

In order for the Florida Supreme Court to reach a result that maximized coverage for the victims, the court needed to analyze the case in a manner that produced this result. In order to do this, the court divided its decision into three new questions:

> First, it is unclear what effect – if any – this policy's definition of 'occurrence' would have under Florida law. Second, it is unclear whether in using the 'cause theory,' we should focus on Koikos's alleged negligence or on Bell's separate gunshots. Furthermore, decisions of other

60 Michael P. Sullivan, *What Constitutes Single Accident or Occurrence Within Liability Policy Limiting Insurer's Liability to a Specified Amount Per Accident or Occurrence*, 64 ALR 4th 668, 693 (1998).

61. Fisher, *supra* note 53, at 173.

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Florida courts are difficult to square with the court's approach in *McQuaig*.[62]

a. Distinguishing Koikos from McQuaig

Within Koikos's argument, heavy reliance is placed on the 5th District Court of Appeal's decision in *American Indemnity Co. v. McQuaig*.[63] Based upon the holding in this case, the court anchors its causation theory analysis, and its ultimate decision that the separate shootings constituted multiple occurrences.[64] Comparing these two cases provides an erroneous basis for the *Koikos* decision, because there are key differences between the two cases. First, the liability policy at issue in *McQuaig* did not contain the same policy language as that contained in the Travelers policy for *Koikos*.[65] Second, the actual shooter in *McQuaig* was the insured, unlike in *Koikos* where the shooter was a third party.

The *McQuaig* court looked at the policyholder's action to determine coverage, which is counter to the manner in which the *Koikos* court analyzed coverage. The *McQuaig* court correctly focused its attention on the action that produced liability.[66] "Liability attached when Croskey fired the shots which resulted in injury to the two deputies."[67] If the *Koikos* court followed the analysis in *McQuaig*, the court's focus would have to be on the negligent security, the action the policyholder controlled. In the *Koikos* case, the suit was brought based on the negligent security causing the victims' harm.

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62. *Koikos*, 849 So. 2d at 265 (citing American Indem. Co. v. McQuaig, 435 So. 2d 414 (Fla. Dist. Ct. App. 1983); Southern Int'l Corp. v. Poly-Urethane Indus., 353 So. 2d 646 (Fla. Dist. Ct. App. 1977)) (holding that defective application of roof sealant to several buildings over the course of several days was a single occurrence).

63. 435 So. 2d 414 (Fla. Dist. Ct. App. 1983). Croskey fired several shots at two police officers from his home. Separate shots injured each officer. Croskey had insurance coverage under a homeowner's policy. Each officer sought to be indemnified for their separate injuries, and without a clear meaning attached to the word 'occurrence' within the policy the court held that each shot constituted a separate occurrence for insurance purposes.

64. *Koikos*, 849 So. 2d at 269-72.

65. *McQuaig*, 435 So. 2d at 415. "The homeowner's policy which insured Croskey provided for liability coverage in the amount of $100,000 . . . the policy provided personal liability coverage in the amount of $100,000 for 'each occurrence.' The policy itself did not define the term 'occurrence.' It is therefore necessary to look elsewhere for appropriate definitions." *Id.*

66. *Id.* at 415.

67. *Id.* at 416.

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> If this alleged negligence on Koikos's part was not, in the view of the *McQuaig* court, the 'proximate, uninterrupted and continuing cause which resulted in all the injuries and damages' sustained by Harris and Armstrong on the night in question, Koikos would have no liability to the injured parties, and [Traveler's] would have no responsibility under its policy.[68]

While both *Koikos* and *McQuaig* involved shootings, a key issue the *Koikos* court seems to miss is that Croskey was both the shooter and the insured.[69] Mr. Koikos on the other hand was just the insured. He was obligated to maintain his property, not to control any and all actions that might occur around or near it (reasonable expectations do not guarantee coverage of any and all events)[70]. By focusing on the gunfire and number of shots fired, and by misapplying the *McQuaig* court's reasoning, the Florida Supreme Court reached an incorrect result.

b. Enabling Travelers to Pay the Harm

The situation in *Koikos* ultimately rests on the idea that Koikos was an enabler.[71] Koikos's negligent security enabled the shooters to come onto his property, and this negligence set into motion the gun violence. It is in these scenarios, that "blameworthiness is not so readily confined,"[72] and the individual or institution that must pay for the victim's injury becomes more difficult to determine. Today there is an increased sensitivity to gun violence, coupled with a desire to compensate victims of this type of violence, with the ultimate goal of deterrence of future violence. Courts attach the third party's responsibility to the "less" wrong policyholder.[73] This is exactly what occurred in the *Koikos* case. Mr. Bell, the third party who shot Mr. Armstrong and Mr. Harris, walked into Mr. Koikos's restaurant, which did not have adequate security. Gun violence is an

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68. Answer Brief of Appellees at 21-22, Koikos v. Travelers Ins. Co., 849 So.2d 263 (Fla. 2003) (No. SC 01-301).

69. *McQuaig*, 435 So. 2d at 414-15 (emphasis omitted).

70. *Bird*, 120 N.E. at 87.

71. *See* Rabin, *supra* note 35, at 437.

72. *Id.*

73. *Id.* at 443. "These scattered situations, in which a seemingly isolated careless act enhances the risk that a malevolent or consciously indifferent intervenor will seriously injure an innocent third-party, create the backdrop against which enabling behavior of a more entrepreneurial kind comes under judicial scrutiny in our contemporary setting of a risk-sensitized society." *Id.* at 443.

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obvious detriment to society, and one way of trying to curtail this violence is to punish not only the shooter, but the enabler (Mr. Koikos) for his behavior which created "the backdrop against which"[74] the gunshots occurred. Attaching a duty to Mr. Koikos would encourage him and other restaurant owners to take precautions to prevent a shooting like this from occurring in the future. [75] However, the court did not see Mr. Koikos's negligence as the act that triggered policy liability, but instead found Mr. Bell's actions, the shootings, to be the acts for which insurance was guaranteed.

The court wanted to impose a duty on Mr. Koikos,[76] and at the same time the court wanted to maximize the victims' compensation. Since the court could not reach Bell, the only person who had insurance money to pay for the injuries was Mr. Koikos, thus the only way to maximize indemnification was to find that Mr. Koikos's role in the harm constituted multiple occurrences. To reach a multiple occurrence result, the court had to construct its analysis in a way that the cause of the harm for which Mr. Koikos was covered was the shootings. This was an improper application of causation theory analysis, as the act for which he was truly responsible was the inadequate security. However, if the court only applied coverage for the cause for which Mr. Koikos bargained and had legal control, the victims would have received $500,000 (single occurrence payment) as opposed to the $1 million (multiple occurrence payment). Since the money was coming out of Mr. Koikos's insurance policy, the goal of maximizing victim compensation controlled the decision.

The person or institution responsible for paying the victims also played a role in the *Koikos* outcome.[77] In this case, it was Travelers that would pay twice. The money paid to the victims was not coming directly from Koikos's pocket ("blood money"),[78] but it came from his insurance policy.

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74. *Id.*

75. *See generally Id.* at 443-45. A line of cases developed in the 1960's, which created a reasonable duty to keep premises safe from violence. *Id.* (citing Kline v. 1500 Mass. Ave. Apt. Corp., 439 F.2d 477 (D.C. Cir. 1970)). "The main thrust of the opinion is to emphasize a deterrence rationale for creating a duty to protect against third-party violence." *Id.* at 444.

76. *Id.* at 443. "The courts have responded by creatively extending, or at least taking seriously the prospect of, liability in contexts where earlier common law courts would most likely have been dismissive on 'no duty' grounds." *Id.*

77. *See generally* Tom Baker, *Blood Money, New Money, and the Moral Economy of Tort Law in Action*, 35 LAW & SOC'Y REV. 275 (2001). The idea is that people do not have a problem taking money from an institution like an insurance company, but generally opt not to go after money from individuals directly. *Id.*

78. "'Blood money' is a term many of my respondents used for what I have been calling real money from real people--money paid directly to plaintiffs by defendants out of their own pockets." *Id.* at 276.

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By indemnifying Travelers twice, the court set up a very morally comfortable situation – Mr. Koikos was not really hurt, as he was not paying any money directly to the victims, and the victims were given the maximum amount of coverage they could receive based on their injuries. Forcing the 'cold' institution to pay does not seem so bad, especially when the beneficiaries are victims of gun violence.[79] The job of the insurance company is to underwrite risk. "The carrier is being paid for taking a certain risk, and he's making payment based on his underwriting policies with respect to that risk, and he's still usually making money . . . that was the purpose of insurance."[80] While morally the court may be comfortable assigning risk this way, the decision does not necessarily benefit society in the long run. First, Mr. Koikos enabled the harm caused by Mr. Bell. It was his negligence that produced liability coverage, and it was this negligence that should have been the focus of the court's causation inquiry. Second, when Koikos entered into a contract with Travelers, he could not have reasonably expected to have coverage over causes far removed from his legal control. Thus, interpreting the contract language to provide coverage for the shootings misinterprets his reasonable expectations of coverage.

c. Discovering a Cause

As stated in Part II, courts often confuse causation theory analysis in an effort to achieve a victim-friendly result. In the *Koikos* case, the court claimed there were two possible ways to analyze cause: "(1) the underlying tortuous omission of the insured—Koikos's failure to provide security and failure to warn; or (2) the intervening intentional acts of the third party—the intruder's gunshots."[81] If the court applied pure causation theory analysis, the only cause for which Mr. Koikos could be indemnified was his negligent security. However, in order to compensate the victims, the court had to focus its analysis on the end result (option 2). By looking to the end result, the court essentially ignores the reason for which the insurance was purchased, and it gives Mr. Koikos overly broad coverage.

Mr. Koikos argued that "the event that was neither expected nor intended from his standpoint was the shooting and not his own negligent failure to provide security . . . thus . . . there were two occurrences because

79. Tom Baker notes that there is a "predisposition to prefer to take money from an insurance company as opposed to an individual . . ." *Id.* at 283.

80. *Id.* at 285.

81. *Koikos*, 849 So. 2d at 269.

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there were two shootings resulting in separate injuries to the two victims."[82] In response to Mr. Koikes's argument, the court applied an effect theory analysis and labeled it causation theory. As stated by the district court, "[t]he shots fired by Bell did not create the insureds' liability; instead, the insureds' alleged negligence in failing to provide adequate security is what created the insureds' potential liability for damages."[83] Switching the focus to shots fired "improperly focus[es] on the *effect*, rather than the *cause*, of the events or incidents that resulted in Defendants' potential liability for damages."[84]

Ultimately, the court wanted to reach Mr. Koikos's insurance policy. The only way for the court to collect insurance money for the victims was to misapply the causation theory. In order to justify using the gunshots fired as the cause, the court implicitly backs up its logic through reliance on an overly broad and improper reasonable expectation theory. By agreeing with Mr. Koikos's argument, that the shooting was "neither expected nor intended from his standpoint,"[85] the court opens the policy up to cover a cause which should not have reasonably been covered. Whenever someone is sued, he or she is going to claim that they expected to be covered for any and all circumstances. However, there are limits to insurance coverage, and there were limits that should have applied in the *Koikos* case. The causes and occurrences for which Mr. Koikos was covered exceeded those over which he had some element of control. These were the causes the parties could have contemplated or that were within the realm of contemplation when the contract was signed.[86] Reasonable expectations should not be used to support expanding coverage beyond that which was bargained for by the parties, no matter what end result might occur.

IV. CONCLUSION

The Florida Supreme Court had one main objective in deciding the *Koikos* case. That objective was maximizing the amount of coverage innocent gunshot victims received. In reaching a favorable end result, the court used the modern trend of attaching duty to enablers, here Mr. Koikos, in an effort to make him responsible for his role in a serious injury. By making enablers financially responsible for the actions of a third party, the

82. *Id.* at 267.

83. *Koikos*, 2000 WL 33993303, at *3

84. *Id.*

85. *Koikos*, 849 So. 2d at 267.

86. *Bird*, 120 N.E. at 87. Justice Cardozo articulates that there are reasonable limits on what causes occurrence insurance policies cover. *Id.*

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courts hope to deter future enabling conduct from occurring. Yet when the *Koikos* court expanded on this principle, attaching a duty beyond the scope of Mr. Koikos, the court used an incorrect analysis. By imposing the third party's duty on Mr. Koikos, the court was able to reach the only money available to pay the victims, Mr. Koikos's occurrence policy. Since the shooter was unable to provide an adequate financial remedy for the victims, the court went to the only other source of money available, an insurance policy. By switching the analysis to focus on the immediate cause of harm, and claiming that it was the gunshot that triggered liability, Mr. Koikos's insurance company had to indemnify the victims with the maximum amount of money the policy would allow. If the court looked to the cause that really triggered Mr. Koikos's liability, his negligent security, the court would have been forced to require only single occurrence coverage.

The court found additional support for switching the focus of its causation analysis to the gunshots by agreeing with Mr. Koikos that he reasonably expected to be covered for such an incident. This was a misapplication of the reasonable expectation principle in relation to the contract and the liability trigger. Mr. Koikos's reasonable coverage expectations should have been limited to those acts for which he exerted some measure of control. Pairing this idea with a focus on his wrongdoing in the injuries that occurred would require the court to find that only one act occurred; Mr. Koikos did not provide adequate security, and for this action he was covered under his policy.

The Florida Supreme Court should have made Mr. Koikos liable for the role he played in the harm that occurred. There are strong policy reasons to impose liability on individuals who enable third parties to engage in harmful and dangerous behavior, especially when it is difficult to make those third parties liable. When the court decides to expand coverage beyond that which was bargained for, it negates the reasons for entering into a contract. Mr. Koikos reasonably bargained for insurance, which would have covered his negligent security. Switching the liability triggering incident to the immediate cause of harm in this case does not advance society's interest in deterring this type of violence from reoccurring. Properly decided, the *Koikos* court should have found that there was one occurrence, the negligent security, and therefore only one payment should have been made.

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SWIMMING IN THE WAKE OF *DEHOYOS*: WHEN FEDERAL COURTS SAIL INTO DISPARATE IMPACT WATERS, WILL STATE REGULATION OF INSURANCE REMAIN ABOVE THE WAVES?

William Goddard[*]

I. Summary

The Fifth Circuit's holding in *Dehoyos v. Allstate Ins. Co.*[1] has extended the reach of federal oversight of insurance well beyond its prior boundaries. Traditionally, the McCarran-Ferguson Act[2] has shielded state regulation of insurance from the effects of most federal laws. Increasingly, however, federal courts have been using federal laws to evaluate insurance underwriting for prohibited discrimination. The decision in *Dehoyos* is a high water mark in this process because it examines insurance underwriting practices through the lens of federal law without drawing a distinction between intentional discrimination and the disparate impact effect of unintentional discrimination. This paper will contend that this decision, if followed, represents a watershed in the relationship between state and federal oversight of insurance practices.

The holding in *Dehoyos* interjects federal law deeply into the fabric of state insurance regulation. The practice at the center of the *Dehoyos* complaint is the use of personal credit information, mathematically distilled into a numerical measure of creditworthiness or "credit score," then factored into the pricing of property-casualty insurance. Yet oversight of insurance pricing has long been the domain of state insurance regulators who carefully examine underwriting models and resulting rates for "unfair" discrimination through formal rate approval mechanisms. Through *Dehoyos*, federal courts have set about the business of analyzing the impact of these models, rather than just seeking out racially discriminatory intent. This change comes in the examination of a criterion which has much more tenuous connections with race than any examined before. Unless a new boundary line can be set, federal courts could examine any and all

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1. 345 F.3d 290 (5th Cir. 2003).
2. 15 U.S.C. §§ 1011–1015 (2000).

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underwriting criteria for discriminatory effect, interjecting themselves into the very heart of state insurance rate regulation. For better or worse, this intrusion seems squarely at odds with the protections built into the McCarran-Ferguson Act.[3]

How states respond to *Dehoyos* and the spreading practice of using personal credit information to underwrite insurance policies may affect the outcome of future litigation, but any effect of state law will be limited by the *Dehoyos* holding itself. The court appears to require a head-on conflict with state law in order for McCarran-Ferguson to apply. Therefore unless a state enacts legislation wholeheartedly embracing the use of credit scores, there appears to be the potential for federal oversight. Many states have chosen to allow the use of credit scoring in insurance underwriting, but have placed many restrictions on the practice. If federal courts should decide that restrictions placed on credit scoring are designed to combat the same evils of discrimination as federal laws, then they may push past McCarran-Ferguson protections and allow full review of underwriting practices. In so doing, courts may have signaled a transition across the watershed to federal oversight of insurance practices.

This comment will explore how the Fifth Circuit's holding in *Dehoyos* has fundamentally expanded federal oversight of insurance by pushing the reach of federal laws into the traditionally state-regulated field of insurance underwriting beyond intentional discrimination into the disparate impact of insurance underwriting practices. In addition, it will discuss how will the wide variety of state laws enacted to regulate the use of credit scores in insurance underwriting may be affected by this holding. In order to develop this discussion, Section Three describes the brewing debate over the use of credit scores in insurance underwriting, Sections Four and Five detail the federal statutes at issue and analyze them in light of the McCarran-Ferguson Act's reverse preemption provisions, Sections Six and Seven discuss the *Dehoyos* holding in a historical context and suggest how it has altered the historical landscape, Section Eight discusses the laws introduced in individual states to regulate the use of personal credit information in insurance underwriting, and Sections Nine and Ten conclude by examining the paths ahead for potential plaintiffs.

II. Introduction

3. This paper does not intend to take a position in the intense debate over whether the use of credit information is an appropriate underwriting tool. This paper will instead address the question of who may regulate this practice and what the involvement of the federal courts may mean for the future of insurance underwriting regulation by the individual states.

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States have traditionally regulated insurance underwriting. State insurance departments review insurance rates to determine if they are "excessive, inadequate or unfairly discriminatory."[4] Under the scrutiny of state insurance regulators, insurance companies underwrite insurance risks by classifying policyholders into groups and then pricing the coverage for each group. By classifying individuals, insurance companies predict the future losses and then price the insurance coverage accordingly. Smokers pay more for life insurance than nonsmokers, young drivers pay more for automobile insurance than older drivers, and homeowners located farther from a fire station pay more for homeowner's insurance than those living closer. Since it is not possible to predict losses for a specific individual, it is possible that a careful young driver will still pay more than a reckless older driver. It has been the role of state insurance departments to analyze insurance classifications to determine if they are "unfair" and prevent abuse.[5]

Federal law has traditionally protected private transactions from intentional racial discrimination through the descendants of the Civil Rights Act of 1866.[6] Federal law also prohibits discrimination in housing through the Fair Housing Act ("FHA").[7] While federal courts have restricted the Civil Rights Act of 1866 to intentional discrimination, courts have allowed the FHA to regulate unintentional discriminatory effects or "disparate impact" cases.

When companies classify individuals for purposes of pricing, there is always a danger that protected groups may fall disproportionately into higher priced classifications, even if there is no discriminatory intent. If, for example, it were shown that a higher percentage of minority groups smoked, minority groups would pay more for life insurance, even if race is nowhere to be found in the underwriting analysis. Yet some classifications, such as residing in a neighborhood consisting primarily of minorities, are so closely identified with race that some degree of intentional racial discrimination may be inevitable.

When insureds bring actions alleging that an insurer's underwriting practices have caused racial minorities to pay higher rates for insurance than Caucasians, state insurance regulation and federal anti-discrimination law can come into conflict. Litigants desire to use federal courts and federal remedies while states use the rate regulatory process and may not

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4. Monroe v. Ins. Serv. Office of Arkansas, 257 Ark. 1018, 522 S.W.2d 428, 429 (Ark. 1975).

5. *See, e.g.*, Thurman v. Meridian Mut. Ins. Co., 345 S.W.2d 635 (Ky. 1961).

6. Now codified at 42 U.S.C. §§ 1981 – 1982 (2000).

7. 42 U.S.C. §§ 3601 – 3631 (2000).

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provide for private causes of action. Normally, federal law will preempt conflicting state law. However, the McCarran-Ferguson Act shields state laws regulating insurance from preemption by a federal statute found to impair, invalidate or supercede state law, but only if the federal statute does not specifically target insurance. [8] The Supreme Court has said repeatedly that "[o]bviously Congress' purpose was broadly to give support to the existing and future state systems for regulating and taxing the business of insurance."[9]

Federal courts have found that McCarran-Ferguson does not bar actions based upon intentional discrimination. Federal courts have applied the Civil Rights Act of 1866 to insurance practices in order to bar racial classification in life insurance, reasoning that laws banning intentional discrimination did not conflict with state law.[10] Federal Courts have applied the FHA to prevent racial discrimination in homeowners' insurance by banning the practice of charging higher premiums in neighborhoods composed of racial minorities; also finding no conflict with state law since state laws did not specifically authorize this practice.[11] Until recently however, federal courts hesitated to review the impact of insurance practices in the absence of intentional discrimination.[12]

In *Dehoyos v. Allstate,* the Fifth Circuit determined that the McCarran-Ferguson Act provided no bar to a complaint alleging that the use of personal credit information in insurance underwriting violated federal law.[13] In the process, the court applied a strict interpretation of McCarran-Ferguson that appears to require a head-on conflict with state law, not

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8. If, as discussed below, Congress is determined to have enacted an applicable federal statute specifically directed toward insurance, then McCarran-Ferguson does not apply. This entire discussion will be rendered moot if Congress passes legislation banning the use of credit scores in insurance activities as has been proposed in House Bill H.R. 2796 introduced by Congressman Thompson in July of 2003. At this writing, the bill has not been reported out of committee. Bill history *available at* http://thomas.loc.gov/cgi-bin/bdquery/z?d108:HR02796:@@@X (last visited 3/11/04).

9. United States Dep't of Treasury v. Fabe, 508 U.S. 491, 500 (1993) (quoting Prudential Ins. Co. v. Benjamin, 328 U.S. 408, 429 (1946)).

10. *See* Moore v. Liberty Nat'l Life Ins. Co., 267 F.3d 1209 (11th Cir. 2001).

11. *See* N.A.A.C.P. v. Am. Family Mut. Ins. Co., 978 F.2d 287 (7th Cir. 1992) (holding that the FHA's anti-discrimination provisions do not impair, invalidate or supercede state law regulating insurance, and infers applicability of the FHA to insurance); Nationwide Mut. Ins. Co. v. Cisneros, 52 F.3d 1351 (6th Cir. 1995) (holding McCarran-Ferguson does not reverse preempt the FHA).

12. *See Cisneros*, 52 F.3d at 1362 (Court refuses to consider disparate impact enforcement until HUD actually enforces the FHA on a disparate impact basis).

13. *Dehoyos*, 345 F.3d at 299.

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simply an impairment of a state regulatory regime.[14] What is most revolutionary about this holding is that the majority of the panel, over a heated dissent, made no distinction between the well-traveled ground of intentional discrimination and potential claims of disparate impact in finding that McCarran-Ferguson did not apply.[15]

The use of personal credit information highlights the distinction between intentional discrimination and disparate impact. A credit score is a mathematical calculation of a person's creditworthiness. A credit scoring model takes into consideration factors such as late bill payments, frequent applications for credit or prior bankruptcies and calculates a score designed to predict an individual's creditworthiness. Insurers have begun to use personal credit scores to price a wide variety of property/casualty insurance products. Insurers believe that credit scores are an effective predictor of future loss experience and therefore an important ingredient in an insurance pricing model. If plaintiffs can show that the use of credit scores constitutes intentional discrimination, it would be a simple extension of existing precedent to ban the practice. If, on the other hand, it is a classification scheme which has a disproportionate impact on minorities, how should it be distinguished from other classification schemes?

