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CONSUMER-DRIVEN HEALTH CARE: MORAL HAZARD, THE EFFICIENCY OF INCOME TRANSFERS, AND MARKET POWER

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ABSTRACT

Consumer-driven health care (CDHC) and health savings accounts (HSAs) have been promoted as ways to reduce national health expenditures. This essay attempts to place these policies in a theoretical perspective. CDHC is intended to reduce expenditures by reducing the additional quantity of health care that consumers purchase when insured, that is, by reducing moral hazard. This essay suggests that while some moral hazard is inefficient and should be discouraged, a large portion of

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moral hazard—the health care that ill consumers can only afford to purchase if they are insured—is actually efficient and should be encouraged. CDHC does not distinguish between these two types of moral hazard, and therefore discourages the purchase of both efficient and inefficient moral hazard. It further suggests that savings accounts are less efficient than standard insurance coverage as vehicles for increasing the resources that are available to consumers who become ill. And finally, it suggests that quantity-reducing policies like CDHC are likely to be less effective in reducing health care expenditures than policies directed at bargaining down provider prices. Indeed, it is possible that CDHC would diffuse buying power and keep prices high. Because CDHC is unlikely to reduce the quantity of health care demanded substantially, national health care expenditures would likely remain high with CDHC.

INTRODUCTION

A number of health economists have suggested consumer-driven health care (CDHC) as a way to reduce national health care expenditures.[1] Recently, the Bush administration has been aggressively promoting CDHC as its main health policy initiative.[2] The thinking behind CDHC is that conventional insurance causes consumers to purchase too much health care because with insurance, consumers do not face the true cost of their care. CDHC would act to reduce health care purchases by increasing the portion of the health care bill that consumers pay for out-of-pocket. According to one administration spokesman, by making consumers pay for a larger portion