Credit scores are not unique to insurance, but McCarran-Ferguson is. Banks use credit scores to make lending decisions and price loans. However, banks are regulated in a two-tier state/federal system, without the special protections of the McCarran-Ferguson Act. It is a far simpler intuitive link between a person's prior credit history and the likelihood of repaying a loan, than it is between a person's credit score and the likelihood they will report a loss on a given insurance policy. Yet, if McCarran-Ferguson protects a state's legislation empowering its insurance department to police the ingredients in underwriting models for unfair discrimination, how far should federal courts go in examining those ingredients for disproportionate impact on minorities?

The Fifth Circuit did not require a finding of intentional discrimination as a prerequisite to federal review, but left the above questions unanswered. If federal courts can evaluate credit scoring under federal law for its disparate impact on racial minorities, it is very difficult to articulate a dividing line that prevents federal review of any other underwriting criteria

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14. *Id.* at 297.

15. As discussed below, another federal trial court permitted disparate impact claims to advance under the FHA shortly after the trial court in *Dehoyos* published its decision. This case, however, was related to redlining which has strong historical ties to intentional discrimination and lacked a substantive McCarran-Ferguson analysis. Nat'l Fair Hous. Alliance v. Prudential Ins. Co. of Am., 208 F. Supp. 2d 46 (D.D.C. 2002).

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such as smoking, driving records, accident history or distance from fire stations, for possible disparate impact.[16] If federal courts can use federal law to review any underwriting criteria, then it is extremely difficult to set a dividing line preventing the review of any other element of a state insurance rate approval process. It is easy under these circumstances to forecast a slippery slope cascading into federal regulation of insurance underwriting.

Future cases will likely follow trial court's colorful summary of *Dehoyos*: "Plaintiffs in this case essentially allege that Caucasians are in good hands with Allstate, but for non-Caucasians it is hands-off. The Court deduces defendants deny dastardly discriminatory dealings."[17] However, if discriminatory effects are not dastardly, but unintentional, federal courts may now be able to review them under federal law.

III. The Debate over Credit Scoring

Insurance companies use credit scores as a tool to help predict future losses on insurance policies and therefore price insurance. Credit reporting agencies make personal credit scores available to insurers for a fee, as regulated by the Fair Credit Reporting Act, 15 U.S.C. § 1681 ("FCRA"). The FCRA, as amended in 1997, provides that an insurer or other purchaser may obtain personal credit information if it "intends to use the information in connection with the underwriting of insurance involving the consumer."[18]

There is a heated debate concerning whether the use of credit scores in insurance underwriting actually leads to a superior ability to predict paid losses. Insurers claim that credit scores are a highly accurate tool to predict insurance losses across many lines of insurance.[19] One actuary has

16. Congress appears to have endorsed some federal scrutiny of the use of credit scores. The Fair and Accurate Credit Transactions Act of 2003, passed by Congress in late November, 2003, mandates the Office of Fair Housing and Equal Opportunity of the Department of Housing and Urban Development to study the effect of the use of credit scores on the "availability and affordability" of a wide variety of financial services, including property and casualty insurance. H.R. Conf. RE. NO. 396, 108th Congress, 1st Sess. 2003.

17. Dehoyos v. Allstate Corp., No. CIV.A.SA01CA1010FB, 2002 WL 1491650, *1 (W.D. Tex. Apr. 5, 2002).

18. 15 U.S.C. § 1681b(a)(3)(C) (2000).

19. Proponents often cite a study, prepared in March of 2003 by Bureau of Business Research, McCombs School of Business at the University of Texas at Austin. The study concluded: "Using logistic and multiple regression analyses, the research team tested whether the credit score for the named insured on a policy was significantly related to incurred losses for that policy. It was determined that there was a significant relationship. In general, lower credit scores were associated with larger incurred losses. Next, logistic and

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speculated as to possible causal links between credit history and loss experience, for example that financially stretched policyholders may be more likely to report a claim because of financial needs or prone to fraud to avoid payment of deductibles.[20] To date, however, no expert has been able to prove a causal link. Critics claim that it is not possible to link a person's credit score to the likelihood that person will have an insured loss; therefore any relationship must be coincidental.[21] Critics say that the use of credit scores invades their privacy and damages those who have limited financial resources or are unfortunate enough to have errors in their credit files. Experts at one nationally recognized actuarial firm have stated that other loss-related factors can be virtually as effective as credit scoring in projecting expected losses.[22] The debate continues to rage.

If credit scores are highly correlated with the race of a potential insured, the practice would likely lead to higher insurance premiums for ethnic minorities if they are found to have lower scores. Critics fear that the use of credit scores may result in racial discrimination in insurance underwriting in much the same way that the use of geographic data resulted in prohibited discrimination in pricing or availability of homeowners insurance ("redlining"). *Dehoyos v. Allstate* involves a claim by non-Caucasian policyholders that Allstate used credit scores in order to charge non-Caucasian policyholders more for insurance than their Caucasian counterparts.[23] The plaintiffs sought relief under federal anti-discrimination statutes.

IV. Applicable Federal Law

Plaintiffs in *Dehoyos* challenged the use of credit scoring under the small group of federal statutes that have been used by many claimants wishing to challenge the discrimination practices of insurance companies:

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multiple regression analyses examined whether the revealed relationship between credit score and incurred losses was explainable by existing underwriting variables, or whether the credit score added new information about losses not contained in the existing underwriting variables. It was determined that credit score did yield new information not contained in the existing underwriting variables." Dr. Bruce Kellison, Dr. Patrick Brockett, Seon-Hi Shin, Shihong Li, *A Statistical Analysis of the Relationship Between Credit History and Insurance Losses*, Bureau of Business Research, The University of Texas at Austin, Mar. 2003, *available at* http://www.utexas.edu/depts/bbr/bbr_creditstudy.pdf.

20. James E. Monaghan, *The Impact of Personal Credit History on Loss Performance in Personal Lines* at 86-88.

21. Chris Pummer, *Insurers Face Regulatory Backlash for Use of Credit Scores*, NAT'L ASS'N PROF'L ALLSTATE AGENTS (Feb.13, 2002).

22. Wayne D. Holdredge & Katharine Barnes, *Good News, Bad News or Both?*, Tillinghast-Towers Perrin Emphasis 2003/2, at 21.

23. *Dehoyos*, No. CIV.A.SA01CA1010FB, 2002 WL 1491650 at *1.

two descendants of the Civil Rights Act of 1866[24] and the Fair Housing Act ("FHA").[25] Traditionally, those actions challenging "redlining" practices in homeowners insurance have used the FHA. Those that challenge other commercial discrimination practices generally apply the descendants of the Civil Rights Act of 1866, which prohibits racial discrimination in private contracts.

A. The Civil Rights Act of 1866

These Reconstruction-era federal statutes[26] have formed the basis for many challenges to the use of discriminatory practices in insurance underwriting. The current form of this legislation is now codified at 42 U.S.C. §§ 1981-1982. The first section prohibits racial discrimination in the making and enforcement of contracts. The second prohibits discrimination in property transactions. Neither statute makes any mention of insurance; however, insurance contracts have been held to be "property" under § 1982.[27] Courts have held that enforcement of these statutes requires a showing of intent to discriminate, not simply the disparate impact of potential discrimination.[28]

> 42 U.S.C. § 1981: Equal rights under the law
>
> (a) Statement of equal rights
>
> All persons within the jurisdiction of the United States shall have the same right in every State and Territory to make and enforce contracts, to sue, be

24. Now codified at 42 U.S.C. §§ 1981–1982 (2000).

25. 42 U.S.C. §§ 3601–3631 (2000).

26. "On April 9, 1866, the Congress of the United States enacted into law the first civil rights bill in the history of the country. Among other things it declared: 'That all persons born in the United States and not subject to any foreign power, excluding Indians not taxed, are hereby declared to be citizens of the United States; and such citizens, of every race and color, without regard to any previous condition of slavery or involuntary servitude . . . shall have the same right, in every State and Territory in the United States to make and enforce contracts; to sue, be parties and give evidence, to inherit, purchase, lease, sell, hold, and convey real and personal property, and to full and equal benefit of all laws and proceedings for the security of person and property, as is enjoyed by white citizens . . . .'" John Hope Franklin, *The Civil Rights Act of 1866 Revisited*, 41 HASTINGS L.J. 1135 (1990).

27. Sims v. Order of United Commercial Travelers of Am., 343 F. Supp. 112, 115 (D. Mass. 1972) (holding that "the purchaser of a life insurance policy makes an investment decision whereby he purchases a promise to pay his designated beneficiary on the event of his death. That promise to pay is property of substantial value to the purchaser . . . within the meaning of § 1982.").

28. Oliver v. Digital Equip. Corp., 846 F.2d 103, 111 (1st Cir. 1988) (holding that claims under § 1981 require intentional discrimination, not a showing of disparate impact).

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> parties, give evidence, and to the full and equal benefit of all laws and proceedings for the security of persons and property as is enjoyed by white citizens, and shall be subject to like punishment, pains, penalties, taxes, licenses, and exactions of every kind, and to no other.
>
> (b) "Make and enforce contracts" defined
>
> For purposes of this section, the term "make and enforce contracts" includes the making, performance, modification, and termination of contracts, and the enjoyment of all benefits, privileges, terms, and conditions of the contractual relationship.
>
> (c) Protection against impairment
>
> The rights protected by this section are protected against impairment by nongovernmental discrimination and impairment under color of State law.

42 U.S.C. § 1982: Property rights of citizens

> All citizens of the United States shall have the same right, in every State and Territory, as is enjoyed by white citizens thereof to inherit, purchase, lease, sell, hold, and convey real and personal property.

B. The Fair Housing Act ("FHA"):

These statutes prohibit racial discrimination in housing and related services. Unlike the preceding statutes, courts have interpreted the Fair Housing Act to apply to disparate impact claims in the absence of a showing of intentional discrimination.[29]

The relevant provisions are 42 U.S.C. §§ 3604 and 3605. One court described the pertinent portions of these provisions as follows:

> Section 3604 makes it unlawful:

29. The District Court in *Nat'l Fair Housing Alliance* cites eleven circuit court opinions that hold that disparate impact claims are cognizable under the FHA including Simms v. First Gibraltar Bank, 83 F.3d 1546 (5th Cir. 1996). "These courts have recognized that the premise of a disparate impact claim is that housing practices may operate in a manner that is 'functionally equivalent to intentional discrimination.'" *National Fair Housing Alliance*, 208 F. Supp. 2d at 58.

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> (a) To refuse to sell or rent after the making of a bona fide offer, or to refuse to negotiate for the sale or rental of or otherwise make unavailable or deny, a dwelling to any person because of race, color, religion, sex, familial status, or national origin.
>
> (b) To discriminate against any person in the terms, conditions, or privileges of sale or rental of a dwelling, or in the provision of services or facilities in connection therewith, because of race, color, religion, sex, familial status, or national origin. . . .
>
> [f]urthermore, section 3605 makes it unlawful:
>
> (a) [T]o discriminate in making available ... a [residential real estate- related] transaction, or in the terms and conditions of such a transaction, because of race, color, religion, sex, familial status, or national origin.
>
> (b) [T]he term "residential real estate-related transaction" means any of the following:
>
> > The making or purchasing of loans or providing other financial assistance— for purchasing, constructing, improving, repairing, or maintaining a dwelling . . ."[30]

Both the FHA and the Civil Rights Act of 1866 are *federal* statutes, enacted by Congress. To apply these statutes to insurance practices regulated by the states, a court must determine that the federal statutes are not required to give way to state insurance laws through the mechanism of the McCarran-Ferguson Act. This was the sole issue presented to the *Dehoyos* court: Did the McCarran-Ferguson Act prevent the application of §§ 1981-1983 and the FHA to the use of credit scoring in insurance underwriting?

V. McCarran-Ferguson Act Reverse Preemption

Until 1944, courts followed the principles set out in *Paul v. Virginia*,[31] holding that the issuance of an insurance policy was not an act of commerce and therefore was beyond the reach of the Commerce Clause powers granted to Congress by the Constitution.[32] As a result, Congress and the courts left the regulation of insurance practices to the individual states. The United States Supreme Court swept away that doctrine in a single stroke, declaring in *United States v. South-Eastern Underwriters*

30. *Nat'l Fair Hous. Alliance,* 208 F.Supp.2d at 54 (emphasis removed).
31. 75 U.S. 168 (1868).
32. *Id.* at 183.

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Ass'n,[33] 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 power to regulate trading in insurance . . . ."[34] Overnight, insurance practices became subject to federal laws regulating anti-trust and a vast array of other federal statutes.[35]

Congress responded swiftly, re-affirming the dominance of the states in the regulation of insurance.[36] Through the McCarran-Ferguson Act, now codified at 15 U.S.C. §§ 1011–1015, Congress provided that federal anti-trust laws would apply to the business of insurance only so far as that business remained unregulated by state law.[37] However, Congress went much further, granting a rare exception to the usual rules of preemption in conflicts between state and federal law. Generally, federal laws take precedence over state law, [38] but under McCarran-Ferguson, if a federal law clashes with state insurance laws, the federal law must yield unless it specifically governs insurance. Because it reverses the normal rules of preemption, this provision of McCarran-Ferguson is described as a "reverse preemption."

The general preemption provision of the McCarran-Ferguson Act, 15 U.S.C. § 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

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33. 322 U.S. 533 (1944).

34. *Id.* at 539.

35. It is very interesting to note that prior *South-Eastern Underwriters* and the McCarran-Ferguson Act, that insurance lay outside Congress' Commerce Clause powers. The Civil Rights Act of 1866 and its many re-affirmations over the years would appear to be grounded in the enforcement clause of the Fourteenth Amendment, U.S.CONST. amend. XIV cl. 5, not of the Commerce Clause Powers, even though the Fourteenth Amendment was not ratified until 1868. Although the McCarran-Ferguson Act does not appear to recognize this dichotomy, at least one court has held that this distinction affects applicability of the reverse preemption. Spirt v. Teachers Ins. & Annuity Ass'n, 691 F.2d 1054, 1065-66 (2d Cir.1982), *vacated*, 463 U.S. 1223, 103 S.Ct. 3565, 77 L.Ed.2d 1406 (1983), *reinstated as modified*, 735 F.2d 23 (2d Cir.1984). Whether this distinction is applicable or has meaning in this controversy is beyond the scope of this paper and best left for another day.

36. "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. § 1011 (2000).

37. 15 U.S.C. §§ 1012–1013 (2000).

38. The United States Constitution provides that, "[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." U.S. CONST. art. VI, cl. 2.

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> imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance. [39]

This provision is actually composed of four distinct tests:

1. Does the Act of Congress specifically relate to insurance?
2. Is the given activity within the business of insurance?
3. Is the state law enacted for the purpose of regulating the business of insurance?
4. Does the federal law invalidate, impair or supercede the state law?

To determine the outcome of a reverse preemption question concerning the use of credit scores in insurance underwriting, courts must examine each test in turn.

A. When does an Act of Congress specifically relate to the business of insurance?

The United States Supreme Court has determined that a federal statute must specifically manifest an intent to govern insurance in order for a federal statute to trump a conflicting state insurance statute. General non-insurance statutes will not have a preemptive effect. While the intent to regulate insurance must be clearly stated, the Court does not require that Congress make a specific declaration that state law is to be preempted. In *Barnett Bank of Marion County v. Nelson*,[40] the Supreme Court determined that that Florida's laws regulating the sale of insurance by banks did not preempt federal legislation allowing banks to sell insurance because Congress had specifically directed portions of the federal law toward insurance.[41] In the same decision, the Court cited the Bankruptcy Code as an example of general federal statutes that would not preempt state

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39. 15 U.S.C. § 1012(b) (2000). The subsection continues with a specific proviso exempting the business of insurance from anti-trust laws. "*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." (citations omitted).

40. 517 U.S. 25 (1996).

41. *Id.* at 42.

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insurance laws because Congress had not specifically targeted the Bankruptcy Code toward insurance.[42]

This test has an evolving role in the application of the Fair Housing Act to discrimination in homeowners' insurance. In the redlining cases, federal courts were reluctant at first to find that the FHA governed insurance in any way, finding that it had no reference or applicability to insurance regulation.[43] Later courts have found that the FHA applies to insurance in two ways: i) by recognizing that the enforcement of the FHA in the area of insurance by the Department of Housing and Urban Development represents a conclusive interpretation of the statute by the agency charged with enforcing it,[44] and ii) by endorsing the argument that homeowners insurance is an essential ingredient to homeownership and therefore is a "provision of services and facilities"[45] to housing or essential in the securing of "financial assistance"[46] to purchase housing as protected by the statute.[47] The FHA does not specifically mention insurance and there is no authority stating that the FHA "specifically relates" to insurance for the purposes of the McCarran-Ferguson test.[48] The recent case law so strongly asserts the FHA's applicability to insurance,[49] that this may be the next logical step, but no court has yet gone this far.

On the other hand, it would be very difficult to maintain that 42 U.S.C. §§ 1981-1982 specifically relate to insurance, even though insurance policies have been determined to be property under § 1982. These statutes are as broad in scope as the Bankruptcy Code, if not broader. There is no

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42. *Id.* ("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-pre-emption rule will apply.").

43. Mackey v. Nationwide Ins. Cos., 724 F.2d 419, 423 (4th Cir. 1984) (holding that redlining was protected from anti-trust challenge by the McCarran-Ferguson reverse preemption, the FHA did not apply to insurance, and a civil rights challenge was possible although not on the facts of the case).

44. *Nat'l Fair Hous. Alliance,* 208 F. Supp. 2d at 56-57.

45. 42 U.S.C. § 3604(b) (2000).

46. 42 U.S.C. § 3605 (b)(1) (2000).

47. *See American Family Mut.,* 978 F.2d at 295 (infers applicability of the FHA to insurance); *Nat'l Fair Hous. Alliance,* 208 F.Supp.2d at 48 (holding that FHA applies to insurance).

48. *Moore,* 267 F.3d at 1220. The court in *NAACP v. American Family Mutual* took a strong stand on the FHA's applicability to insurance, but still concluded that it did not specifically relate to insurance in order to breach the McCarran-Ferguson test. *American Family Mut.,* 978 F.2d at 295. *See also Nationwide Mut.,* 52 F.3d at 1360–61.

49. *See Nat'l Fair Hous. Alliance,* 208 F. Supp. 2d at 56 – 58.

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mention of insurance in either section. In fact, courts have found that Congress did not intend for these laws to specifically relate to insurance.[50]

Until a court interprets that the FHA specifically relates to insurance, all of these statutes appear subject to the remaining McCarran-Ferguson tests because they do not specifically relate to the business of insurance.

B. When is a practice part of the business of insurance?

The United States Supreme Court has provided three tests to determine if a practice is part of the business of insurance. The Court originally developed these tests evaluate the McCarran-Ferguson Act's exemption from anti-trust laws, but courts have extended the tests to include review of the general reverse preemption provisions as well. Specifically, courts examine a particular activity to determine if it: i) transfers a policyholder's risk, ii) represents an integral part of the policyholder relationship and iii) is restricted to entities within the insurance industry.[51] The Supreme Court has suggested that satisfaction of all three tests is not required to consider an activity to be part of the "business of insurance."[52]

It would seem clear that insurance underwriting is part of the business of insurance. Underwriting of insurance policies has the effect of spreading policyholder risk, is integral in establishing the policyholder relationship, and is restricted to entities within the insurance business.

C. When is an act enacted by a state for the purpose of regulating the business of insurance?

State statutes need not specifically regulate detailed insurance practices in order to enjoy protection from federal preemption. In *United States Dep't of the Treasury v. Fabe*,[53] the United States Supreme Court found that the "broad category of laws enacted 'for the purpose of regulating the business of insurance' consists of laws that possess the 'end, intention, or

50. *Moore*, 267 F.3d at 1220.

51. Union Labor Life Ins. Co. v. Pireno, 458 U.S. 119 (1982) (specifying characteristics of the business of insurance).

52. Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355, 373 (2002) ("[b]ecause the factors are guideposts, a state law is not required to satisfy all three McCarran-Ferguson criteria to survive preemption."). This decision was rendered in the context of the ERISA "savings clause" which, until recently, followed the McCarran-Ferguson tests for the business of insurance. The Court unlinked ERISA from the McCarran-Ferguson test and developed a separate test for ERISA preemption in Kentucky Ass'n of Health Plans, Inc. v. Miller, 123 S.Ct. 1471, 1478 (2003). It is unclear if the Court would require all three tests to be satisfied if it were to revisit the "business of insurance" post *Moran*.

53. 508 U.S. 491 (1993).

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aim' of adjusting, managing, or controlling the business of insurance."[54] The Court observed that "[t]his category necessarily encompasses more than just the 'business of insurance.'"[55]

This test leaves a broad field of laws and regulations eligible for protection under the McCarran-Ferguson Act. Federal appellate courts have wrestled with the breadth of *Fabe*, almost from the moment it was decided. One circuit court tested a state statute piece by piece to determine if each regulated practice constituted the "business of insurance."[56] Later circuit court opinions have suggested that entire state regulatory regimes may enjoy a blanket protection.[57] Courts may find limits to the business of insurance, however, when a state regulator strays too far from insurance practices.[58]

An act passed by a state legislature to regulate criteria used in underwriting would appear to be an act enacted for the "end, intention, or aim" of regulating the business of insurance. In fact, courts have found statutes governing insurance underwriting to be safely covered within this test.[59] State legislation empowering a state insurance department to regulate the components used in underwriting models, including the use of credit scores, would seem a natural extension of a state's power to regulate insurance underwriting.

D. When does an Act of Congress impair, invalidate or supercede state law?

In *Humana Inc. v. Forsyth*,[60] the Supreme Court reviewed the application of Racketeer Influenced Corrupt Organization Act (RICO)[61] to insurance activities and concluded that RICO remedies did not impair state law remedies, but rather served the same ends.[62] The Court also defined all three terms: "The term 'invalidate' ordinarily means 'to render ineffective,

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54. *Id.* at 505.

55. *Id.*

56. Garcia v. Island Program Designer, 4 F.3d 57 (1st Cir. 1993) (holding that state statutes must be parsed to determine reverse preemption).

57. Munich Am. Reinsurance Co. v. Crawford, 141 F.3d at 585 (5th Cir. 1998) (implying that entire state statutory systems may preempt federal statutes).

58. Suter v. Munich Reinsurance Co., 223 F.3d 150 (3d Cir. 2000) (specifying certain acts by an insurance regulator that are outside the business of insurance).

59. *See Moore*, 267 F.3d at 1220.

60. 525 U.S. 299 (1999).

61. 18 U.S.C. § 1961-68 (2001).

62. *Humana*, 525 U.S. at 314. "Because RICO advances the State's interest in combating insurance fraud, and does not frustrate any articulated Nevada policy, we hold that the McCarran-Ferguson Act does not block the respondent policy beneficiaries' recourse to RICO in this case." *Id.*

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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.'"[63] The Court also 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.'"[64]

Litigants have enjoyed their greatest success in applying federal law to discriminatory insurance practices by arguing that federal law does not "impair, invalidate or supercede" state law in the area of racial discrimination. In the redlining cases, courts used this test to push aside the McCarran-Ferguson Act in every case, finding that the FHA did not "impair, invalidate, or supercede" state insurance regulation since no state had endorsed redlining practices.[65] The Eleventh Circuit has advanced the most sweeping application of the "invalidate, impair, supercede" doctrine to insurance regulation in the context of life insurance. In *Moore v. Liberty National Life Ins. Co.*,[66] plaintiffs maintained that a life insurer had targeted ethnic minorities for the sale of high-cost "industrial life" policies between the 1940's and the 1970's. The court found that McCarran-Ferguson posed no bar to the pursuit of a racial discrimination claim under § 1981 and § 1982 because Alabama's insurance laws prohibited "unfair discrimination" but did not specifically encourage other types of discrimination.[67] This is significant because many states prohibit "unfair discrimination."[68] The circuit court concluded that the federal laws did not impair, invalidate or supercede the state law because the state law did not specifically condone intentional racial discrimination.[69]

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63. *Id.* at 307.

64. *Id.* at 310.

65. *See Am. Family Mut. Ins. Co.*, 978 F.2d at 287 (holding that the FHA's anti-discrimination provisions do not impair, invalidate or supercede state law regulating insurance); *Nat'l Fair Hous. Alliance, Inc.*, 208 F. Supp. 2d at 61 (holding that FHA applies to insurance and McCarran-Ferguson is no bar because federal remedies for discrimination should not await outcomes in state courts where relief is not available). Even the original and narrowest redlining case reached this result. *Mackey*, 724 F.2d at 421.

66. 267 F.3d 1209 (11th Cir. 2001).

67. *Id.* at 1220-23.

68. *See, e.g.*, discussion of Connecticut below and Anziger v. O'Connor, 440 N.E.2d 1014, 1021 (Ill. App. 1982).

69. *See Moore*, 267 F.3d at 1220. A second life insurance case is working its way through the courts of the Fifth Circuit. The district court denied class certification to plaintiffs challenging racially discriminatory underwriting of low-value ("industrial") life insurance policies in the period prior to 1970, but the circuit court reversed. In re Monumental Life Ins. Co., Indus. Life Ins. Litig., 343 F.3d 331 (5th Cir. 2003). The district court has postponed the McCarran-Ferguson question, however, until later in the litigation.

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Because civil rights statutes do not specifically mention insurance, and insurance underwriting practices are closely regulated at the state level, the battle over credit scoring will be fought over whether federal law regulating the practice will impair, invalidate or supercede state law. Courts have held that efforts to prevent intentional discrimination do not impair state insurance statutes, because state laws do not authorize racial discrimination. If credit scoring can be shown to be motivated by a desire to use credit scores as a surrogate for race, federal courts will have clear authority under *Moore* to use § 1981 to intervene.

Until recently, courts have been much more reluctant to suggest that disparate impact claims do not "frustrate any declared state policy" or "interfere with a state's administrative regime"[70] related to the regulation of insurance underwriting.[71] Insurance by its very nature discriminates among classes of individuals. State regulation oversees this discrimination. The rubric of state insurance regulation is that insurance rates should not be excessive, inadequate or *unfairly* discriminatory.[72] Primarily, federal law regulates the use of racial discrimination in private practices. If a state law regulating an insurance practice provides for the use of "fair" discrimination, can courts or plaintiffs use a federal statute to examine that practice for racial overtones?

It is one thing to say that rooting out intentional discrimination in life insurance does not impair state laws. However in the absence of proof of intentional discrimination, it is quite another thing to say that a federal court, delving into eventual impact of the elements in the insurance underwriting formula does not "interfere with a state's administrative regime"[73] of regulating those factors that may be considered in insurance underwriting.[74] This was to prove no barrier for the *Dehoyos* court.

VI. Placing *Dehoyos* in History

A. *Discrimination and Insurance before* Dehoyos

In re Industrial Life Ins. Litig., 148 F. Supp. 719 (E.D. La. 2001). Metropolitan Life has recently settled another class action alleging discrimination in life insurance for a substantial sum. Thompson v. Metro. Life Ins. Co., 216 F.R.D. 55 (S.D.N.Y. 2003).

70. *Humana*, 525 U.S. at 310.

71. *See Cisneros*, 52 F.3d at 1361-63 (although decided before *Humana*, the court declined to examine disparate impact claims outside McCarran-Ferguson because HUD had not yet begun to enforce the FHA in insurance on a disparate impact basis).

72. *Monroe*, 522 S.W.2d at 429.

73. *Humana*, 525 U.S. at 310.

74. Interference is defined as "the act of meddling in another's affairs" and "an obstruction or hindrance." BLACK'S LAW DICTIONARY 818 (7th ed. 1999).

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Courts have applied federal law to geographic discrimination in homeowner's insurance. As discussed above, courts have developed a line of jurisprudence which has determined that McCarran-Ferguson provides no bar to examination of "redlining" or charging more for homeowners insurance in minority neighborhoods. Courts first struggled with the applicability of the FHA to insurance,[75] but eventually concluded that courts could examine redlining for intentional discrimination. Courts concluded that McCarran-Ferguson did not apply because states had not condoned redlining or intentional discrimination.[76]

One trial court has recently allowed disparate impact claims to go forward in the redlining context.[77] After the trial court decision in *Dehoyos*, a federal district court permitted disparate impact claims as part of an FHA action. The court dismissed McCarran-Ferguson in a brief mention without any substantive analysis on expediency grounds.[78] This case appears readily distinguishable from *Dehoyos* both because it fails to seriously consider McCarran-Ferguson and because redlining has been so closely aligned with intentional discrimination, that the disparate impact claims seem a sidelight.[79] Yet, this case may have been a harbinger of what was developing in the Fifth Circuit.

Courts have allowed federal review of intentional discrimination in life insurance. *Moore* is typical of a group of cases advancing in the federal courts that attack the sale of industrial life products to minorities in decades past.[80] Because minorities were specifically targeted, these cases center on intentional discrimination. They conclude that McCarran-Ferguson does not apply because states do not condone intentional discrimination.[81]

B. Federal Court Review of Credit Scoring before Dehoyos

Until recently, plaintiffs seeking to stop insurers from using credit information have enjoyed little success in federal courts. [82] Most of the reported decisions concern allegations that the use of credit scoring violates rights under the Fair Credit Reporting Act or comparable state statutes. To

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75. *Mackey*, 724 F.2d at 419.

76. *See Cisneros*, 52 F.3d at 1363; *Am. Family Mutual*, 978 F2d. at 297.

77. *Nat'l Fair Hous. Alliance*, 208 F. Supp. 2d at 46.

78. *Id.* at 61.

79. In fact the case was not cited in either the trial or appellate decisions in *Dehoyos*.

80. *See, e.g.*, In re Industrial Life Litigation, 148 F.Supp.2d 719 (E.D. La. 2001).

81. *Moore*, 267 F.3d at 1223.

82. Interestingly, while some of the federal actions have involved state statutes (the Minnesota law on privacy for example), there appear to be no reported decisions in state court actions governing this practice. This may be because many state laws do not provide for enforcement by a private cause of action.

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date, federal courts have not generally found that releases of credit data violate FCRA. Many courts have dismissed actions by making distinctions on very narrow grounds.[83] Other courts appeared to go to great lengths to avoid federal authority over the use of credit scores in insurance.[84] Due to the narrow grounds of these decisions, these cases have not reached a McCarran-Ferguson analysis.

The lone exception is *Davenport v. Farmer's Ins. Group*, [85] in which a federal district court examined some McCarran-Ferguson implications of a potential conflict between the Minnesota Insurance Fair Information Reporting Act ("MIFIRA")[86] and FCRA after rejecting common law invasion of privacy claims on a failure-to-publicize grounds.[87] The court found that the state act had been specifically amended so as not to conflict with FCRA, but hints that McCarran-Ferguson would come into play if there were a head on conflict.[88]

The only possible hint of what was to come was indirect at best. In *Braxton v. Farmer's Ins. Group*,[89] a federal court allowed a plaintiff to subpoena rate making records directly from the Alabama Department of Insurance, but does so without any mention of McCarran-Ferguson.[90] If

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83. For example, related to which member of a corporate family committed an act based upon credit information, dismissing suits against a corporate parent or related entity different from the actual insurer. *See Ashby v. Farmer's Ins. Group*, 261 F. Supp. 2d 1213 (D. Or. 2003); Rasilov v. Nationwide Mut. Ins. Co., 242 F. Supp. 2d 977 (D. Or. 2003). Other courts have found no violation of FCRA when credit data is used in the solicitation of insurance before a formal application is filed or a policy is requested. *See* Scharpf v. AIG Marketing, 242 F. Supp. 2d 455 (W.D. Ky. 2003); Wilting v. Progressive County Mut. Insur. Co., 227 F.3d 474 (5th Cir. 2000). The *Scharpf* court, however, was sharply critical of AIG's practice of misleading consumers in the collection of their social security numbers and allowed the case to move forward on this issue. *Scharpf*, 242 F. Supp. at 467 n.17.

84. One court has gone so far as to find that there was no "adverse action" to be regulated under the FCRA when credit data was used to price a new policy as opposed to an increase in price on an old policy Mark v. Valley Ins. Co., 275 F. Supp. 2d 1307 (D. Or. July 17, 2003). Another court refused to allow a defendant to use the FCRA to gain federal question jurisdiction for removal of a credit scoring claim based upon state statutes. Wells v. Shelter Gen. Ins. Co., 217 F. Supp. 2d (S.D. Miss. 2002). The case was allowed to proceed in federal court, however, on diversity grounds because the court found a fraudulent joinder of the non-diverse party.

85. Davenport v. Farmer's Ins. Group, Case No. Civ. 03-1180 PAMJSM, 2003 WL 21975843 (D. Minn. Aug 12, 2003).

86. MINN. STAT. § 72A.491-505 (1999).

87. *Davenport*, 2003 WL 21975843 at *3 - *4.

88. *Id.* at *4.

89. 209 F.R.D. 651 (N.D. Al. 2002).

90. The plaintiff maintained that Farmers had used credit information to raise the premium on his homeowners' insurance without the proper FCRA notice. The plaintiff desired to subpoena the Alabama Department of Insurance to obtain any and all documents

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the materials were related to the changing of rates on account of credit information, then the Alabama Department was regulating the practice and a review of this material would appear to be a direct interference with "the state's administrative regime" as described in *Humana*.[91] McCarran-Ferguson should have been implicated. It is possible, however, that the defendants did not raise McCarran-Ferguson, therefore the court did not consider it.[92]

VII. *Dehoyos* Changes The Landscape

In *Dehoyos v. Allstate Corp.*,[93] the Fifth Circuit has rendered a sweeping opinion declaring that the use of credit scores in insurance underwriting is not protected from federal civil rights laws by the McCarran-Ferguson reverse preemption. The court found that states had not condoned racial discrimination in insurance; therefore, federal remedies serve to augment state remedies not impair them. As a result, an action based upon § 1981, § 1982 and the FHA was allowed to proceed, immune from a McCarran-Ferguson challenge.

The *Dehoyos* majority reviewed the prior "impair, invalidate, supercede" jurisprudence, applying a broad interpretation to each case, and then linking those interpretations into a sweeping doctrine. The court begins with *Humana*, but rather than focusing on the technical definition of the term "impair," the court chooses to emphasize the Supreme Court's discussion precluding a "field preemption" for insurance.[94] The circuit court reads *Humana* as requiring the frustration of "a *particular* and *declared* state regulatory policy"[95] to find preemption. This is a very strict extrapolation of the Supreme Court's words. The Fifth Circuit then uses its

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related to "changing or increasing homeowners' insurance premiums or rates within the last 2 [sic] years including but not limited to correspondence and actuarial materials." *Id.* at 652.

91. *Humana*, 525 U.S. at 310.

92. The Eleventh Circuit has ruled that consumer credit reports cannot be used in investigating insurance claims. Yang v. Gov't Employees Ins. Co., 146 F.3d 1320 (11th Cir. 1998). This decision was rendered on very narrow grounds and the issue of McCarran-Ferguson was not raised.

93. 345 F.3d 290 (5th Cir. 2003).

94. Although not directly quoted by the *Dehoyos* court, the Supreme Court stated in *Humana*, "We 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." *Humana*, 525 U.S. 310. The *Dehoyos* majority fails to note the qualification to this language, "While we reject any sort of field preemption, we also reject the polar opposite of that view, *i.e.*, that Congress intended a green light for federal regulation whenever the federal law does not collide head on with state regulation." *Id.* at 310.

95. *Dehoyos*, 345 F.3d at 294. Curiously, the Supreme Court never used this phrase or the word "particular" in this context.

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own precedent to require that a particular state law be impaired, not "a mechanism in place for regulating insurance contracts."[96] The majority follows with a novel interpretation of *Moore*, arguing that *Moore* stands for a rejection of redlining and actuarially based racial discrimination in insurance, [97] although there is scant support in the text of *Moore* for either conclusion. Finally, the *Dehoyos* majority refers to a redlining case[98] for the proposition that in order for a redlining matter to be reverse preempted, a state law would have to authorize redlining.

Having reached a very broad interpretation of the case law, the majority takes an equally broad application of these decisions to the facts of *Dehoyos*. First, the majority finds that the insurer has failed to implicate the tests found in *Humana* because they failed to cite a state law, or declared state regulatory policy requiring or condoning the use of credit scoring; rejecting the possibility of interference with the state's rate approval apparatus in general. The majority accuses the insurer of advocating a "field preemption" for insurance rate making.[99] This is remarkable in that the *Humana* holding specifically declined to require a head-on conflict with a particular state law.[100] When the insurer attempts to apply the phrase "interfere with a State's administrative regime" to state regulation of credit scoring, the majority dismisses this saying that both states and the federal government can occupy the same field without interference.[101] The majority concludes with its own test for interference:

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96. *Id.* at 295, referring to Am. Heritage Life Ins. Co. v. Orr, 294 F.3d 702 (5th Cir. 2002).

97. The majority in *Dehopyas* states, "[i]n *Moore* . . . . the Eleventh Circuit considered a challenge to the application of §§ 1981 and 1982 to allegedly racially discriminatory "red-lining" insurance practices. The Eleventh Circuit upheld the application of the federal anti-discrimination laws despite the fact that Alabama law purportedly implicitly authorized racially discriminatory practices which have an "actuarial basis." The Eleventh Circuit rejected the contention that allowing the application of federal civil rights statutes would frustrate or interfere with Alabama's policy of allowing discriminatory practices which were based on actuarial reality." (citation omitted) *Id.* at 296. This is curious because the *Moore* court neither discusses "redlining," except to cite a single redlining case, nor in any sense discusses actuarial practices except for a single reference to the insurer's brief.

98. *Am. Family Mut. Ins. Co.*, 978 F.2d at 287.

99. "However, in this argument Appellants adopt entirely a 'field preemption' posture, declining to direct the Court to a particular law or declared regulatory policy, and instead confining their argument to the observation that states regulate insurance pricing and then vaguely conjecturing that, somehow, 'federal civil rights laws will interfere with and frustrate the abilities of states to regulate insurance rate making.' " *Dehoyos*, 345 F.3d at 298.

100. *See* discussion, *supra* note 94.

101. *Dehoyos*, 345 F.3d at 299.

"the question is whether the regulatory goals are in harmony."[102] The majority appears to have arrived at the conclusion that any insurance practice is the legitimate subject of a federal action if it is not specifically authorized by state law and can be alleged to be racially discriminatory, the provisions of the McCarran-Ferguson Act, notwithstanding.

It is critical to note that because the action involves both the FHA and §§1981-1982, part of the complaint would require a finding of intentional discrimination, but part would be able to proceed on a disparate impact basis alone. The majority fails to make any distinction between the two, simply concluding that McCarran-Ferguson was no bar to going forward. The majority hints in a footnote that it would not stand in the way of a challenge based specifically upon disparate impact.[103]

The decision drew a sharp dissent from Judge Edith Jones, one member of the panel. Judge Jones strongly criticizes the majority for failing to find the action reverse preempted by the McCarran-Ferguson Act. The dissent carefully points out (and the majority quietly acknowledges in a footnote) that at the time the action was commenced, Texas and Florida had not adopted statutes regulating credit scoring in insurance, but have done so since.[104] Whether or not such statutes are on the books, the dissent asserts that *Humana* does not require the head on conflict sought by the majority.[105] "It is enough that the federal law may 'interfere with a State's administrative regime.' The majority seems to ignore this clear alternative, however, by repeatedly, and incorrectly, demanding evidence of 'an enacted law' or a 'declared policy.'"[106] Judge Jones also points out that all of the cases cited by the majority were decided prior to *Humana* except *Moore*, which she distinguishes as a life insurance case involving only claims of intentional discrimination.[107]

The dissent is extremely apprehensive about the majority's clear course into disparate impact waters. Because of class underwriting, insurance is replete with disparate impact. "The majority, in my view, fails to recognize

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102. *Id.*

103. "Thus, if Appellants were to bring a proper motion to dismiss the disparate impact claims under this new theory, and the district court were to decline to dismiss the claims, it would be because the federal regulatory goal of disallowing racially discriminatory insurance pricing is in harmony with the state's goal of disallowing racially discriminatory insurance pricing." *Id.* at 298 n.5.

104. *Id.* at 302 (Edith H. Jones, J. concurring in part and dissenting in part). Although Judge Jones concurs that intentional racial discrimination claims are not preempted, she believes that these are "a diversion" to cover a disparate impact action.

105. *Id.* at 301.

106. *Dehoyas*, 345 F.3d at 301.

107. *Id.* at 302-03.

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that a disparate impact claim goes to the heart of the risk adjustment that underlies the insurance business."[108] The dissent argues that credit scoring was a "facially neutral risk classification factor, utilized within a complex state regulatory scheme,"[109] fully protected by McCarran-Ferguson. She accuses the majority of condoning an action which "inevitably draws federal courts into the mechanics of insurance pricing and, by the same token, must diminish the scope of action available to state insurance commissioners."[110] The dissent closes by raising the specter of deeper and deeper federal intervention into insurance rate regulation. "In today's case, credit scoring is alleged to have a disparate impact. Tomorrow, some other facially neutral criterion, such as the age of one's car or the number of one's dependents, or the city of one's residence, may fall under legal attack."[111]

The case reached the Fifth Circuit on an interlocutory appeal and did not address the merits of the civil rights claims. It is unclear if the plaintiffs will be able to demonstrate that credit scoring violates the civil rights statutes, but they can now make their case under the federal statutes alone.

The holding in *Dehoyos* is significant because it represents a large step in a sequence marching toward federal regulation of insurance practices. The majority hast taken the strongest elements of each of the prior cases and pushed their implications one degree farther. What makes *Dehoyos* so compelling is that the majority has taken a series of cases related to clear allegations of intentional discrimination (typified by *Moore*), mixed them with the broad holdings barring geographic discrimination in the redlining cases, then applied this strong medicine to the disparate impact of an underwriting element such as credit scoring. In the process, the majority has taken the narrowest possible view of the *Humana* tests. If courts proceed along this continuum, the dissent's predictions seem all too realistic. If the number of auto accidents or traffic violations is found to bear a statistical relationship, however coincidental, with racial demographics, what is to prevent a federal court's investigation of these factors? The majority is quite critical of the insurer's "ominous description of the court's role as a 'super actuary' sitting in judgment on the specific

108. *Id.* at 300.

109. *Id.* at 303.

110. *Id.* at 301.

111. *Id.* at 303. The dissent is extremely concerned that disparate impact claims might be extended to insurance. The dissent makes the pointed criticism that the mixture of "diversionary" intentional discrimination claims with disparate impact claims applied to facially neutral criteria cannot help but impair state regulation.

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insurance-rate policy"[112] of the underlying states. However, how else will courts review facially neutral conduct for discriminatory impact than by scrutinizing and evaluating actuarial data? If courts were to take on this "super actuary" role, would that not constitute the federal oversight of insurance regulation that McCarran-Ferguson was designed to prevent?

Despite the dissent's warning that "it seems clear to me that federal courts are not competent to tread in the essential domain reserved to state regulators,"[113] the *Dehoyos* majority has put states on notice that federal courts may review of the disparate impact of any insurance practice unless a state law specifically endorses the practice. It will be critical to watch if other courts follow the *Dehoyos* lead.[114]

VIII. Review of State Law Regulating Credit Scoring

As discussed above, the nature of a state statute has an impact on the McCarran-Ferguson analysis and on the conflict sought by the *Dehoyos* majority. Whether in response to *Dehoyos* or on their own initiative, states have taken widely divergent paths in regulating credit scoring and this may lead to widely divergent applications of the McCarran-Ferguson reverse preemption. The various approaches to credit scoring and potential responses by federal courts may also reflect the fate of other elements of insurance underwriting models. These are some of the paths states have followed:

A. NCOIL Model Act

The National Conference of Insurance Legislators has proposed a model act to regulate credit scoring and offered it for passage by individual states. The Act allows the use of credit scoring in underwriting, prohibits it in cancellation or non-renewal of insurance, and mandates standardization of credit information provided to insurers. At least 12 states are reported to have enacted the model act.[115]

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112. *Dehoyas*, 345 F.3d at 298 n.5.

113. *Id.* at 303.

114. There has been only one written federal decision concerning credit scoring since *Dehoyos*. Judge Barefoot Sanders, presiding in another court within the Fifth Circuit, allowed another credit scoring case to survive a motion to dismiss, but mentions only intentional discrimination grounds, repeating the defendant's assertion that FHA §3604 requires intentional discrimination. Judge Sanders includes no McCarran-Ferguson analysis. Owen v. Nationwide Mut. Ins. Co., No. Civ. 303CV1184H, 2003 WL 22364319 (N.D. Tex. October 1, 2003).

115. Wayne D. Holdredge & Katharine Barnes, *Good News, Bad News or Both*, 2 EMPHASIS 18-21 (2003).

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B. Specific State Legislation

Some states propose to ban the use of credit scoring: California and Connecticut have both proposed to follow this path, but neither has yet passed legislation. On May 15, 2003, the California Senate passed SB 691 prohibiting the use of credit scoring in underwriting of homeowners insurance. The California Assembly has yet to act.[116] In Connecticut, a bill to prohibit the use of credit scores was not reported out of committee.[117]

At least one state has freely permitted the practice: New Hampshire allows credit scoring to be used without restriction if based upon objective underwriting criteria, but requires underwriting models to be approved by the Insurance Department.[118]

Some states allow credit scoring only when used with other factors: Florida allows and regulates credit scoring in underwriting but prohibits use of credit scoring as sole factor in a broad array of "adverse actions" and restricts the types of credit information that can be used.[119] Wyoming permits credit scoring to be used in conjunction with other factors.[120] North Carolina mandates that credit scoring cannot be the sole reason to terminate automobile insurance, but it may be used as the sole basis to discount rates.[121]

Other states have adopted a mixture, restricting the type of information or how it can be used: Georgia regulates the types of credit information that may be used in underwriting[122] and requires credit scoring models to be filed with the Insurance Commissioner.[123] Rhode Island permits "insurance scores" based upon credit information to be used in underwriting, but makes requirements that credit information be current (within two years) unless an insured is in the most favorable price category and regulates the types of information that can be used.[124] Texas allows the use of credit scoring for purposes of rate setting and underwriting in residential property insurance and personal automobile insurance, but prohibits denial of

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116. SB 691 (Cal. 2003) *available at* http://info.sen.ca.gov/pub/bill/sen/sb_0651-0700/sb_691_bill_20030611_amended_asm.pdf (last visited 3/11/04); bill history available at http://info.sen.ca.gov/pub/bill/sen/sb_0651-0700/sb_691_bill_20030702_history.html (last visited 3/11/04). [note: former source 15 No. 4 California Insurance Law and Regulation Reporter 104, 2003].

117. *See* CT H.B. 5490, Jan. Session 2003.

118. N.H. REV. STAT. ANN. § 412:14a (2002).

119. FLA. STAT. ch. 626.9741 (2002).

120. WYO. STAT. ANN. § 26-2-134 (West 2003).

121. N.C. GEN. STAT. § 58-36-90 (2003).

122. GA. CODE ANN. §33-24-91 (West 2003).

123. GA. CODE ANN. § 33-24-95 (West 2003).

124. R.I. GEN. LAWS 1956, § 27-9-56 (1956).

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insurance based solely on credit score.[125] Before the passage of this new statute, the Texas Insurance Code also required the underwriting models using credit scores to be filed with the Commissioner as part of a legislative study.[126]

C. Conclusions on State Law

States have followed a number of paths in their regulation of credit scoring. These can be broadly classified as: i) no legislation has been passed, ii) credit scores may not be used in insurance underwriting, iii) credit scores may be freely used in underwriting as they reflect objective underwriting criteria and are part of filed rating methodologies, and iv) credit scores may be one factor in a multi-factor analysis, but not used alone. Those states that have passed laws in this area now have statutes enacted for the purpose of regulating the business of insurance and have therefore passed the first McCarran-Ferguson test.[127] The other tests require independent analysis.

If credit scoring is prohibited in a state or if a state has not enacted a statute on the subject, the field would appear open to actions under federal law, since federal remedies will only augment existing state remedies and fail to impair state law.

If a state has passed statutes authorizing insurers to use credit scores in underwriting, constrained only by sound actuarial practice, it would appear that actions based upon federal civil rights laws would be reverse preempted because they will interfere with state laws enacted for the purpose of regulating the business of insurance. The majority in *Dehoyos* cynically points out, "The application of anti-discrimination laws cannot reasonably be construed to supplant the specific rate controls of Florida and Texas. The application of the civil rights laws cannot even supplant whatever anti-discrimination components may be inherent or express in the insurance rate controls which Florida and Texas may choose to adopt."[128] Yet the majority's test to determine if state and federal goals are "in harmony" leaves the door open for any federal statute to apply in the absence of a strict endorsement of credit scoring.

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125. TEX. INS. CODE ANN. art. 21.49-2U (Vernon 2004)).

126. TEX. INS. CODE ANN. art. 5.141 (Vernon 2004).

127. It can also be said that the practice of using credit scores in insurance underwriting is i)related to spreading policyholder risk, ii) directly part of the policyholder relationship, and iii) restricted to entities in the insurance industry. The practice would, therefore, fit comfortably within the "business of insurance" as determined in Union Labor Life Ins. Co. v. Pireno, 458 U.S. 119, 129 (1982).

128. *Dehoyos*, 345 F.3d at 297 n.5.

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If states allow the use of credit scoring in combination with other factors, but prohibit it on its own, one can speculate scenarios both allowing and avoiding reverse preemption. On the one hand, an insurer can argue that the state is regulating the activity and therefore a federal action is reverse preempted. However plaintiffs will argue that either a strict regulation of credit scoring by statute or a prohibition on use of credit scores as a sole factor in insurance pricing could be designed to prevent harmful discrimination. Plaintiffs will maintain that if state and federal laws both prevent harmful discrimination, the *Dehoyos* holding would appear to preclude reverse preemption. Who will win is an open question, but if courts follow *Dehoyos*, they may find that the restrictions are "in harmony" with the federal goal of preventing discrimination.

In the wake of *Dehoyos*, the Fifth Circuit's broad interpretation of prior precedent leaves ample room for federal challenge to credit scoring in the absence of any statute not broadly embracing the practice. It is difficult to know how to craft legislation that does not either prohibit or endorse the use of credit scores and still know the preemption outcome. State legislatures must resist the temptation to overdraft their statutes in this area as over restriction will likely invite more federal scrutiny as the common law in this area develops.[129]

Moving beyond credit scoring, states must concern themselves with the possibility that other practices may soon be questioned. If credit scoring is shown to involve intentional discrimination, it may be lost over the horizon, but the disparate impact implications of *Dehoyos* may remain long after credit scoring is gone. If states are concerned about federal review of their insurance rate approval processes, state legislatures may need to enact laws authorizing a wide variety of underwriting practices. If they fail to do so, litigants may use federal law to compel federal courts to examine the impact of each practice in turn, without the historical protections of McCarran-Ferguson.

D. Case Study: Connecticut

Connecticut presents an interesting case to review potential regulation of credit scoring in insurance. There would seem to be many possible directions for future litigation in Connecticut depending on what path the

129. "When background permits, however, a healthy respect for the scarcity of unclouded crystal balls counsels caution about the risks of statutory overdrafting." Ellen Ash Peters, *Common Law Judging in a Statutory World: An Address,* 43 U. PITT. L. REV. 995, 1003 (1982). In an unusual twist, overdrafting might encourage development of the federal common law, but overdrafting might straitjacket both state insurance departments and state courts without providing reverse preemption.

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Legislature chooses to follow in regulating the practice. Yet Connecticut's strong history of restricting the use of race in insurance underwriting, combined with very strong anti-discrimination provisions of the Connecticut Constitution, leave the state few options to prevent application of federal law on McCarran-Ferguson grounds.

1. Connecticut's Existing Statutes on Race in Insurance

Connecticut prohibits the use of race in any facet of life insurance[130] and prohibits declination or termination of auto insurance on racial grounds.[131] With regard to rate setting, however, Connecticut appears to follow the common practice of prohibiting only *unfairly* discriminatory rates.[132] Given the strong policy against racial discrimination elsewhere, the Connecticut Insurance Department would always be free to prohibit any practice that suggested racial discrimination.

2. Connecticut's Attempt to Pass a Credit Scoring Statute

A bill banning the use of credit scoring in insurance underwriting was introduced in the Connecticut House early in 2003,[133] however it failed to survive the Joint Committee on March 27, 2003. At the time of this writing, no new legislation has been proposed.

3. Implications of the Connecticut Constitution

Article First § 20 of the Connecticut Constitution provides a blanket prohibition on many types of discrimination within Connecticut. It states:

No person shall be denied the equal protection of the law nor be subjected to segregation or discrimination in the exercise or enjoyment of his or her civil or political rights because of religion, race, color, ancestry, national origin, sex or physical or mental disability.

If the Connecticut Legislature specifically authorizes the use of credit scoring and the practice is found to be discriminatory, can the law withstand court scrutiny?[134] The broad language of § 20 would seem to prohibit enforcement of a law endorsing any conduct that could be shown to be racially discriminatory. The Connecticut courts have had difficulty with racially discriminatory practices before.[135] If racial discrimination is

130. CONN. GEN. STAT. § 38a-447 prohibits discrimination on the grounds of race in life insurance.

131. CONN. GEN. STAT. § 38a-358 prohibits declination, cancellation or non-renewal of certain automobile insurance on the grounds of race.

132. *Id.* "Rates shall not be excessive, inadequate or unfairly discriminatory." CONN. GEN. STAT. § 38a-686(a).

133. CT H.B. 5490, Jan. Session 2003.

134. For a discussion of scrutiny in review, see City Recycling, Inc. v. State, 778 A.2d 77, 257 Conn. 429 (2001); Franklin v. Berger, 560 A.2d 444, 211 Conn. 591 (1989).

135. Conn. Bank & Trust Co. v. Cyril & Julia C. Johnson Mem'l Hosp., 294 A.2d 586, 30 Conn. Supp. 1 (Conn. Super. Ct. 1972) (holding that a will provision creating a trust

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unconstitutional in Connecticut, it is difficult to imagine how courts could find that any federal action seeking redress for discrimination would impair, invalidate or supercede any policy of the state of Connecticut, regardless of what statute the Legislature enacts, especially in light of *Dehoyos*. As a result, the Legislature may simply choose to allow the Connecticut Insurance Department to regulate the use of credit scores as part of the Department's ratemaking function and allow litigation to fall where it may.

IX. The Path Ahead for Potential Plaintiffs

The decision in *Dehoyos* appears to suggest that McCarran-Ferguson will not bar racial discrimination actions where credit scoring is involved. However, there are three items a potential litigant will want to consider before launching a federal action against an insurer; i) the type of conduct alleged, ii) the type of insurance involved, and iii) the type of state law that may apply.

The type of conduct is important because in a § 1981 action, intentional discrimination is required. While disparate impact may lend some evidence of intentional discrimination, it is not sufficient to prevail. In an FHA action, however, disparate impact alone may be sufficient, but the FHA is restricted to matters affecting housing. While *Dehoyos* broke new ground by making no distinctions between disparate impact and intentional discrimination for McCarran-Ferguson purposes, it did not expand §§ 1981 – 1982 to embrace disparate impact. If a plaintiff wishes to establish the broadest possible base of law and take advantage of a longest history of federal intervention, then a determination of intentional discrimination would still be required.

Litigants should also consider the type of insurance involved because some types may lend themselves better to discrimination actions than others. Homeowners insurance enjoys the special protections of the FHA, while other types of property/casualty insurance, such as automobile insurance do not. Homeowner's insurance could therefore be reviewed for potential disparate impact under the FHA while automobile policyholders must rely on other anti-discrimination statutes such as § 1981 and § 1983, and intentional discrimination to survive McCarran-Ferguson challenges. One trial court has determined that McCarran-Ferguson is a bar to

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based on racial discrimination cannot be applied). *See also* Lockwood v. Killian, 179 Conn. 63 (1979) (Bogdanski, J. dissenting).

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discrimination actions in automobile insurance,[136] while another dismissed an action before reaching a preemption analysis.[137] The plaintiffs in the *Dehoyos* action alleged misconduct involving both automobile and homeowners insurance and alleged violations of the FHA. It is unlikely that the court would have been able to sweep as broadly if only automobile insurance was implicated.[138]

The third factor, and perhaps the most complex, is the nature of the state law involved. *Dehoyos* involved laws in Texas and Florida, which had yet to pass comprehensive regulation of credit scoring at the time the action commenced. The purpose and scope of state law are critical factors in determining two elements of the McCarran-Ferguson reverse preemption: whether the state law is enacted for the purpose of regulating the business of insurance and whether the state law is impaired, invalidated or superceded by federal law. However, as noted above, the *Dehoyos* holding requires a direct head on conflict with state law to find reverse preemption. If other courts follow *Dehoyos*, and states do not enact broader statutes authorizing credit scoring, plaintiffs will have a much easier time pursuing causes of action under federal law. Still, plaintiffs must carefully consider the wording of any applicable state statute to determine if it conflicts with state law.

X. Conclusion

Credit Scoring has become a widespread tool in insurance underwriting, but now faces a significant legal challenge. The Fifth Circuit appears to have granted plaintiffs the ability to use federal civil rights statutes to challenge credit scoring, unfettered by the restrictions of the McCarran-Ferguson reverse preemption. States may attempt to re-establish supremacy in the regulation of credit scoring by enacting statutes authorizing the practice, however if the practice is shown to have racially discriminatory implications, a blanket authorization may run afoul of state

136. Camarena v. Safeway Ins. Co., No. 00 C 5826, 2002 WL 472245 (N.D. Ill. March 27, 2002) (holding that McCarran-Ferguson barred a racial discrimination claim against an auto insurer because it interfered with a state's administrative regime).

137. Harris v. Allstate Ins. Co., 83 F.Supp.2d 423 (S.D.N.Y. 2000) (evaluating a racial discrimination claim against an insurer in its claims handling procedure, but dismissing the claim without reaching a McCarran-Ferguson analysis).

138. A litigant's chances of prevailing over a McCarran-Ferguson challenge in a § 1981 claim in the life insurance context appears very strong. Because there are a limited number of underwriting factors in life insurance, such as health and age, it is much easier to allege intentional discrimination, but as credit information has yet to play a substantial role in life insurance, this is unlikely to be of use to those concerned with detrimental uses of credit information.

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constitutional restrictions on racial discrimination in states such as Connecticut. Yet anything less than a blanket authorization runs the risk of impairing the McCarran-Ferguson reverse preemption and subjecting the practice to federal scrutiny.

The greatest implication of the *Dehoyos* court's review of credit scoring goes well beyond credit scoring itself. If *Dehoyos* is followed by other courts, then the federal courts will have built a beachhead on the traditionally state-based system of insurance underwriting regulation.[139] Federal courts have now moved from intentional discrimination to a review of the disparate impact of insurance underwriting. From using geographically-based discrimination as a proxy for intentional discrimination to implying discrimination from the impact of a criterion one step further from the race of the individual. In making this shift, the Fifth Circuit has also embraced a very narrow interpretation of the McCarran Ferguson reverse preemption which requires a head-on conflict with a state law, rather than the impairment of a state regulatory regime to bar enforcement of a federal law. These sweeping developments have pushed federal review of insurance practices much more deeply into the state regulation of insurance than ever before. If other courts follow, what is left of McCarran-Ferguson?[140]

In the short term, insurers may wish to revisit their use of credit scoring methodologies or prepare to face a mounting wave of federal challenges. In the longer term, insurers and regulators alike may wish to question how far federal courts may go into examining all underwriting criteria. If federal courts push their analysis into other underwriting criteria such as accident history or driving record, we will have indeed crossed the watershed to federal regulation of insurance.

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139. There are other examples of federal incursion into insurance underwriting, (for example The Terrorism Risk Prevention Act of 2002 mandated terrorism provisions into property insurance policies), however these are beyond the scope of this paper.

140. It is possible that states will be left to determine if insurance rates in the aggregate are sufficient to maintain the solvency of insurance companies. Ironically, in the area of insurance insolvency, the federal courts have recently taken strong positions that federal law must yield to state law. *See, e.g.*, In re Amwest Ins. Group, Inc., 285 B.R. 447, 451 (Bankr. C.D. Cal. 2002); In re Advanced Cellular Sys., 235 B.R. 713 (Bankr. D. PR 1999). This apparent dichotomy may prove fertile ground for future research, but is beyond the scope of this paper.

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THE NEXT STEP FOR BROWNFIELDS: GOVERNMENT REINSURANCE OF ENVIRONMENTAL "CLEANUP" POLICIES

Daniel A. Schenck[*]

I. INTRODUCTION

What are Brownfields?

Across the country we can find several remnants of past American industry. These remnants are sometimes in the form of empty factories, abandoned buildings, or other vacant commercial sites. Here is where the industrial movement reached its peak and flourished during the late 19th and early 20th century. Eventually, as technology advanced and the industrial revolution wound down, many companies moved from these sites leaving seen and unseen dangers behind. Today we are left with prime but contaminated real estate.[1] It is estimated that there are over 450,000 of these abandoned contaminated sites in the United States.[2] These parcels extend across five million acres of wasted industrial property, occupying roughly the same amount of space as that used by sixty of our largest cities.[3]

This "contaminated land problem," otherwise known as the "brownfields problem" has drawn the public and private sectors' attention

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1. Robert D. Fox, *Brave New World: Residential Development on Brownfields Property*, THE LEGAL SUBURBAN, Apr. 6, 1998, *available at http://www.mgkflaw.com/articles/bravenewworld.html* (last visited Apr. 14, 2004).

2. NEW YORK LAWYERS FOR THE PUBLIC INTEREST, BROWNFIELDS BASICS: INTRODUCTION 1 *at* http://www.nylpi.org/brownfields/introa.html (Nov 10, 2003) [hereinafter *Brownfield Basics*].

3. U.S. DEP'T OF HOUS. AND URBAN DEV.,, BROWNFIELDS FREQUENTLY ASKED QUESTIONS 1 *available at* http://www.hud.gov/offices/cpd/economicdevelopment/programs/bedi/bfieldsfaq.cfm (last visited Apr. 14, 2004).

since the mid-eighties.[4] Yet, it wasn't until 2001 with the Small Business Liability Relief and Brownfields Revitalization Act that the government first defined brownfields.[5] The term, "brownfields" now refers to, "real property, the expansion, redevelopment, or reuse of which may be complicated by the presence or potential presence of a hazardous substance, pollutant, or contaminant."[6]

The Public Sector's Initiative to Remediate Brownfields

Without remediation,[7] these sites are extremely harmful. The presence of lingering toxic substances poses a significant threat to the local environment and jeopardizes the health of people living or working nearby.[8] Brownfields undermine the viability of their surrounding communities by scaring off investment and productive economic activity.[9] This, in effect, lowers the neighborhoods' quality of life while attracting further undesirable land use.[10] Whether significantly polluted or not, these sites are often abandoned, tax delinquent, or pose other hazards.[11] Predominantly in low-income areas, brownfields further degenerate public resources as they become the responsibility of the public sector.[12] Year after year these idle sites waste the communities' assets while the surrounding urban communities cry out for parks, open space, housing, businesses, jobs and investment.[13]

In recognition of these problems, several branches of government have strongly promoted the cleanup and redevelopment of brownfields.[14] Brownfields have become a public initiative. Their redevelopment

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4. KRISTEN R. YOUNT & PETER B. MEYER, MODELS OF GOVERNMENT-LED BROWNFIELD INSURANCE PROGRAMS 5 (October 2002), *available at* http://www.epa.gov/brownfields/pdf/nku2002.pdf (last visited Apr. 14, 2004).

5. *Id.*

6. *Id.*

7. Depending on the range of contamination and the future land use, the required level of remediation may range from removing all of the contaminated soil ("dig 'n' haul") to a less costly cleanup of the site with a removal of most, but not all, of the contamination.

8. NEW YORK LAWYERS FOR THE PUBLIC INTEREST, COMMUNITY PLANNING: GETTING A BROWNFIELDS PROJECT OFF THE GROUND 1 *at* http://www.nylpi.org/brownfields/chapter2a.html, 1 (last visited Apr. 14, 2004) [hereinafter *Community Planning*].

9. *Id.*

10. *Id.*

11. Yount & Meyer, *supra* note 4, at 5.

12. *Community Planning, supra* note 8, at 1-2.

13. *Brownfield Basics, supra* note 2.

14. Yount & Meyer, *supra* note 4, at 5.

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represents one of the best hopes for turning the tide of economic disinvestment and environmental degradation afflicting many low-income communities.[15] In response to this opportunity, many governmental programs have been developed to facilitate the remediation and reuse of these sites for new "greener" purposes.[16]

Why Real Estate Developers are Interested in Brownfields

Brownfield opportunities are abundant.[17] There are nearly half a million brownfield sites in the United States with many owners that are more than willing to divest themselves of these troubled and *potentially* troubled properties.[18]

A major element to the brownfield opportunity is that many of these properties "fit the bill" of the central maxim of any development: location, location, location.[19] These sites are often ideally located near public transportation and along convenient and scenic waterways. There are also usually within close proximity to restaurants, shopping, and other attractive amenities.[20] Examples of former brownfield sites that were re-developed and are now popular commercial centers include: Penn's Landing in Philadelphia, South Street Seaport in New York, and the Inner Harbor in Baltimore.[21]

Despite their prime locations, brownfields are often available at a substantial discount. The contamination factor significantly reduces their market price.[22] If a piece of land has even the "potential presence" of hazardous material then it is considered a brownfield.[23] It can then be

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15. New York Lawyers for the Public Interest, *How to Use This Handbook*, *at* http://www.nylpi.org/brownfields/introc.html (Nov 10, 2003). [hereinafter *Handbook*].

16. *Id.*

17. Fox, *supra* note 1, at 1.

18. *Id.*

19. *Id.*

20. Fox, *supra* note 1, at 4 . Other advantages to these brownfields locations include: (1) demographic shifts and recent changes to the federal income tax law which have increased the number of elderly home buyers and created tax incentives for these buyers to move to smaller homes in urban locations, (2) available, existing infrastructure and services (sewer, water, waste collection), and (3) lower property taxes. *Id.*

21. *Id.*

22. Kermit L. Rader, *Federal Brownfields Legislation: Another Piece of the Puzzle*, THE LEGAL INTELLIGENCER, June 21, 2001, at 2 (brownfield sites have been recognized as great redevelopment opportunities because of their ideal locations).

23. The definition of brownfields includes: "real property, the expansion, redevelopment, or reuse of which may be complicated by the presence or potential presence of a hazardous substance, pollutant, or contaminant." Yount & Meyer, *supra* note 4.

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purchased far below its market price had there not been the threat of contamination.[24]

Many states offer grants and low-interest loans to promote further brownfield redevelopment.[25] One state even offers eligible developers a dollar-for-dollar corporate tax credit of up to 100% of their investment up to a maximum of $100,000,000.[26] Nationwide, there are favorable economic and political environments that create a unique opportunity for developers: an abundance of discounted properties in prime locations that provide access to government grants, subsidized financing and generous tax credits.

The Catch

Well then, what's the catch? With both the public and private sectors sharing a common interest in brownfields one would think that most of these sites have already been redeveloped. But they haven't. Why not? The answer: liability.

Toxic substances create liability concerns for both current landowners and prospective developers. Many current landowners don't want to sell their brownfield properties because of the liability risks. These risks stem from three sources:

- Future brownfield law liability,[27]
- State law cleanup liability,[28] and
- Common law toxic tort liability.[29]

Although there are approximately 450,000 brownfield sites in the United States,[30] some well-financed and sophisticated landowners are still

24. Rader, *supra* note 22, at 2.

25. Fox, *supra* note 1, at 4.

26. CONN. DEP'T OF ECON. & CMTY. DEV., INDUSTRIAL SITE INVESTMENT TAX CREDIT PROGRAM (2004) *at* http://www.ct.gov/ecd/cwp/view.asp?a=1101&q=249822 (Mar. 9, 2004). Tax credits are dispersed over a ten-year period. *Id.*

27. *See infra* sec. II.

28. *See infra* sec. II.

29. The issues with common law tort liability are sufficiently different from that of future brownfield law liability, "Superfund liability," and state law cleanup liability. The remedies under common law also sufficiently differ from the other two, so much that I will not touch on common law toxic tort liability in this comment.

30. *Brownfield Basics, supra* note 2.

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hesitant to sell.[31] They don't want to return the land to the real estate market because of lingering liability questions with federal, state, and common law.[32] These landowners would likely be happy to be rid of the properties, along with the hazardous material, but there is currently too high of a liability risk when selling contaminated land. Rather than selling the sites to be redeveloped, many hesitant owners have subscribed to the safer approach of paving asphalt over the contaminated areas and then fencing-of the parcel.[33] This does not resolve the hazard problem. It only reduces the immediate effects of the contamination while allowing the owners to "sit on it" as they wait for favorable legislation. This is not a long-term solution to the liability question. It is simply a staring contest between legislators and the landowners. Unfortunately, under the current conditions, if legislators don't blink, then many of these sites will remain idle for decades.

The developers also can't forget the contamination and many choose not to purchase brownfields because of the liability. The liability risks for a developer for purchasing a contaminated site include:

- Future brownfield law liability,
- State law cleanup liability,
- Common law toxic tort liability,[34] and
- Uncertainty as to the costs and risks of cleaning up the contamination.[35]

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31. ENVTL. PROT. AGENCY, PUB. NO. 500-F-97-106, POTENTIAL INSURANCE PRODUCTS FOR BROWNFIELDS CLEANUP AND REDEVELOPMENT 1-2 (1997) *available at* http://www.epa.gov/brownfields/pdf/insurance.pdf (last visited Nov. 13, 2003) [hereinafter *EPA Potential Insurance Products*].

32. *Id.*

Owners of properties still concerned with CERCLA liability. Many larger, financially strong companies are not interested in returning their properties to the real estate market until Federal and state hazardous waste laws further limit or clarify their liability following a cleanup and transfer of property.

Lenders reluctant to finance properties. Major sources of credit, like large, financially strong companies, fear being viewed as "deep pockets." They are not interested in financing the return of contaminated properties to the real estate market if contingent liability risks are unacceptable, based on the uncertainties of future liability. *Id.*

33. The use of a perimeter fence surrounding a brownfield has become a common practice of brownfield owners. The fence serves both to protect the property and to limit the public's exposure to the contamination.

34. See the discussion above concerning the current landowner's liability risks.

35. *See infra* sec. III. A.

By purchasing a brownfield, a developer assumes new risks concerning the site's cleanup *plus* he inherits the same liability concerns that plagued the previous owner. A brownfield site must first be cleaned up before it can be redeveloped. This involves an expensive and uncertain remediation process. The remediation for a minor contamination problem could easily cost in the excess of $100,000. Major problems can exceed $1 million and cost as much as tens of millions for some high profile sites.[36] Although extensive testing is often done to assess the required level or remediation and to predict the clean-up costs, there is still a great amount of uncertainty as to how much the remediation will finally cost – this risk continues to dissuade many interested developers.[37] Although environmental insurance is currently available to "cap" clean up costs, these policies are often out of reach and too expensive for many developers, especially for owners of smaller sites.[38] With all of these liability concerns and potential costs it's no wonder that many developers choose to avoid brownfields.

New Federal Brownfields' Law and Reopeners

In an attempt to address these liability concerns, recent federal legislation provided some relief and clarifications. The new brownfield laws also offer some protection to new purchasers.[39] However, as this

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36. *Handbook, supra* note 15; New York Lawyers for the Public Interest, *Making the Deal: Brokering the Agreement and Securing Funds* 2 *at* http://www.nylpi.org/brownfields/chapter4f.html, (Nov 10, 2003) (hereinafter *Making the Deal*).

37. Yount & Meyer, *supra* note 4, at 13-14.

38. See *EPA Potential Insurance Products, supra* note 31.

39. Robert D. Fox & Paul R. McIntyre, *Bush Signs New Brownfields Legislation – Is Half a Loaf Better Than None?*, THE LEGAL INTELLIGENCER, Jan. 17, 2002, 3-4 *available at* http://www.mgkflaw.com/articles/bushsignsnewbrownfieldslegislation.html (Nov. 13, 2003).

According to the 2001 statute, a "bona fide prospective purchaser" is a person, or a tenant of that person, who acquires ownership of a facility after the date of enactment of the Brownfields Amendments, Jan. 11, 2002, and by preponderance of the evidence establishes the following:

- disposal at the facility occurred prior to the acquisition;
- the person made all appropriate inquiry into previous ownership and uses of the facility in accordance with generally accepted practices and in accordance with the standards contained elsewhere in the Amendments;
- the person provided all legally required notices with respect to hazardous substances found at the facility; the person exercised "appropriate care" with respect to the hazardous substances found at the facility;
- the person provided full cooperation and access to the facility to those authorized to conduct response; the person is in compliance with any land

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comment will discuss,[40] these new brownfields laws did not go far enough to curb landowners and developers' concerns, particularity with reopeners.

A "reopener" is a past brownfield site that has been cleaned and redeveloped but later requires additional remediation.[41] A reopener may occur if: 1) contamination is later released from the site and presents an "imminent and substantial endangerment," or 2) the state discovers new information concerning the extent of the contamination that presents the need for further remediation to protect public health or the environment, or 3) the risk evaluation has changed due to advances in new technology and science.[42] If any of these conditions arise, then the Environmental Protection Agency ("EPA") may require additional remediation.[43] Under current brownfields law, the liability for this clean-up may fall on a previous landowner, the developer, or the current landowner.[44] A great amount of uncertainty already exists in the initial clean-up process, the possibility of additional remediation in the future subject to new discoveries, changes in science and new technology creates an insurmountable amount of risk.

Through tremendous due diligence and at great expense, some insurers offer insurance to cover the risks of reopeners.[45] But this coverage does not come cheap. Nor has it proven to be a widespread solution.[46]

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use restrictions and does not impede the effectiveness or integrity of any institutional control;

- the person complies with any information request or administrative subpoena under CERCLA; and,
- the person is not potentially liable for response costs at the facility. *Id.*

40. *See infra* sec. III. A.

41. Fox & McIntyre, *supra* note 39, at 1. This concern may also materialize during the remediation process if liability is finalized before cleanup begins. Many unknown toxins are discovered during the remediation process; if additional contamination is discovered, the developer's liability will not be shielded by the previous agreement. The developer will be liable for the cleanup of the known and discovered pollution. *Id.*

42. *Id.*

43. *Id.*

44. *See infra* sec. III. A.

45. ENVTL. PROT. AGENCY, PUB. NO. 500-F-03-232, ENVIRONMENTAL INSURANCE HELPS ENSURE REDEVELOPMENT (2003), *available at* http://www.epa.gov/brownfields/success/insurance.pdf (July, 2003).

Different policy terms and types of coverage are available, including:

- Cleanup Cost Cap coverage provides the developer with protection against the possibility that actual cleanup costs exceed original estimates.
- Pollutions Liability Protection covers developers and long-term owners of redeveloped brownfields, up to specific amounts, in the event that users of those properties make claims based on continuing pollution conditions.

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As the risks associated with brownfields have continued to stack up against developers, many of the social and economic benefits of brownfield redevelopment have not been realized.[47] The missing nexus to the brownfield movement is appropriate *and affordable* liability release. The inherent complications and risks of brownfields have hindered private environmental insurers' ability to offer sufficient and affordable coverage.[48] Being that Congress is unlikely to act to reduce contamination liability, there will likely continue to be a gap between available coverage and what developers and landowners need. The alternative to the status quo, however, is for the government, federal and or state, to "fill in the gap."

Government Insurance to Cap Cleanup Costs and Indemnify Reopeners' Liability

The purpose of this comment is to offer a concept for a new government reinsurance program for environmental cleanup policies. The new policies under such a program would be designed to address the risks associated with brownfield cleanups: both the initial remediation and potential reopeners.

The government playing a role in the insurance business is not a new idea.[49] Flood insurance is currently backed by the government.[50] Likewise, the government involvement proposed in this comment would not be intended to monopolize or hinder the private environmental

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• Through Secured Creditor policies, lenders are guaranteed loan repayments in the event that a borrower defaults on loan payments, or if collateral value is lost, due in some way, to the pollutions condition. *Id.*

46. *See, infra* sec. III. B.

47. New York Lawyers for the Public Interest, *The Legal Framework: Federal & State Laws That Govern Brownfields Redevelopment, at* http://www.nylpi.org/brownfields/chapter3a.html (last visited Nov 10, 2003) (the risks of unanticipated cleanup and the fears of unforeseen liability cause developers not to invest in brownfield redevelopment) [hereinafter *Legal Framework*].

48. DAVID A. MOSS, WHEN ALL ELSE FAILS: GOVERNMENT AS THE ULTIMATE RISK MANAGER 286 (Harvard Univ. Press 2002) (It has become exceedingly difficult, if not impossible, to obtain adequate insurance coverage for brownfields); Thomas S. Seguljic, *Overview of Environmental Insurance Products,* ENV'T NEWSMAGAZINES 2 *available at* http://www.environews.com/Brownfields%20Section/insurance_products.htm (last visited Nov. 21, 2003) (each policy must be individually tailored to the particular needs of the parties; this involves time-consuming and costly investigation).

49. *See id.* at 1. Other examples of forms of government insurance include deposit insurance for banks (FDIC) and Price-Anderson liability limits for nuclear reactors.

50. *Id.* at 262.

insurance market. The concept for a new program, however, is offered in recognition of the inherent limitations of private environmental insurers. The government can create coverage to provide for the long-term risks that private environmental insurers are unlikely to assume.

This comment will begin by discussing the legislation history and liability concerns of brownfields. Next, the paper will discuss some specific "holes" in current legislation that continues to deter brownfield redevelopment. The need for insurance or indemnification will then be discussed. To better familiarize the readers with brownfields, two case studies of brownfield projects in Connecticut will follow. After a short analysis of the two projects, the comment will discuss why government involvement in brownfields insurance is necessary. The concept for a government reinsurance program for brownfield cleanups policies will follow and a short summary of this comment's discussion will conclude.

II. BACKGROUND TO BROWNFIELD LEGISLATION

To better understand the need for liability protection against brownfield reopeners, we must first discuss the legislation that has created this liability. Modern property owner liability for contamination stems from old nuisance principles.[51] Deeply rooted in our judicial system, these nuisance laws have held property owners liable for all nuisances that originate from their property –this includes pollution.[52] Although a site may be abandoned, the property owner is still liable for the nuisance (pollution). The EPA first addressed this type of nuisance issue in the late seventies and narrowly defined it by 1980 as the "contaminated land problem."[53] Since then, this problem has continued to be heavily debated and addressed by numerous federal and state legislations.

Response to the Environmental Threat of the Contaminated Land Problem

In 1980, Congress first addressed the environmental threat of brownfields by enacting the Comprehensive Environmental Response,

51. However, the nuisance test used to have a reasonable balance test. See also *Legal Framework*, *supra* note 47, at 2.

52. For a discussion of common law doctrines of nuisance and environmental law, see ROBERT V. PERCIVAL, ET AL., ENVIRONMENTAL REGULATION: LAW, SCIENCE AND POLICY (2000).

53. Yount & Meyer, *supra* note 4.

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Compensation and Liability Act ("CERCLA").[54] CERCLA's goal was to return these contaminated sites to a state that, at minimum, "assures protection of human health and the environment."[55] To accomplish this goal, CERCLA created a regulatory mechanism for the investigation, cleanup, and recovery of brownfields.[56] In order to initiate the remediation of these sites, CERCLA's first step was to determine who was responsible for the cleanup. It then provided means and recourse to encourage or compel remediation.[57]

Both state and federal laws that regulate the cleanup of brownfields are called, "Superfund laws."[58] CERCLA and many state programs created revolving[59] Superfunds.[60] In practice, the EPA and individual state programs administer these funds to clean brownfield sites and then recoup the costs from the polluter, often through litigation.[61] As the funds are replenished, the Superfund is used to clean up additional projects. However, the threat of federal intervention will sometimes result in the responsible party agreeing to clean up the site on their own.[62]

Although Congress can vote to add money to the Superfund, the Superfund has heavily relied on getting "potentially responsible parties" ("PRPs")[63] to reimburse it for the costs of government-led remediation. CERCLA recognized four (4) broad categories of PRPs:

- Current owners and operators of a facility where hazardous material is released.
- Owners and operators at the time a hazardous material was put there.
- Persons or entities who arranged for the treatment or disposal of hazardous material at the facility.

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54. *Id.*

55. 42 U.S.C. § 9621(d) (1997).

56. *Legal Framework, supra* note 47.

57. Later discussion will expand on developers' concerns with the broad definition of "potentially liable parties" under CERCLA. This issue has been highly publicized and continues to remain a deterring factor in brownfield redevelopment. *Id.*

58. *Id.*

59. *Id. at* 2.

60. Large, federally managed, brownfield projects are also referred to as "Superfund" sites, in reference to the EPA funds that might be used to pay for the sites' remediation.

61. *Legal Framework, supra* note 47, at 2.

62. *Id.*

63. Individuals or parties that would likely be found to be a "potentially responsible party" under CERCLA and current brownfields' law are referred to in this comment as "PRP."

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- Persons or entities that selected the facilities for the disposal of hazardous waste or any persons and entities that transported hazardous material to or from the facility.[64]

CERCLA liability is lethal. CERCLA applied strict liability jointly and severally among all PRPs.[65] This liability was also retroactive.[66] As a broad net, it increased the potential defendant pool and enhanced the EPA's ability to find a viable party to foot the bill. Jointly and severally liable, any of the PRPs could be held responsible for the entire cost of remediation.[67]

Continued Legislation

As a work in progress, the CERCLA or "Superfund" was amended by the Superfund Amendments and Reauthorization Act of 1986 ("SARA").[68] Congress' recognition and response to the economic threats associated with brownfields also led to the Asset Conservatory, Lender Liability, and Deposit Insurance Protection Act in 1996.[69]

Emergence of Brownfield Programs

By allocating some of the Superfund for grants, the EPA initiated a Brownfields Program in 1995 to further promote the redevelopment of brownfields.[70] The EPA's Brownfields Program has provided over $250 million in funding to states, tribes and local governments.[71] These funds have successfully leveraged $3.7 billion in brownfields remediation.[72]

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64. 42 U.S.C. § 9607 (1997).

65. *See, e.g.*, United States v. Chem-Dyne Corp., 572 F.Supp. 802, 809-10 (S.D.Ohio 1983).

66. *See, e.g.*, United States v. Northeastern Pharm. & Chem. Co., 579 F.Supp. 823, 844 (W.D.Mo. 1984). *aff'd in part and rev 'd in part*, 810 F.2d 776 (8th Cir. 1986), *cert. denied*, 484 U.S. 848 (1987).

67. *Legal Framework*, *supra* note 47, at 2.

68. *See* MOSS, *supra* note 48.

69. Yount & Meyer, *supra* note 4.

70. *See* ENVTL. PROT. AGENCY, PUB. NO. 500-F-02-148, THE BROWNFIELD PROGRAM: SETTING CHANGE IN MOTION (2002), *available at* http://www.epa.gov/brownfields/pdf/bfglossy.pdf (last visited Nov. 13, 2003) [hereinafter *EPA Brownfields Program*]. Grants include: Assessment Grants, Revolving Loan fund Grants, Cleanup Grants, and Job Training Grants. *Id.*

71. Yount & Meyer, *supra* note 4, at 7.

72. *EPA Brownfields Program*, *supra* note 70.

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Individual states have also developed their own brownfield programs. By 1998 thirty-five (35) states developed active state-funded brownfield programs and volunteer clean up initiatives.[73] Recent legislation relies heavily on these state programs, which are currently available in all 50 states; in fact, Congress stated that most sites will not be remediated under EPA authority but under state authority.[74]

Liability Issue

Brownfield remediation has always presented several complications, including problems with the neighborhoods, the actual contaminants, and the public stigma caused by a history of pollution, yet the issue of *"Whose fault is it?"* has prevailed as the hot topic for brownfields in the legal arena.[75]

It has been argued that, up to date, the entire focus of the enforcement of Superfund laws has been on obtaining cleanup funding from currently viable PRPs.[76] Consequently, the legal rules governing who is liable for the initial pollution and the subsequent damages have been clearly established.[77] This threat of litigation[78] has been the cause for many brownfield sites not to get redeveloped.[79] According to CERCLA, once a developer purchases contaminated land for redevelopment, now as the current owner, the developer could be liable for the cleanup of the

73. Fox, *supra* note 1, at 4.

74. Sarah Max, *Would you live on a waste dump? A lot of people are doing just that as 'brownfield' conversions become the next hot thing*, CNN/MONEY (Mar. 30, 2004), *at* http://money.cnn.com/2004/03/29/pf/yourhome/brownfields/ (Apr. 10, 2004) (today, all 50 states have some form of a brownfield program); ENV'T PROT. AGENCY, *State and Tribal Response Programs*, *available at* http://www.epa.gov/brownfields/state_tribal.htm (last visisted on Apr. 10, 2003) ("Congress recognized in the legislative history of the Brownfields Law, 'The vast majority of contaminated sites across the nation will not be cleaned up by the [federal] Superfund program. Instead, most sites will be cleaned up under State authority.'").

75. For a brief discussion concerning various insurance complications with brownfield cleanups, *see* Yount & Meyer, *supra* note 4, at 13-16; Concerning liability being the predominant issue addressed, *see* Lindene E. Patton & George Van Cleve, *Zurich's Institutional Controls Protection Program: Forging a Public- Private Partnership for Managing Residual Contamination, in* IMPLEMENTING INSTITUTIONAL CONTROLS AT BROWNFIELDS AND OTHER CONTAMINATED SITES (Amy L. Edwards ed., 2003).

76. Patton & Van Cleve, *supra* note 75, at 81.

77. *Id.*

78. Refer to this comment's *Introduction* for more details concerning the legal framework that has caused developers' continued concerns with reopener liability.

79. *Brownfields Basics, supra* note 2.

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hazardous material.[80] This risk for brownfield purchasers created the unintended consequence of discouraging investment by developers.[81]

Uncertainty with State Programs and Law

Both federal and state Superfund laws encouraged developers to participate with state brownfield programs,[82] but these programs presented additional complications and risks that also deterred investment. The state programs and relevant law varied, and continue to vary, from state to state.[83] Even if the law is the same, such as with federal Superfund laws, each contaminated site is different and must be handled individually. As a result, what a developer may have learned on an earlier project in New Jersey is often irrelevant for another project in Virginia.

State laws also failed to protect developers against the potential costs of reopeners.[84] After successfully participating in a state brownfield program, a developer could usually obtain liability protection from future cleanup requirements of the state.[85] Contrary to the legislative goal of alleviating liability concerns, the state liability shield was not absolute and flawed with substantial "holes." For example, the discovery of unknown contamination could pierce through a developer's liability protection.[86] With a site reopened, a developer would again be liable for the costs of additional remediation.

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80. 42 U.S.C. § 9607 (1997).

81. *Brownfields Basics, supra* note 2.

82. EPA shows a preference for states to handle the majority of brownfield projects within the state. Telephone Interview with Grant Stevens, Econ. Analysis, Conn. Dep't of Econ. & Cmty. Dev. (Nov. 20, 2003).

83. On August 7, 2003, the National Conference of Commissions on Uniform State Laws adopted a Uniform Environmental Covenant Act (UECA). This Act is a major advancement towards eliminating the many variations between the states' environmental laws. In reference to this comment, it is important to note that the UECA, discusses the remediation standards and land use restrictions for risk based cleanups, but it refers to existing state and federal statutes concerning reopener standards. Although state environmental laws may come into conformity with the UECA, it is likely that reopeners will continue to pose a risk for developers under federal, state and common law. *See also* Fox, *supra* note 1.

84. Fox, *supra* note 1, at 5.

85. ENVTL. PROT. AGENCY, THE NEW BROWNFIELDS LAW (2002), *available at* http://www.epa.gov/brownfields/pdf/bflawbrochure.pdf (last visited Nov. 13, 2003) [hereinafter *EPA The New Brownfields Law*].

86. Fox, *supra* note 1, at 5.

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Another major flaw with state liability protection was that it failed to protect developers from federal action.[87] Even in the absence of a reopener, the EPA could circumvent the state liability shield and pursue independent actions against a developer.[88] Although a developer may have complied with all state requirements and law, the state liability guarantee did not protect the developer from CERCLA's PRP liability net.[89] The state liability shields were inadequate. They failed to elevate developers' concerns with PRP liability.

The Current Brownfields Law

After more than five years of debate and negotiations, these and many other concerns were addressed with the enactment of the 2001 Business Liability Relief and Brownfields Revitalization Act ("Act").[90] The new Act, Public Law 107-118, was signed by President Bush on January 11, 2002.[91] Its goal was to provide communities with tools to redevelop brownfields, reduce sprawl, and to create taxes and new businesses.[92]

The new Act codified many of the EPA's policies. Many of these policies clarified CERCLA liability.[93] Some of the more significant changes included:

- Clarification of Superfund liability for prospective purchasers, innocent landowners, and contiguous property owners.
- Liability protection for certain small contributors.
- Protection from Superfund liability for sites cleaned up under State programs.[94]

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87. *Id.*

88. *Id.*

89. Fox, *supra* note 1. The EPA could require more stringent remediation than what is or was required by the state, but the EPA has not generally exercised this discretion. In fact, the EPA has encouraged states to implement standards and to manage the sites participating with their programs according to the state's standards. However, the risk that the EPA might exercise their discretion and require remediation beyond the state's requirement still remains. *Id.*

90. Fox & McIntyre, *supra* note 39.

91. *EPA The New Brownfields Law*, *supra* note 85.

92. *Id.* The Brownfields Revitalization Act expanded the EPA's Brownfields Program, boosted funding for assessment and cleanup, enhanced the roles of State and Tribal response programs, and clarified Superfund liability. *Id.;* Yount & Meyer, *supra* note 4, at 7. The new federal spending under the 2001 act also represented a major expansion forward; President Bush's budget proposes an annual budget of $200 million. *Id.*

93. *EPA Brownfields Program*, *supra* note 70.

94. *EPA The New Brownfields Law*, *supra* note 85.

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These steps were a needed addition to brownfields legislation, but as the following section will discuss, they were not enough to alleviate developer's concerns.

III. A. DEVELOPERS' CONCERNS WITH CURRENT LEGISLATION

Despite the Act's many accomplishments,[95] there are still three significant liability concerns under the current legislation: (1) remaining holes in reopener liability shields, (2) inability to transfer the liability protection to future owners/developers, and (3) the exemption of petroleum contaminated sites from the Act's liability protection.[96]

Remaining Holes in States' Liability Shields

Current legislation recognizes that if a site has successfully been remediated in compliance with a state program then the federal government should be barred from seeking action concerning the remediation.[97] State programs would be meaningless without this federal enforcement bar. Although the 2001 Act provides a shield from federal liability, section 231(b)(1)(B)(iv) of the Act provides for a broad reopener exemption.[98] The EPA may bring an enforcement action if:

> The Administrator determines that information that on the earlier of the date on which cleanup was approved or completed, was not known by the State. . . has been discovered regarding the contamination or conditions at a facility such that the contamination or conditions at the facility present a threat requiring further remediation to protect public health, welfare or the environment.[99]

This provision creates two fundamental problems: First, the site is subject to being reopened by the EPA if *any new* information is discovered

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95. The clarification of Superfund liability has been boasted as the greatest achievement of the 2001 act to promote further brownfields' remediation, but this comment will discuss why the act still fell short by not providing the guaranteed liability protection that would foster significant redevelopment.

96. Fox & McIntyre, *supra* note 39, at 6-7.

97. *EPA The New Brownfields Law*, *supra* note 85.

98. Fox & McIntyre, *supra* note 39, at 5.

99. *Id.* (emphasis added).

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after the remediation is completed or approved.[100] The provision, in effect, discourages remediators from generating further data on these sites. Yet, wouldn't testing past cleanup sites provide valuable information on how to improve future cleanups? Public policy, and common sense, should seek to encourage engineers to test these sites in order to learn what was successful in the past. This could help improve future remediation design. Do we expect engineers to test past sites, when this provision stipulates that doing so may trigger further liability?

Second, the provision is overly broad.[101] The exception does not set a boundary or offer constraints to the quality, reliability, authority or environmental significance to the new information. Advances in science will provide us with updated information, but do we also look to the site for new information? If so, would the migration of contamination within a site, a common occurrence,[102] subject the site to being reopened? What if a particular contaminant is now only marginally a greater threat? The reopener exception of this provision leaves us with more questions than answers. One thing is clear: the reopener provision broadly eliminates the same protection that the federal enforcement shield sought to create.[103]

Inability to Transfer the Liability Protection to Future Owners/Developers

It is unclear whether the enforcement shield is transferable.[104] The enforcement bar likely applies only to individuals or entities that complete the remediation under a state program; it potentially excludes future developers, owners and tenants from its protection.[105] The Act does not clarify if the shield covers these other parties.

If the remediation is completed by the previous owner or an independent contractor, the future developer and landowner will not be the person "conducting" or "completing" the cleanup. The developer and landowner, therefore, would not fall under the statute's liability shield.[106] It is also unclear what happens if the land is later sold to a third party. This issue needs to be resolved because future purchasers will have Superfund "owner" liability.[107] Any future owners are unlikely to have been the ones

100. *Id.*
101. *Id.*
102. *Id.* at *5-6.*
103. Fox & McIntyre, *supra* note 39, at 1.
104. *Id.* at *6.*
105. *Id.*
106. *Id.*
107. *See infra* sec. II.

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"conducting" or "completing" the cleanup and there is still uncertainty as to whether they will receive any liability protection under the statute. Without a clarification of this protection, the risk of EPA reopeners continues.

Exemptions of Sites with Petroleum Contamination from the Act's Liability Protection

The Act does not provide any protection to sites contaminated with petroleum.[108] The Act provides that CERCLA's enforcement authority may not be used against any person conducting or completing remediation in compliance with a state brownfield program, but it also expressly exempts sites contaminated with petroleum products.[109] Therefore, any site with petroleum contamination is expressly exempt from the Act's liability protection.

This exemption applies to a significant population of brownfields.[110] Of the 450,000 brownfield sites nationwide, the EPA estimates that 100,000 to 200,000 are impacted with petroleum.[111] This exemption expressly impacts one-fourth (1/4) to one-half (1/2) of the country's brownfields sites. Even the remaining brownfields, those not expected to have petroleum contamination, are at risk to this exemption. Under a fair reading of the Act, a remediator's "hoped for" protection would become unattainable if petroleum contamination is discovered during the cleanup.

In sum, these three failures of the liability protection of current federal brownfield legislation create the following picture:[112] liability protection from federal action is available if a party complies with a state program, BUT it exempts the protection from up to half of the nation's brownfield sites, it will be stripped if a common contaminant (petroleum) is discovered during the cleanup. The liability shield is also useless if any new information is discovered (this could be anything) and it's unknown whether or not it will be honored if the land is purchased or developed by someone other than the one that completed the clean-up.

Did Congress expect developers and landowners to redevelop brownfields under these terms? Or did they just expect private environmental insurance to be the answer to these risks?

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108. Fox & McIntyre, *supra* note 39, at 6.

109. *Id.*

110. *Id.*

111. *Id.*

112. There may also still be cleanup liability under state Superfund laws. Another relevant concern may also include common law toxic tort liability.

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III. B. THE NEED FOR ENVIRONMENTAL INDEMNIFICATION OR INSURANCE

Current Private Environmental Insurance Policies are Not Appropriate For the Majority of Brownfields

The shortcomings of liability protections and the risks of reopeners create a market for environmental insurance. This insurance can indemnify parties from these risks. Currently, however, environmental reopener policies are not efficiently "filling in the gap."[113] There are many obstacles to ensuring that the majority of the current and future brownfields projects find adequate environmental insurance coverage.[114]

Private environmental insurance policies against reopeners require time-consuming research by the insurer to review the remediation plans and relevant environmental law.[115] Each policy must be tailored to the varying complexity of the individual remediation and the needs of the parties:[116]

> First, the cleanup costs that need to be covered are generally high. For example, a minor contamination problem can easily cost in excess of $100,000; the occasional major problem can exceed $1 million; and the full-blown problem of a "Superfund" site can cost tens of millions of dollars. The minimum amount of coverage provided by environmental insurance policies generally range from $100,000 to $1 million, with maximum coverage ranging from $10 million to $40 million per policy. Premiums for such policies range from $5,000 to $1 million, and the deductible amounts (the costs the site's developers must pay before the insurance policy starts paying) vary widely. In some cases, the cost of insurance for a site will be out of reach, due to a combination of the extent of the site's contamination and the proposed future use.

113. For a list of potential problems associated with brownfield insurance coverage. *See* Yount & Meyer, *supra* note 4, at 32-34.

114. MOSS, *supra* note 48, at 286.

115. Seguljic, *supra* note 48, at 2.

116. *Id.*

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> Underwriting factors, especially the difficulty in assessing the cost of cleanup and determining the property value of a site, make many insurance companies reluctant to provide coverage for brownfields redevelopment projects. Lack of awareness on the part of the developers of the kinds of environmental insurance available, also limits the risk pools, raising costs.[117]

Even the lead environmental insurer Zurich has recognized that the industry has failed to adequately meet the needs of the majority of developers.[118] Existing environmental products focus on the risk of the remediation process and potential failures, breaches, and unexpected events associated therewith.[119] As policyholders and insurance companies have disagreed on whether commercial general liability and property policies covered loss arising from contamination, the insurance industry has severely restricted, if not eliminated, coverage of this type in the standard policies they sell today.[120]

The environmental insurance industry has primarily geared its products to the large, well-financed projects.[121] As a result of these obstacles, environmental coverage is too expensive for most developers –especially those seeking to redevelop smaller projects.[122]

IV. A. INTRODUCTION TO CONNECTICUT BROWNFIELD CASE STUDIES

To familiarize those new to brownfields to the redevelopment process, this comment will review two completed projects in Connecticut. Both of the projects discussed in this comment began prior to the 2001 Act. The developers for these two projects were subject to full PRP liability without the current liability shield. Consequently, the developers, like many other developers today, were greatly concerned about the costs of remediation and the risks of potential reopeners. Even in this setting, however, the

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117. *Making the Deal, supra* note 36, at 2-3.

118. Patton & Van Cleve, *supra* note 75, at 81.

119. *Id.* at 83.

120. Failures with engineering controls will often require additional cleanup. *See* Brad A. Maurer, *Applicability of Insurance to Activity and Use Limitations, in* IMPLEMENTING INSTITUTIONAL CONTROLS AT BROWNFIELDS AND OTHER CONTAMINATED SITES 71, 73 (Amy L. Edwards ed., 2003).

121. *Making the Deal, supra* note 36, at 3.

122. Andrew Steneri, *Managing Brownfield Redevelopment With Environmental Insurance,* ENV'T NEWS MAGAZINES, *available at* http://www.environews.com/Features/managing_risk.html (last visited Nov. 21, 2003).

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concerns of these developers were successfully alleviated through the tremendous efforts of the local and state governments. This comment's analysis of these projects will demonstrate how the risks of reopeners can be eliminated through government action. Although this comment's proposal for government involvement differs from that which was done with these projects, these case studies will demonstrate some of the challenges and hoped-for results that other developers may also share.

Connecticut's Remediation Agency

The Department of Economic & Community Development has been Connecticut's ("DECD") lead agency for managing the economic development and redevelopment of "brownfields" for over a decade in cooperation with Connecticut's Department of Environmental Protection ("DEP").[123] During this time, the DECD has successfully lead the clean-up and redevelopment of fifty (50) brownfield sites for commercial use.[124]

To promote the redevelopment of more brownfield sites, the DECD has recently posted a PowerPoint presentation on its web site that explains some of its brownfield tools.[125] This presentation also highlights some of the agency's "large-scale" projects.[126] It presents these and other projects as having been highly successful. Two of the DECD's completed projects discussed in this comment, the Brass Mill Regional Mall Center in Waterbury and the Windham Mills Technology Center in Windham have been largely consider the DECD's "poster" brownfield projects.[127]

IV. B. WATERBURY CASE STUDY – BRASS CITY REGIONAL MALL

In a cooperative effort with the DEP, City of Waterbury, and the Chicago-based private developer General Growth Properties ("GGP"), 90 acres of a former brass mill site were successfully redeveloped.[128] The

123. DEPT. OF ECON. & CMTY DEV., BROWNFIELDS' POWERPOINT (2003), *at* http://www.ct.gov/ecd (Dec. 1, 2003) [hereinafter *DECD PowerPoint*].

124. DEPT. OF ECON. & CMTY DEV., THIS COULD BE YOUR GOLDEN OPPORTUNITY (2003) at 7, *available at* http://www.ct.gov/ecd (last visited Dec. 1, 2003).

125. *DECD PowerPoint, supra* note 123.

126. The Pfizer Global Development Facility in New London, Derecktor Shipyard in Bridgeport, and several other more recent brownfield projects are also reviewed. *Id.*

127. *DECD PowerPoint, supra* note 123; Thomas B. Scheffey, *Northeast Connecticut's Tech-Style Mill – Will It A Legacy of Inventiveness?*, 28 CONN. L.TRIB. 9 (Mar. 4, 2002).

128. DEPT. OF ENVTL. PROT., URBAN SITES REMEDIAL ACTION PROGRAM – STATE FUNDED PROJECTS (April, 1998), *available at* http://www.dep.state.ct.us/wtr/remediation/urbsite.html (last visited Dec. 1, 2003).

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demolition and remediation commenced from 1994 to 1996 and cost a staggering $35.9 million.[129] The developer began construction in June 1996 and opened the new 1.1 million acre mall in September 1997.[130] Anchored by Filene's, Sears, and J.C. Penney, the mall is now home to over 150 shops and small businesses in Waterbury.[131]

The $150 million project is highly visible along I-84 and is largely considered the catalyst that stimulated the revitalization of Waterbury's economy.[132]

Prior to Remediation

The Waterbury economy in the early nineties was deeply depressed.[133] Waterbury was hit particularly hard, losing 10,000 jobs between 1989 and 1992.[134] Businesses were shutting down or relocating and retail malls in the Waterbury area had to offer month-to-month leases to entice merchants—but many buildings still remained empty.[135]

Prior to the redevelopment, the Brass Mill site was a heavy burden on the City of Waterbury. According to Attorney Francis Grady who represented Naugatuck Valley Development Corporation ("NVDC"), the agency charged by the municipality to manage the site's remediation, the trustees conveyed the land to the New Waterbury Co. after the site's previous owner went bankrupt.[136] For the next fifteen years, New Waterbury Co. tried but failed to develop the land. The dormant land became delinquent on its annual $800,000 property tax and by 1993 it had nearly $5 million in delinquent taxes.[137] The land was unproductive, polluted, and a burden on the local area –like most brownfields.

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129. *Id.*

130. *Id.*; Matthew Kauffman, *Waterbury Mall's Debut A Crowd Pleaser*, HARTFORD COURANT, Sept. 18, 1997.

131. *Id.*

132. Telephone Interview with Francis Grady, Esq., Counsel, Naugatuck Valley Dev. Corp. (Nov. 23, 2003).

133. Joseph Slepski, *The Transformation Of the Waterbury Area* (Nov. 1997), *available at* http://ctdol.state.ct.us/lmi/misc/cednov97.html (last visited Dec. 1, 2003).

134. *Id.*

135. *Id.*

136. After Century Brass filed bankruptcy, the New Waterbury Company consisted of three separate companies. These companies had common principles that later combined these companies to form New Waterbury. Grady, *supra* note 132.

137. *Id.*

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A critical barrier to the economic growth in Waterbury has consistently been its lack of space for business expansion.[138] The expansion of industry in Waterbury in the early 19th century stripped the area of most of its virgin land fit for industrial use.[139] In fact, the first objective for 2003 mentioned in Waterbury's "Inner City Business Strategy Initiatives" is to increase available land for redevelopment by 100%.[140] The plan calls for continued progress in the remediation of brownfields and notes that the bulk of industrially zoned land in Waterbury that is free of topographic constraints are brownfields.[141]

The Remediation Project

The project began with GGP's purchased of an option to acquire the site from New Waterbury Co. This option, however, provided an "out" for GGP if the land was not certified clean by Connecticut's DEP within eighteen (18) months. New Waterbury Co. agreed to allow the city's agent, NVDC, to have access and control of the site during the remediation process, but GGP did not take title to the land until after the remediation was complete. In order to protect its assets from potential liability, NVDC formed a new non-profit corporation, Brass Center Limited ("BCL"), to manage the project. BCL received funds from NVDC to pay for the remediation, demolition, environmental engineering, and other clean-up expenses. All contracts concerning the project were executed by BCL. After $35.9 million of government spending, the remediation was completed and the site was certified clean by the DEP. The land was then purchased from New Waterbury Co. for $16 million. GGP then completed the new mall within just fifteen (15) short months (a private investment of $120 million).[142]

Despite the challenges and tight schedule requirements of remediation, NVDC was able to remediate the land on time. As a result of the

138. DEP'T. OF ECON & CMTY. DEV., WATERBURY: INNER CITY BUSINESS STRATEGY INITIATIVE OVERVIEW, 5 (Apr., 2000), *available at* http://www.ct.gov/ecd (last visited Dec. 1, 2003) [hereinafter *Waterbury Initiative Overview*].

139. DEP'T. OF ECON & CMTY. DEV., *WATERBURY: INNER CITY BUSINESS STRATEGY INITIATIVE FULL REPORT, 30* (April, 2000), *available at* http://www.ct.gov/ecd (last visited Dec. 1, 2003).

140. *Waterbury Initiative Overview, supra* note 138, at 5.

141. *Id.*

142. Kauffman, *supra* note 130 (developer completed construction in 15 months); Grady, *supra* note 132 (developer made $120 million investment in construction of mall).

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completed project, the city now receives an additional $4 million annually in taxes![143]

Governmental Indemnification from Environmental Reopener Liability

Potential environmental liability often scares potential developers from brownfields, especially with reopeners.[144] GGP, however, was an exception when it built the new mall. GGP's willingness to build on the Waterbury site was due to extraordinary environmental indemnification, not offered by a private insurer, but by the City of Waterbury.[145] The city agreed to indemnify GGP against environmental liability and future clean up costs for thirty (30) years.[146] The city is still liable for the future environmental cleanups on the site.[147] Regardless of unexpected cleanup costs, the city arranged the indemnification agreement so that the municipality will always receive a positive cash flow from the project. The city's annual expenses for this environmental liability is capped to not exceed one-half (1/2) of the mall's annual municipal taxes.[148] This agreement effectively removed the developer's risks with the uncertain costs of reopeners.

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143. Grady, *supra* note 132. Before remediation, the city was entitled to an annual property tax of $800,000 with the previous land use but this tax was regularly delinquent. *Id.*

144. *Brownfields Basics, supra* note 2.

145. Telephone Interview with John Limpo, Project Manager, Naugatuck Valley Dev. Corp. (Nov. 19, 2003).

146. *Grady, supra* note 132. During the remediation, the city's agent, BCL, purchased a five (5) year environmental insurance policy from AIG, but that policy was never renewed. *Id.*

147. BCL has not purchased a subsequent private environmental insurance policy since the AIG policy expired. BCL continues to have resources available from the initial funding of the project and uses these funds when additional cleanup is required. In fact, when mercury deposits were discovered during the building of a new Shaw's grocery store, the city managed and funded the cleanup through BCL. It also funded the removal of asbestos from the site when a new museum was built. *Id.*

148. The current annual municipal tax revenue paid by the completed site is approximately $4 million. In accordance with the city's indemnification agreement, the city is liable up to $2 million annually for additional cleanup expenses. If cleanup over and above the city's annual limit is required, the agreement allows the city to complete the additional cleanup immediately or to remediate it in the preceding years in compliance to the annual spending limits. *Id.*

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Success of Remediation

The executive director of NVDC, Jeff Cugno, was optimistic from the beginning and predicted that, once complete, the project would "inject new life into Waterbury."[149] And it has. The Waterbury project has been called, "the single biggest happening in the Waterbury area" to help turn the city's economy around.[150]

During the grand opening of the Brass Mill Regional Mall, Governor John Rowland stated that this project is, "probably the best thing that's happened in Waterbury this century."[151] As part of the ceremonies Governor Rowland and Waterbury Mayor Giordano tried to christen the mall by cutting a huge red ribbon with an oversized pair of scissors. After an awkward attempt, they were still unable to cut the ribbon with the oversized scissors. Governor Rowland finally pulled out a pair of regular scissors to make the cut. A Hartford Courant article pointed out that this was one of the few times that the project had problems with "red tape."[152]

The general consensus is that the project has been the key to Waterbury's rebirth.[153] An article from a research analyst from the Connecticut Department of Labor confirms that the Brass Mill project substantially contributed to the "rebounding" of Waterbury's economy.[154] In his article, Mr. Slepski mentioned that since the mall's opening, it has brought in more than 2,500 jobs and caused more than half of the jobs lost during the previous recession to be regained.[155]

There is a strong distinction between how long it took the previous owners to do little or nothing with this site and how quickly NVDC and GGP were able to get it remediated and redeveloped. The New Waterbury Co. owned the Waterbury site for nearly fifteen (15) years and was unable make a productive use of it.[156] Both government subsidies and environmental indemnification played a significant role in this success.

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149. Janice D'Arcy, *Elm City Leaders High On Mall Plan*, HARTFORD COURANT, Apr. 18, 1999.

150. Slepski, *supra* note 133.

151. Kauffman, *supra* note 130.

152. *Id.*

153. Telephone interview with David Dietsch, Waterbury City Assessor (Nov. 19, 2003).

154. Slepski, *supra* note 133.

155. *Id.*

156. Grady, *supra* note 132.

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IV. C. WINDHAM CASE STUDY – WINDHAM TECHNOLOGY CENTER

The redevelopment of Windham Mills involved the conversion of a historic, but polluted site to a modern high-tech office/light industry facility. As the world's largest cotton mill from the 1890s to early 1900s, the Windham Mills once exemplified the power of Connecticut's industrial revolution.[157] During that time, it was the largest employer in Connecticut and produced 85,000 miles of thread each day –enough to wrap around the world three times.[158] Mill 4 also provided Thomas Edison with his first paying job as he made it the first mill in the world to be illuminated by electrical lighting.[159]

Prior to Remediation

After the American Thread Company left and closed the mill in 1985, many area residents were left unemployed. Since then, several futile attempts were made to revitalize the mills.[160] Despite these efforts, the Windham site was virtually unused for nine years following American Thread's move.[161] During this time Windham was known as one of the poorest places in the nation's wealthiest state.[162] Drugs and prostitution became prominent in Windham because it lacked a "real" economy.[163]

Process of Remediation

The remediation process began with the Town of Windham acquiring the site's land and 1.1 million sq. ft. of antiquated polluted space by eminent domain in 1993.[164] The non-profit Windham Mills Development Corporation ("WMDC") then acquired quitclaim to the property in 1994.[165]

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157. Scheffey, *supra* note 127.

158. WINDHAM MILLS DEV. CORP., *History* (2001), *at* http://www.windhammills.com/history.asp (last visited Dec. 1, 2003).

159. *Id.*

160. Jeff Vose & Martin Brogie, *Brownfields Redevelopment and Financing: The Windham Mills* (2002), CAMBRIDGE SCI. ABSTRACTS, *available at* http://www.csa.com/hottopics/brown/biblio17.html (last visited Dec. 1, 2003).

161. Scheffey, *supra* note 127, at 2.

162. Paul Zielbauer, *Connecticut Town Ties History and High-Tech Comeback in Comeback Plan*, N.Y. TIMES, Feb. 7, 2000.

163. Scheffey, *supra* note 127, at 1.

164. *Id.* at 2-3.

165. Telephone Interview with Jeffrey Vose, President & CEO, Windham Mills Dev. Corp. (Nov. 27, 2003).

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After that, nearly $5 million was spent with public funds for the remediation of the site, including, the removal of lead, asbestos, fuel oil, and polychlorinated biphenyls (PCBs).[166] This substantial remediation and renovation was completed in less than five (5) years.[167]

After a total investment of nearly $30 million, the Windham Mills Technology Center opened in 2000 with 100,000 sq. ft. of renovated rental space.[168]

Governmental Indemnification from Environmental Reopener Liability

WMDC also received government environmental indemnification for their brownfield project. The Windham site was the first recipient of the DEP's covenant-not-to-sue for completed brownfield projects.[169] This covenant would usually cost three (3) percent of the remediated land's value, but as a non-profit organization, WMDC was exempt from being required to pay.[170] This covenant is not only a shield against further action by the state for *known* contaminants, it also serves as a reopener insurance policy against additional state cleanup requirements concerning *unknown* contaminants and includes protection against changes in remediation standards caused by new science and technology.[171] Although reopeners are not common, this DEP covenant-not-to-sue offers unparallel environmental liability protection by indemnifying the developer from all future state-led environmental cleanups forever![172]

166. *Brownfields Case Study: Demolition vs. Renovation* (2000), *available at* http://environews.com/Brownfields%20Section/Windham%20Mills.htm (last visited Dec. 1, 2003); Scheffey, *supra* note 127, at 2.

167. Vose, *supra* note 165.

168. *Id.*

169. C.G.S.A. 22a-133aa. There are two types of covenants-not-to-sue in Connecticut. The first is available to all brownfield projects that receive DEP cleanup certification. The covenant only protects the owner from additional state cleanup requirements concerning the known contaminants. However, this first covenant is also free. The other covenant-not-to-sue—the type that was granted to WMDC—is broader. It also has additional requirements: (1) DEP Commissioner approval, and (2) the payment of 3% of the property's value after remediation. *See id.*

170. Vose, *supra* note 165.

171. Stevens, *supra* note 82.

172. DECD's covenant-not-to-sue policy does not terminate and is transferable. *Id.*

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Concerns with Government Grant Requirements

The remediation and renovation of the Windham Mills was substantially funded by public grants.[173] According to Mr. Jeffrey L. Vose, president and CEO of WMDC, the government grants for Windham project were a blessing and a burden for the non-profit developer. The grants required that the exteriors of all the buildings be renovated before any of the buildings' interiors were to be rebuilt. This requirement compelled WMDC to first restore all of the buildings' exteriors leaving the developer with only enough money to renovate one-third (1/3) of the interior.[174] According to Mr. Vose, a private developer with limited funds would likely have renovated both the interior and exterior of a single building, rented out its space, and then repeated the process with the remaining buildings. The grants, however, required WMDC to spend a disproportionate amount of its resources renovating the exterior of buildings that would remain empty.[175]

Land Valuation Litigation

The Windham site's property transfer was also very controversial and is even under litigation. According to Mr. Vose, in 1994 the land was polluted, essentially unused and falling apart. Some buildings were falling down and others were obvious fire hazards. Acting as the town's agent, Northeast Connecticut Economic Alliance acquired the polluted site by eminent domain and filed a statement of compensation of just $1.[176] The title was then conveyed to WMDC in November 1994.[177] The previous owner, American Thread Company challenged the token $1 compensation and later received a judgment of $1.675 million. The trial court ruled that when taking property by eminent domain, the municipality could not deduct potential environmental cleanup expenses from the value of the property.[178]

Following an appeal, however, the Connecticut Supreme Court determined that the trial court committed error by excluding, as a matter of

173. *Id.*

174. *Id.*

175. *Id.*

176. $1 seemed a reasonable compensation to the city due to the site's apparent need for environmental remediation and the poor condition of the structures. CONN. L.TRIB., *$1 Assessment Takings Assessment Increased to $1.7 Million* (Mar. 24, 2003).

177. Dianne Struzzi, *Appeal Planned on Mill Ruling: The Selectmen Will Contest a Judge's Decision on the Value of the Former American Thread Complex,* HARTFORD COURANT, Feb. 3, 2003, at B3.

178. *Id.*

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law, the evidence of environmental contamination and the costs of needed remediation. The court reversed the trial court's judgment and remanded it for a new trial.[179]

In light of the court's decision that environmental costs should be considered when valuing contaminated property, the city expected the remand to significantly lessen the previous $1.675 million judgment. Yet, the opposite happened. The subsequent trial court ruled that *after* deducting projected remediation costs, the fair value of the property equaled $1.7 million.[180] Yet, the previous court valued it at only $1.675 million based on the condition of the site at the time of the taking *before* remediation (un-rentable and in immediate need of renovation). Adopting a completely different property value model, the later trial court significantly increased the estimated value of the property to $8.2 million (in ideal rental conditions after remediation and renovation).[181] The later court then deducted its estimated remediation and renovation expenses from the new $8.2 million value of the property to reach its $1.7 million award. This new property valuation approach cost the city's agent an additional $25,000 above the previous reversed judgment![182]

This case has national implications concerning the value of contaminated properties.[183] Mr. Vose was involved with this project from the beginning and contends that American Thread did not likely have intentions of redeveloping the land and was happy to have gotten rid of it.[184] Yet, he recognized that although American Thread is the obvious polluter, if the property had not been taken by eminent domain, American Thread might have chosen to remediate the land for a different use. But it certainly did not have plans to remediate and renovate the site to a high-tech facility.[185]

Had this remediation been done under the common Superfund model, similar to current EPA and state brownfield programs, more efforts would likely have been made to compel American Thread to complete the needed remediation. This approach would have required the use of less public

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179. Northeast Conn. Econ. Alliance, Inc. v. ATC P'ship, 2003 WL 553265 (Conn. Super. Feb. 14, 2003).

180. Struzzi, *supra* note 177.

181. Vose, *supra* note 165.

182. $1,700,000 - $1,675,000 = $25,000. According to WMDC's CEO, Mr. Vose, WMDC was not affected by these judgments. *Id.*

183. Should the contaminated property's value by based upon its condition at the time of the eminent domain taking or upon its potential state after successful remediation?

184. Vose, *supra* note 165.

185. *Id.*

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funds, but may have resulted in American Thread demolishing these historic buildings.

Successes of Remediation

For the past few years, Windham Mills has been "teetering on the brink of success."[186] Contrasting its many accomplishments, the project has been dealt more than its fair share of challenges: current civil litigation concerning a drowned child,[187] suspicious fires,[188] and deep financial troubles.[189] Earlier this year, WMDC was in negotiations with Greenwich Company discussing the company's possible take over of the project.[190] These negotiations, however, were fruitless.[191] Since its inception, the project has received more than $6.5 million in private funding. The financing of these loans is the source of the project's current financial difficulties.[192] The state has subsequently become weary that the project may face foreclosure,[193] but according to Mr. Vose, a recent agreement with Art Space will help the Windham Mills Technology Center gain needed capital.[194]

The project has successful rented 90% of the renovated 100,000 sq. ft. Another 200,000 sq. ft. is in "shell" condition and could be rent-ready with an additional $8 to $10 million.[195] To remediate the site and renovate all of the buildings would have initially cost $40 to $45 million.[196] WMDC received only $22.5 million in public funding. The additional $6.5 million

186. Scheffey, *supra* note 127.

187. *See* Thomas B. Scheffey, *Death Case Turns on Whether Rock Was 'Natural'- No Obvious Answer To Basic Question*, 29 CONN. L. TRIB. 35 (Sep. 1, 2003).

188. Don Bond, *Fire Chief Deems Early Morning Mill Blaze 'Suspicious,'* NORWICH BULLETIN, Mar. 28, 2002.

189. Dave Altimari & Tom Condon, *Tomasso Mill Deal Under Scrutiny*, HARTFORD COURANT, June 3, 2003, at B1.

190. *Id.*

191. Vose, *supra* note 165.

192. *Id.*

193. Altimari & Condon, *supra* note 189.

194. WMDC expects to gain $11 million from the Art Space purchase. Vose, *supra* note 165.

195. Additional renovations will likely follow the Art Space transaction. The completion of the remaining 200,000 sq. ft. of interior space has been delayed because of the lack of funds. *Id.*

196. These figures are according to estimations and reports that are available to Mr. Vose. *Id.*

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from private loans was acquired in an attempt to make up the difference but it still fell short.[197]

The Connecticut Center for Economic Analysis (CCEA) has recently completed an analysis of the Windham Mills project. Although the study's report has not yet been released, its findings will provide a great resource for evaluating the economic impact of the project. A recent draft of the report shows that the CCEA concluded that the Windham Mills project "represents an extremely productive use of public funds."[198] To reach this conclusion the report weighed the $30 million cost of remediation and renovation against the project's benefits.[199] According to the report, the project has the potential to create 750 new jobs.[200] Additionally, it is projected that from 2000 to 2012 the site will add $59 million annually to total personal income in Connecticut.[201] The private sector will also benefit from the 10,000 visitors that are expected annually in the Windham area because of the site.[202]

The Windham Mills project has also been considered a catalyst that encouraged new development beyond the actual site.[203] By bringing new jobs into the area and sponsoring community events, it has fostered amenity, value and community spirit.[204] Although some critics argue that the technology center is not enough to turn things around in Windham, they acknowledge that it has provided hope to the area's economy.[205] Although it may take years or even decades, the technology center brings new potential to the Windham area.[206]

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197. WMDC could only renovate and rebuild one-third of the interior space with its available funds. *Id.*

198. Connecticut Center for Economic Analysis, *The Windham Mills Complex Economic Impact – DRAFT* (Apr. 24, 2002) at 7.

199. A more detailed analysis and discussion of the remediation costs is provided in a later section.

200. Connecticut Center for Economic Analysis, *supra* note 198, at 3.

201. *Id.*, at 4.

202. *Id.*

203. Vose & Brogie, *supra* note 165.

204. Connecticut Center for Economic Analysis, *supra* note 198, at 1.

205. Zielbauer, *supra* note 162, (a nearby strip mall, the Willimantic Plaza on Route 32 was almost totally empty in 1998—but is now 95% occupied); Vose, *supra* note 165 (some of the site's tenants have also expanded their business and leased additional space on Main Street); Vose, *supra* note 165 (A recent expansion also includes an agreement for an additional $11 million investment for the site that is currently being finalized. Art Space of Windham has agreed to purchase the site's Building 8 and has plans to build-out 48 units (80,000 sq. ft.) for artists' housing, studios, and retail space.).

206. Zielbauer, *supra* note 162.

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IV. D. ANALYSIS OF CONNECTICUT BROWNFIELD CASE STUDIES

"*Frankly, I can't think of a better use of tax dollars.*"
– Jeff Cugno, NVDC Executive Director[207]

Environmental indemnification was necessary but not sufficient to produce the outcome of these two brownfield projects. Government subsidy played the key role in financing and promoting the remediation of these two sites. Subsidies alone, however, would not likely have been enough. Even with these generous subsidies, these projects were still contingent upon liability protection. The fact that both developers required indemnification cannot be overlooked. Had the developers not received the indemnification, it is unlikely that they would have been willing to redevelop these sites. Subsidies plus indemnification got the job done – both were necessary and neither alone would have been sufficient.

Concerning the subsidies, these sites have become test cases on the wisdom of funneling public funds into the redevelopment of brownfields.[208] Combined they represent over $50 million in state investment.[209] Proponents of these sites, however, contend that these projects were a great use of tax dollars.[210] I agree that the public funds were a necessary component of the remediation of these two projects but I will not go as far as to further the argument that these projects are examples of how the government should continue to participate in the remediation process. Another form of government involvement will be endorsed in this paper.

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207. D'Arcy, *supra* note 149.
208. Scheffey, *supra* note 127.
209. The source of the total investment for these two projects is outlined below:

WATERBURY		WINDHAM	
$30.9 million	State Grants	$13.7 million	State Grants
$5.0 million	Department of Defense	$7.3 million	State Loans
$120.0 million	GGP Investment	$2.5 million	Municipal Grants
$155.9 million	Total	$6.5 million	Private Loans
		$29.0 million	Total
$35.9 million	Spent on Remediation	$5 million	Spent on Remediation
		$24 million	Spent on Renovation & Expenses

Grady, *supra* note 132; Vose, *supra* note 165.
210. D'Arcy, *supra* note 149.

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Connecticut Case Studies are not the Model for Government Involvement

Despite the economic and social impacts of the Waterbury and Windham projects, using these projects as models of successful government-aided remediation is problematic. With over six hundred (600) brownfield sites remaining in Connecticut,[211] another model of how to resolve developers' concerns with remediation is necessary for the state. The local governments in Connecticut cannot likely afford to duplicate similar high state spending on the hundreds of remaining brownfield sites. I agree that the Waterbury and Windham projects' economic and environmental results are exemplary. But I think the means[212] of achieving those results is not the model for remediation that should be promoted for the state's remaining brownfield sites.

This comment proposed that similar results could be achieved through an alternative form of government involvement: reinsurance of environmental cleanup policies.

V. GOVERNMENT REINSURANCE PROGRAM NEEDED

Connecticut's Legislature's Commerce Committee toured the Windham Mills project on February 12th, 2002. Impressed by the progress seen at Windham, some committee members commented that because most developers wouldn't tackle old structures, it made sense for the government to assist in preserving old buildings and renovating them for new uses.[213] Rep. Gary LeBreau, co-chair of the Commerce Committee stated:

> [T]he government's priorities are different from a business... It's in the state's interest to try to help people, by helping business develop – and that means urban areas, where it's most needed. Business, which has to make a quick buck, goes to a greenfield. It's easier for them to put up a Butler building or a shell, that has no lasting architectural value, and in ten years, they might be out of. They're there to make a buck as fast as they can, which is the nature of business. We're looking at a little bit longer time frame.[214]

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211. ENVTL. LAW INST., ELI Project No. 981621, AN ANALYSIS OF STATE SUPERFUND PROGRAMS (Nov. 2002) at 134.

212. High state costs and free governmental indemnification of environmental liability.

213. Scheffey, *supra* note 127.

214. *Id.*

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Government's priorities are often different from that of a business. Without government assistance or obvious economic gain, developers are unlikely to absorb the costs and risks of public initiatives like brownfield redevelopment. Yet, determining how much governmental assistance is enough and how much is too much is a hard line to draw.

One thing is certain: insurance companies and PRPs will likely come and go, but the government and the land will remain. Unlike private insurers, absent an unprecedented global event, the government and brownfield sites will continue to exist for ages. They will also always continue to be dependent upon each other. The governments' social and economic interests are inherently intertwined with the good health and efficient use of land, including brownfield sites. The municipal, state and federal governments will always have a relationship with the land within their borders. The recognition of this long-term relationship is essential when structuring a comprehensive approach to facilitate the redevelopment of brownfields.

Government subsidy for private environmental insurance alone is not the likely solution. Commercial insurance policies are not long term.[215] There appears to be an assumption by the insured and the insurers that when the current policy expires there will be another policy available to replace it. It is a dangerous assumption for a developer to make. Although the availability of subsidies for environmental cleanup policies would likely induce more private insurers to enter the market, each of these subsequent policies would still carry the same long-term deficiencies as the original policy.

The finite lifespan of private environmental insurance policies is problematic. Policies are defined and limited in terms of years.[216] They are often annual or as long as ten years and occasionally longer.[217] Yet, a developer's liability will likely continue for many years beyond that of the scheduled expiration date of a private insurance policy.[218] Each time one of these policies expires developers will be required to repeat the process of seeking affordable coverage. But at what price will coverage be available in the future? Will it even be available, and if so, with what new limits, restrictions, deductibles and exception?

Even with government subsidies, renewing or finding new coverage in the future may prove to be a significant challenge if the site was reopened

215. Maurer, *supra* note 120, at 75.
216. *Id.*
217. *Id.*
218. *See* MOSS, *supra* note 48, at 286.

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during a previous policy. If a site has been reopened and required additional costly remediation, will the developers and the brownfield site later be flagged by insurers as being "high-risk?" If so, will insurers then demand a higher, more costly premium like that imposes on high-risk auto drivers and automobiles? This potential increase in cost may again put environmental coverage beyond the reach of many property owners (unless the government's subsidy is a blank check).

What if private insurers offered environmental cleanup coverage that did not expire, that ran with the land and was not subject to cost fluctuations of premiums? This would be a tremendous leap forward in recognizing the long-term needs and risks of brownfield cleanups and reopeners. But this type of coverage would not come cheap because of the long-term risks. This coverage would likely cost more than what most developers could afford.[219] It's also unlikely that private insurers acting alone will offer this type of coverage? A developer or landowner would also have to ask themselves if they honestly believed that such a risk-prone insurer was likely to still be in business in fifty years. Because of the current inherent limitations of private environmental insurers, it seems very unlikely that such a private insurance policy will be offered to the public in the near future.

For long-term cleanup and reopener insurance to be meaningful, the government's involvement should go beyond offering just subsidies.

VI. PROPOSAL FOR GOVERNMENT REINSURANCE OF ENVIRONMENTAL CLEANUP POLICIES

The next step for brownfields is for the government to reinsure private environmental cleanup policies. By utilizing the strengths of both governments and private insurers, an appropriate – better - environmental insurance program is possible.

The Concept

Private insurers should continue to issue environmental insurance policies for brownfield remediation. An important aspect of these new policies will be that they will concretely define the depth of the insured's risk - both with the initial remediation and any future cleanups (reopeners). Regardless if an additional cleanup is required by either the state or the EPA, these policies should "cap" the costs for both the initial cleanup and

219. *Id.*

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any reopeners. Other important characteristics of the new environmental cleanup insurance program should include:

- Cost to the insured is locked and will not fluctuate; possibly a single premium.
- Policies will not expire, they will "run with the land";
- Policies are backed by the government (like FDIC with banks);
- The government will reinsure the policies;
- Policies include a "cut-through" provision[220] that will allow the policyholder to seek benefits directly from the reinsurer, the government, after a certain number of years or upon dissolution or insolvency of the private insurer;[221]
- Policies are transferable.[222]

Why Use the Government as the Reinsurer?

The government's role in this new insurance program would benefit both the insured and the insurer. Because the government is behind the insurance policy, as a guarantor and a reinsurer, the policyholder can be confident in the satisfaction of coverage. This significantly reduces and limits the landowners and developer's risks. Once the premiums and deductibles of the insurance policy are negotiated, the insured knows its potential costs and can plan accordingly. The transferability of these policies will also help facilitate more brownfield sites being returned to the real estate market because the existing policy will also protect the new owners.

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220. Two general conditions for "cut through" or guaranty provisions are that, 1) a covered loss must have occurred, and 2) the insured must be unable to pay (which was usually interpreted as "insolvent.") For a discussion and review of "cut through" provisions, *see* John F. Langen, *Special Clauses and Endorsements*, *in* REINSURANCE CONTRACT WORDING 590, 601-13 (Robert W. Strain ed., 1998).

221. After the term of private policy ends, the government should move from being the reinsurer to the primary insurer. This would allow the policies to NOT EXPIRE and run with the land. The policies not expiring avoid the hassles of renewing or finding other private insurance.

222. Because the liability risk with a brownfield site may be increased by the potential negligence or inaction of the property owner, private insurers are likely to consider who the policyholder is when determining the price and terms of the coverage. With this in mind, to protect the insurers, the policies should include some restrictions on the transferability of the coverage, such as requiring the consent of the insured. But the restrictions should also stipulate that the consent cannot being unreasonably withheld.

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Private insurers also benefit from the proposed government's role. The government's reinsurance and cut-through provisions significantly reduces the insurers' risks. Once the reinsurance agreement is complete, the private insurers should be able to offer environmental policies at a price lower than that currently available to the public.

Another benefit of the reinsurance program is that the government's guidelines or incentives could require private insurers to target environmental policies to smaller brownfield projects. Insurance is currently too expensive and out of reach for many of these low-profile sites.[223] The government's reinsurance could not only make it more feasible but could require that insurance is made available to a wider spectrum of brownfield sites.

The Continued Use of Private Insurers?

Keeping environmental insurance in the open market has many advantages. As private insurers compete to gain customers they not only create a fair market price for the coverage, they also invest their own money in research and innovation. They have established relationships with many businesses and can create an awareness of new coverage through this network.

The government is not necessarily the best party to manage this reinsurance program but they are the party most able to bare the risks. A conventional reinsurer may be better at providing most reinsurance coverage, but would private reinsurers be willing take on this amount of uncertainty? And would we want them to? This type of reinsurance program relies on the reinsurer being the long-term indemnifier of substantial long-term risk.[224] Although this uncertainty may ultimately add to the government's costs, it is important to remember that the government has a long-term interest in furthering the redevelopment of brownfields whereas a private reinsurer does not. With its ability to tax and enact law the government becomes an ideal candidate to undertake substantial risks and liability.[225]

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223. MOSS, *supra* note 48, at 286; *Making the Deal, supra* note 36.

224. An additional option is for the government to subsidize commercial reinsurance. The government could simply mail a check to conventional reinsurance companies to drive down the costs to the private environmental insurers. This option, however, would likely be less effective in regulating the insurers, alleviating the concerns of increased costs triggered by reopeners, reducing the costs to the consumers, and ensuring that affordable coverage is offered to smaller projects.

225. *See* MOSS, *supra* note 48.

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Procedure Considerations

The state programs should continue to play an active role in working with the parties to determine the cleanup requirements for the sites and approving their completed remediation. In fact, their assessments of a site's level of contamination and needed remediation could be used to help determine the cost of the government's role in the proposed insurance program. A grid or some type of a category system could be based upon the state's findings and then used to set the cost for the government's reinsurance for individual sites. Knowing their cost for the reinsurance based upon the grid, the private insurers could rely on the state's assessments or complete their own tests when determining what price to offer the environmental insurance. Insurers, like the policy holders, will benefit from knowing the limits of their costs and risks from the outset of the creation of the policy.

Other Points to Consider for Further Development of the Proposed Concept

This comment provides the concept for a new government reinsurance program but many other issues need to be addressed, including, but not limited to: how much should the reinsurance cost the private insurers, how much would a program like this cost the government, how much of the government's cost would be a subsidy, would these policies be available to polluter landowners or only new developers,[226] should a single policy "cap" both the costs of the initial remediation and future reopeners or should there be two separate policies, how do we ensure that these policies become affordable to smaller projects, how should private insurers be monitored, and what restrictions should there be to determine which insurers qualify for the government reinsurance, and would the government costs for this program influence Congress to reduce[227] cleanup liability?

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226. The goal behind this concept is to further the remediation and redevelopment of additional brownfields. As such, these policies could be sold to either the polluter landowner or a developer for that purpose as long as they were issued as part of an approved remediation and redevelopment plan. Some form of a settlement or penalty fee could be required of polluter landowners so that the coverage does not cost an "innocent" developer the same amount as it would cost a "guilty" landowner.

227. A major assumption to this comment is that Congress is unlikely to reduce Superfund liability. If they were to further limit this brownfield liability, then private insurance may be enough. This, however, seems unlikely to happen.

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Additional research and discussion beyond this comment is necessary to provide a proper recommendation concerning these and other details for a new reinsurance program.

VII. CONCLUSION

The contaminated land problem is not being resolved because of the many remediation and reopener liability concerns with brownfields redevelopment. State programs are able to offer a liability protection to landowners and developers, but current federal legislation creates too many holes in this shield to alleviate the concerns. Because the liability issues, like the contaminants, are not likely to disappear, many parties are looking to private environmental insurance to alleviate these risks.

Current private environmental insurance policies, however, have proven not to be enough. They do not reach out to many smaller brownfield sites and offer limited coverage to others. Because these policies also have a finite life span, they only offer a temporary solution.

The two brownfield projects discussed in this comment were examples of successful remediation. But their success was due, in part, to FREE government indemnification of environmental cleanups.[228]

This comment offers a concept for a new government reinsurance program of environmental cleanups. This new program would offer the same long-term liability protection through private environmental insurance policies reinsured by the government, but unlike the Waterbury and Windham projects, the protection would not be free. The government should require reasonable compensation for this protection. This program would not be intended to be a freebie or a welfare system for developers. Its design should be made with the goal of utilizing the synergy between the government and private insurers to offer *sufficient and affordable* environmental insurance to promote the further remediation and redevelopment of brownfields.

228. *See infra* sec. IV. A.

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FROM THE JOURNALS: INSURANCE LAW ABSTRACTS

Edited by Sarah Sia

GENERAL

Keith J. Crocker and Sharon Tennyson, *Insurance Fraud and Optimal Claims Settlement Strategies*, 45 J. LAW & ECON. 469 (2002).

The article examines the role of underpayment as a tool to deter fraudulent insurance claims when auditing is not a practical alternative. The article opens with discussions of the problem of fraudulent claims and the potential consequences for the insurer. It then proceeds to briefly discuss two strategies insurers may adopt to reduce the incidence of fraudulent claims. The strategy to be employed will depend on the nature of the claim.

If a claim has associated physical manifestations that can be identified and reviewed, then an audit can be an effective tool to employ to deter filing of fraudulent claims. However, if a claim is devoid of physical manifestations from which fraudulent behavior may be detected, then auditing is ineffective as a tool to deter such behavior. Thus, the authors propose a second strategy insurers can employ to deter such fraudulent claims, *systematic underpayment of claims at the margins to mitigate incentives for claimants to expend resources on claims inflation.* Central to this strategy is the balancing of the savings in potential fraudulent or inflated claims against potential damage awards to claimants who sue the insurer alleging bad-faith. Insurers are held to an implied covenant of good faith and fair dealing, the violation of which is considered a tort that exposes them to "extracontractual liability" such as consequential and punitive damages, in addition to their contractual liability.

To test their theory, the authors conducted an empirical analysis of automobile insurance claims data. The authors felt this data set to be particularly useful as automobile insurance claims are an area highly prone to fraud and exaggeration due to the possibility of compensation for pain and suffering in addition to economic loss. From this analysis, the authors concluded that the "optimal strategy of an insurer is to reduce, at the margin, the settlement payment as a function of the claimed amount, thereby mitigating the incentives facing claimants to expend resources on claims inflation." The economic trade-off for insurers, however, are that such a strategy may generate costs in claims negotiation and potential civil

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damages awards should the claimant bring suit and the court finds the insurer acted in bad faith. Their empirical analysis, however, favors such an economic trade-off.

LIABILITY

Charles Silver, *Symposium: The Future Structure and Regulation of Law Practice: When Should Government Regulate Lawyer-Client Relationships? The Campaign to Prevent Insurers from Managing Defense Costs*, 44 ARIZ. L. REV. 787 (2002)

The article argues that state bars and other authorities should only regulate attorney-client relationships when reliable information suggests an advantage of doing so. The article applies this doctrine to the current controversy over regulation of insurance defense lawyers. At the heart of the controversy is the awkward tripartite relationship between an insurer, the insured and counsel for the insured. Cannons of legal ethics requires an attorney to represent his/her client to the best of their ability. The problem that arises in this situation is that a third-party is paying the legal costs and understandably will want a say in how the defense is carried out as that will ultimately impact the final bill. Insurance defense lawyers will, however, want to retain decision-making authority over the matter.

The article notes that since the mid-1990s, there has been a plethora of advisory committee and court opinions issued questioning and critiquing insurance defense practices. Specifically, such opinions have criticized such practices as use of staff counsel, litigation management guidelines, flat fees and fee audits. The author argues, however, that there is no evidence such practices are harmful and concludes that these opinions came about only because insurance defense lawyers sought them out, not because any harm was occurring. The author proceeds to defend such practices. He points to a survey conducted by the American Insurance Association (hereinafter "AIA") in 1999 that shows insurers were able to decrease average defense costs by 1% while decreasing average amount paid to plaintiffs on litigated cases by 7.6%. The author concludes that this is evidence that modern defense management techniques help insurers reduce cost without undercutting the quality of defense provided to policyholders. The author further notes that there has been no evidence produced to show policyholders have been harmed by the current tripartite system and argues that absent any showing of harm, government regulation need not be imposed.

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GENERAL

Brian J. Glenn, *Risk, Insurance, and the Changing Nature of Mutual Obligation*, 26 LAW & SOC. INQUIRY (reviewing *Embracing Risk: The Changing Culture of Insurance and Responsibility*) 295 (2003)

The article is a review of a collection of eleven essays sharing a common theme: "the manner in which risk is constructed has profound implications for the politics of mutual assistance." *Id.* at 295. The article begins by stating the author's opinion of the purpose of insurance and its role in shaping society. It then notes the change in the definition of risk as something to be spread in order to avoid large losses, to something that is to be embraced in order to enjoy large rewards and how this shift is impacting society at large. The author cites a 2002 U.S. Supreme Court decision that narrowed the definition of what it means to be disabled under the Americans with Disabilities Act to demonstrate shifting of responsibility for loss from employer to individual employees. The decision demonstrates a change in society's view of whom should bear the risk of work-place injury, the employer or the employees. More broadly, it demonstrates a change in society's definition of risk. Rather than being a loss to be spread among many, risk is now something to be borne in the pursuit of profit.

To further explore the issue, the article gives a brief explanation of the relationship between risk and insurance. Specifically, it notes how insurance, by defining what is insurable and what is not, define what activities society can engage in and how such activities are conducted and thereby hold vast regulatory powers over the daily lives of most individuals. Thus, insurance makes financial and social statements about responsibility. The types of accidents for which we can purchase insurance are predicated on the ideas of what is or is not socially acceptable.

Next, the author begins his analysis of *Embracing Risk* by discussing what he believes are the reasons for this volume of work. The editors of *Embracing Risk* wanted to present a "methodological tool for studying what insurance is and what it does, especially in terms of governing through risk." The author highlights certain articles he felt were especially helpful in demonstrating the central theme that insurance, by defining risk, governs society indirectly. Beyond accepting that insurance can govern society, the author also highlights articles that discuss what guidelines insurers should consider when setting their policies given the impact on the political culture such policies is sure to have.

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TERRORISM

Jeffery Thomas & Tiera M. Farrow, *Insurance Implications of September 11 and Possible Responses*, 34 URBAN LAW. 727 (2002).

The article discusses the impact the September 11, 2001 attack had on the insurance industry. The September 11 attack was the largest insured event in history. The losses were widely distributed throughout the insurance industry, ranging from property and casualty claims to workers compensation claims to life insurance claims. Given the enormity of the losses, a visceral reaction would be that insurers will attempt to delay or deny payments. Specifically, some may speculate that insurers would attempt to deny payments under the war exclusion clause in standard property and liability policies. However, that does not seem to be the case. Out of 20,000 claims filed as of December 2001, only sixty-three complaints were filed with the New York Insurance Department. The industry is responding in a different arena.

Prior to the September 11 attack, most insurers did not take terrorism-related losses into account when underwriting risks. Subsequent to the attack, most insurers began to exclude terrorism-related losses from coverage. The initial terrorism exclusion clause was drafted so broadly that most state regulators rejected the exclusion. Ultimately a compromise was reached between insurers and state regulators on a standard terrorism exclusion, consisting of three elements: 1) the event must have been caused by terrorist activity; 2) those engaged in the activity must have requisite terrorist intent; 3) the losses caused by the activity must either exceed a specific threshold or be of a specified type.

Although the new terrorism exclusion will have an impact for all policyholders, it is especially significant for cities and municipalities as compared to private property owners. Cities and municipalities hold billions of dollars in property and without insurance coverage, they are at risk of substantial losses. Because the terrorism exclusion is so broadly worded, many acts of violence could be excluded under clause. Even if insurers were willing to include terrorism coverage, cities and municipalities will most likely not be able to afford the high prices insurers are likely to charge for such coverage.

The author suggests both legislative and judicial strategies to address this problem. He proposes adoption of an effective federal backstop to allow the federal government to bear some of the risk of future catastrophic losses from terrorism. If, however, legislative strategies are unsuccessful, cities file suit and employ the doctrines of *contra proferentum* (ambiguous

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provision should be construed in favor of coverage) and *reasonable expectations* (insurance policies should be construed consistent with policyholders' reasonable expectations). Should both of these strategies fail, the author suggests catastrophe bonds as an alternative to seeking traditional coverage. No one is sure of all the long-term ramifications of the September 11 attack on insurance coverage but one clear consequence is that insurance covering terrorism risk will become harder to find and more expensive.

ENVIRONMENTAL

Benjamin J. Richardson, *Mandating Environmental Liability Insurance*, 12 DUKE ENV. L. & POL'Y F. 293 (2002)

The article discusses the role of insurance in managing environmental risks. Specifically, it considers whether environmental liability insurance should become compulsory. It considers how a wide-range of environmental problems can be regulated by the insurance market. Through the setting of premiums and coverage limits, insurance can provide an incentive for firms to behave more carefully. Environmental damage has now become a standard risk insurers consider in their evaluation process. Typically a firm seeking insurance will make a proposal to an insurer, who then evaluates all risks associated with the proposal and stipulates conditions and prices for the policy. With the rise of statutory environmental liabilities in the United States in the late 60's to early 70's, a market for environmental insurance also arose. Traditionally, pollution liability was covered under a firm's general public liability policy. As environmental liability became more prevalent, insurers began to include specific provisions related to environmental liability.

Even though insurers have begun to recognize environmental liability, there still exist potential constraints to insurance markets that limits insurance's ability to regulate environmental risk. Uncertain liability standards, adverse selection, moral hazards, insufficient financial resources, and ecological damage all represent potential constraints to the insurance market's ability to regulate environmental liability.

To address these shortcomings of regulating environmental liability, the state can mandate coverage for those engaged in environmentally sensitive activities. The difficulty arises in determining when compulsory coverage is needed and when the market should be allowed to regulate itself. Requiring environmental liability insurance would minimize the problem of adverse selection as all firms would be required to have

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coverage. Because insurers would still do a risk analysis when creating policies, firms would be compelled to adopt appropriate safety measures to qualify for coverage. Insurers would become quasi-regulators and facilitate compliance with existing environmental regulations in order for a firm to qualify for coverage. But to be effective, the insurance market will need government backing. Suitable sanctions such as fines and penalties for lack of insurance must be available to ensure firms comply with compulsory coverage. Redress to courts to deny coverage of a claim in cases of fraud or violations of terms of the policy must also be available.

Although compulsory environmental insurance provides one potential source of redress, it cannot be the only source of regulation. Environmental tax and direct statutory regulation will continue to play an important role in addressing environmental hazards. But the insurance market will continue to play an important role in regulating a firm's behavior by the price and coverage insurers are willing to provide.

LIABILITY

Walter J. Andrews & Michael S. Levine, *Is There Insurance Coverage for Lawsuits Against the Firearm Industry?*, 2 NEV. L.J. 533 (2002)

The firearm industry has recently seen an increase in suits seeking to impose liability upon firearm makers for the increasing number of shooting injuries. The firearm industry has, in turn, looked to its insurers to pay for its defense-related expenses and sought indemnification for any judgments entered against them. This article examines the issues surrounding the availability of insurance coverage for the firearm industry on such suits.

Generally, two classes of plaintiffs have brought suit, government lawsuits and victims of gun violence lawsuits. Government lawsuits have three different theories of recovery: 1) promotion of an underground gun market for criminals; 2) failure to prevent shootings by unauthorized gun users; 3) false advertising about guns and self-defense. All three theories are rather self-explanatory. Under the 'promotion of an underground gun market for criminals', the allegation is that the "manufacturers and distributors market and distribute guns in a manner that generates an underground market for firearms in which criminals and other unauthorized gun users have easy access to guns."[1] The second theory is basically a defective design theory. Here, the plaintiffs claim that the "gun

1. Walter J. Andrews & Michael S. Levine, *Is There Insurance Coverage for Lawsuits Against the Firearm Industry?*, 2 NEV. L.J. 533, 533 (2002).

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manufacturers have failed to incorporate personalized locking devices into guns, even though such alleged technology is currently available."[2] The third theory alleges "that gun manufacturers have knowingly, purposefully and intentionally misled, deceived and confused members of the general public...regarding the safety of firearms and the need for firearms with in the home."[3] Such government suits generally seek equitable relief such as injunctions against the manufacturers.

The second class of plaintiffs are victims of gun violence and not only are their theories of recovery different, but the relief requested are more traditional types of relief such as compensatory and punitive damages. These plaintiffs typically proceed under tort-based liabilities such as product liability or negligence.

The author argues there are significant barriers to coverage for these types of claims against the gun industry. Specifically, there are five coverage defenses an insurer may raise against the gun manufacturer: 1) lack of an 'occurrence' or untimely 'occurrence'; 2) the expected or intended defense 3) absence of bodily or property damage; 4) absence of a claim for covered damages; 5) products hazard exclusion.

The author concludes that case law "demonstrates on a whole that the firearm industry is not entitled to coverage for lawsuits that attack the manner in which it does business."[4] Specifically, the five barriers listed above are successfully raised as coverage defenses by the insurers. Despite these defenses, however, the gun industry continues to assert claims for coverage. As such, because of the significant barriers to coverage and the continued claims by the gun industry, this will continue to be a "hotly disputed" area in the insurance industry.

GENERAL

Jeffery W. Stemple, *Favorite Insurance Cases*, 2 NEV. L.J. 287 (2002)

This article provides a summary of the cases discussed at the Symposium held at the Boyd School of Law, University of Nevada Las Vegas in summer 2002. Professor Stemple begins by highlighting the importance of insurance law to all aspects of the legal and business worlds. Yet, it is a topic that is often overlooked by law schools when establishing their 'core' curriculum. Nor is it a topic that although, not required,

2. *Id.* at 536.
3. *Id.*
4. *Id.* at 549.

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students consider a "must" take course before graduating such as corporation or taxation. As among general practitioners', there is no 'notable' insurance law case that almost every lawyer knows such as *Marbury v. Madison* for constitutional law or *Hadley v. Baxendale* for contract law.

This Symposium is an attempt to address the last of the three shortcomings regarding insurance law. It brings together leading teacher-scholars as well as practitioner-scholars of insurance law to share their favorite insurance cases. Some based their selection on personal involvement or enjoyment while others based their selection on the case's precedential importance or unusual factual circumstances. The Symposium brings together some of the nation's most knowledgable insurance lawyers and scholars and is viewed as a promising first step in addressing the absence of focus on key or cutting edge insurance case law.

GENERAL

Robert H. Jerry, II, *May Harvey Rest in Peace: Lakin v. Postal Life and Casualty Company,* 2 NEV. L.J. 292 (2002)

The article examines the concept of moral hazards as it relates to life insurance by analyzing *Lakin v. Postal Life and Casualty Company*, a case that piques the author's interest. The author states at the outset that "*Lakin* stands for the unremarkable proposition that the legal relationship of one partner to another is not, by itself, sufficient to establish an insurance interest. If one partner takes out insurance on the life of the other partner in circumstances where the partner *cestui que vie*[5] has neither capital nor skills to contribute to the partnership, it does not automatically follow that the partner who owns the policy on the other's life has an insurance interest sufficient to support the policy."[6]

To set the stage for analyzing *Lakin*, the author begins with *Rubenstein v. Mutual Life Insurance Co. of New York*, a very well known case in this genre of insurance case law. Rubenstein had placed a notice seeking assistance in developing a local periodical Rubenstein just recently started. Harold Connor responded to the notice and the two men entered a business agreement whereby Connor agreed to pay Rubenstein $1,000 a month for a franchise in exchange for a 25% stake in the business. On the same day,

5. Cestui que vie ("CQV") is a French term meaning the person whose life is the subject of the policy. The CQV may or may not be the owner of the policy.

6. Robert H. Jerry, II, *May Harvey Rest in Peace: Lakin v. Postal Life and Casualty Company*, 2 NEV. L.J. 292, 293 (2002).

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the men also met with an insurance agent who recommended that Rubenstein purchase a $240,000 life insurance policy on Connor to secure Connor's debt to Rubenstein. Shortly thereafter, Rubenstein, Connor and a few of Rubenstein's friends went on a hunting trip. On that trip, Connor was shot in the back by one of Rubenstein's friends who claimed the shotgun accidentally went off when he tripped.

When Rubenstein attempted to claim the proceeds of the life insurance policy on Connor, the insurer declined to pay and Rubenstein sued. The insurer cited various misrepresentations on the application and Rubenstein's lack of insurable interest. The insurer based its 'lack of insurable interest' defense on "the 'grossly disproportionate' amount of insurance Rubenstein purchased relative to the value of Connor's contribution to this anemic, undercapitalized business venture."[7] The court concluded "that Connor was killed under highly suspicious circumstances, circumstances that suggest something far more sinister than a mere accident"[8] and dismissed the plaintiff's complaint.

Although *Lakin* occurred some twenty-six years earlier, the facts are very similar to *Rubenstein*. Harvey Hankinson was a World War II veteran who became "a drunkard, a derelict and a floater" after returning home from the war. Hankinson answered a help wanted ad put in the newspaper by Henry Lakin, a local roofing and siding contractor. After Lakin hired Harvey, Lakin convinced Harvey to apply for life insurance and to name Lakin as the beneficiary. Lakin was good friends with the insurance agent that helped Harvey apply for the policy. It was later discovered that Harvey's application contained several false answers and that Harvey gave a number of false answers at his medical examination as well. The policy was issued on October 13, 1954. The first quarterly premium was due on January 13, 1955 but it was never paid. On January 17, 1955, conveniently within the policy's thirty-day grace period, Henry Lakin killed Harvey Hankinson on a hunting trip. Lakin would testify that the two men had been drinking and swear that the shooting was an accident. Lakin's explanation of how the accident happened, however, did not square up with the findings of the pathologist. Even so, Lakin was not prosecuted for Harvey's death.

The insurer, sharing the prosecution's suspicions about the incident, challenged Lakin's claim on the policy. The insurer argued that Lakin's conduct in bringing about Harvey's death prevented him from taking the proceeds. In addition, the insurer also argued that the policy was invalid on

7. *Id.* at 295-96.

8. *Id.* at 295 (internal quotations omitted).

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account of the misrepresentations in the application and on Lakin's lack of insurable interest in Harvey's life. The court ultimately decided the case on the lack of insurable interest defense. Under this doctrine, one cannot take out an insurance policy on the life of another unless one has an insurable interest in the life of that person. Such an insurable interest "can be base on either a close familial relationship...or an economic or pecuniary relationship, such that the person taking out the insurance stands to benefit or be advantaged from the continued living of the cestui que vie. The logic of this rule is directly related to moral hazard: if the owner of the policy benefits from or is dependent upon the cestui que vie's continued living, it follows that the owner will not seek to bring about the cestui que vie's death in order to secure insurance proceeds."[9]

Lakin puts forth two justifications for why he was entitled to the proceeds. First, Lakin's argues he had an insurable interest in Harvey because they were business partners. The court rejects this claim because it found that their partnership lacked a "mutual dependence based on a legitimate economic relationship" and thus no insurable interest existed. Lakin's second argument is that Harvey was free to assign his ownership rights in the policy to whomever he wished. The beneficiary need not have an insurable interest in the policy owner's life. The only limitation is that the assignment cannot be a cover for wagering. In the context of insurance law, if a policy would produce a windfall, i.e. – "the coverage is disproportionately larger than the value of the economic contribution of the copartner or key employee makes to the business... then the insurance policy *functions* as a wager, with the attendant problems of moral hazard."[10] The court rejected Lakin's second claim and held that "[i]f the beneficiary designation, like an assignment, serves as a subterfuge to escape the constraints of the insurable interest doctrine, the designation will not be enforced and the policy will be deemed void."[11] The author concludes that *Lakin*'s is an example of how common law can be used to address the moral hazards associated with the dark side of insurance. The facts of the case show proper procedures were followed in beneficiary designations but closer examination reveals deliberate efforts to evade the safeguards put in place in the insurance industry to prevent from profiting from the intentional killing of others.

9. *Id.* at 306-307.
10. *Id.* at 308.
11. *Id.*

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GENERAL

Kenneth S. Abraham, *Interpretation or Regulation? Gaunt v. John Hancock Mutual Life Insurance Co.*, 2 NEV. L.J. 312 (2002)

The significance of *Gaunt* is that it highlights the different perspectives on the role of courts in the resolution of insurance coverage disputes. The facts surround *Gaunt* are as follows. Gaunt applied for a life insurance policy with John Hancock. He paid his first premium with his application. As with most life insurance policies, it required that Gaunt pass a medical exam. In addition, the application provided that Gaunt had to be alive when the Company approved the complete application, including the medical exam. Once approved, coverage would be backdated to the date Gaunt passed his medical examination. The crucial provision in the application is that the insured, Gaunt, be alive when his application is finally approved.

Gaunt passed his first medical exam and the report was submitted to the Home Office on August 9th. But because of his poor eyesight, as revealed by the initial exam, the Home Office required a second exam. This second exam was submitted on August 19th. Subsequently, the application was approved from a medical standpoint on August 26th. But on that same day, the Home Office learned of Gaunt's death the day before, August 25th. Gaunt's body was found besides some railroad tracks in South Dakota with a bullet hole in his head. Gaunt's wife filed suit for the proceeds of the policy.

Two issues were before the court: whether Gaunt was covered at all, and, if so, whether his death was accidental and thus entitled him to double indemnity. The second of the two issues was the easier one to decide. The facts surrounding Gaunt's death clearly indicated it was not an accidental death. The first issue, whether Gaunt was covered at all is the crux of the court's opinion.

The majority opinion, written by Learned Hand, takes an interpretative route to answer this question. Hand conceded that read literally, the terms of the application created a condition precedent to backdated coverage, namely that the applicant be alive upon the final approval of his application. Hand felt, however, typical applicants would not understand the wording of the application to mean that benefits would only become available earlier *if* the applicant were still alive at the time of approval. This was simply too esoteric an understanding to impose on the applicants. Rather, the typical applicant would assume he was getting immediate coverage for his money. Hand acknowledges that such an interpretation

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does "some violence to the language of the application...it did greater violence to this language to make the insurance in force only from the date of approval."[12] Hand felt that the burden of any resulting confusion from the language of the application should fall on the insurer rather than the applicant.

Clark's concurrence, although reaching the same conclusion, is based on different reasoning. For Hand, what was 'unpardonable' was the insurer's expectation that an applicant understand the condition precedent established by the language of the application. For Clark what was 'unpardonable' was the "insurer's failure to tell the applicant that he was getting noting (or almost nothing, and no real coverage) for something – the first premium."[13] Clark, however, had a different view of the court's role in matters such as this. Clark felt that basing a decision on a court's interpretation of policy language and applicable state law would produce continuing uncertainty. Rather Clark felt that the court's role should be to regulate rather than just interpret law. His candid preference for regulation over mere interpretation can be seen as a precursor to the doctrine that insurers honor the reasonable expectations of the insured in spite of contrary policy language. Thus, *Gaunt*'s significance lies in the clear manifestation of the tension in insurance law between interpretation and regulation as expressed by the opinions of two of the most celebrated common law judges of the twentieth century.

GENERAL

John F. Dobby, *Judicial Broken-Field Running Perl v. St. Paul Fire & Marine Ins. Co.*, 2 NEV. L.J. 346 (2002)

This article discusses a case that has an unusual outcome, one in which the court set a dual goal for itself – finding coverage, under a single policy, for one insured and denial of coverage for another. The facts of *Perl v. St. Paul Fire & Marine Ins. Co.* are as follows. Norman Perl was hired to represent Ms. Rice in her Dalkon Shield intrauterine device lawsuit. Perl negotiated a $50,000 settlement with the adjuster of the defendant's insurer. Rice later discovered that, at the same time that her settlement was going on, the same adjuster was also employed by Perl's firm to do investigative work on other cases. Rice sued Perl and his law firm on

12. Kenneth S. Abraham, *Interpretation or Regulation? Gaunt v. John Hancock Mutual Life Insurance Co.*, 2 NEV. L.J. 312 (2002).

13. *Id.* at 316-17.

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various causes of action. The defendants filed a motion for summary. The only theory that survived the motion for summary judgment was breach of fiduciary duty because Rice could not prove actual damages. The trial court refunded Rice the full $20,000 attorney's fee. Perl and the law firm filed suit against their own malpractice insurer seeking coverage for the $20,000 refund. The problem the Minnesota Supreme Court had to face was how to find coverage under a single policy for the law firm but deny coverage for the individual attorney Perl. The linchpin of this decision was how to categorize the $20,000 forfeiture. The court began by agreeing that if a defendant's conduct results in no loss to a plaintiff, no legal right has been violated and no actual damages. But it continues by recognizing certain "absolute rights" that requires a defendant to refrain from certain conduct even if no loss will result. Violation of an "absolute right" will result in 'nominal' damages. A lawyer's fiduciary duty his clients qualify as one of these "absolute rights." In this case, however, the court takes a leap of logic and says rather than nominal damages, fee restoration shall be provided and called it "money" damages.

Now having dealt with the issues of damages, the court had to deal with the exclusion clause in the policy that barred coverage for "exemplary or punitive damages." To find that the restitution was punitive would have denied coverage to the firm. But the intent of the restitution was clearly to punish the attorney and deter such future conduct. The court skirts the issue by finding that there are elements of both punishment and compensation in the award. As such, the court finds that there is ambiguity in the policy and reinforces its finding by relying on the long established doctrine that "ambiguity must be construed against he insurer which drafted the language"[14] and thus the policy covers the $20,000 restitution.

The problem now facing the court was how to grant coverage to the firm but not to Perl. The court turns to the old reliable 'public policy' argument. It asks "whether or not public policy should raise its indignant head to prevent insurance coverage from taking the punitive sting out of a judgment of fee forfeiture."[15] Clearly the court already had its mind made up. The problem, again was, how to deny Perl coverage while granting coverage to the firm. The court drew a distinction as between Perl and the firm. Perl breached his fiduciary duty to the client but the firm was only vicariously liable because of Perl's action. Thus public policy did not apply with the same force against the firm as against Perl. The court

14. John F. Dobby, *Judicial Broken-Field Running Perl v. St. Paul Fire & Marine Ins. Co.*, 2 NEV. L.J. 346,349 (2002).

15. *Id.*

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wanted to leave nothing to chance however. It thus reminded the insurer that if the insurer is required to pay the restitution on behalf of the firm, "it is subrogated to the claim of the firm against Perl for that same $20,000."[16] In the end, the $20,000 comes from Perl, and the firm and the insurer break even.

16 *Id.* at 350.

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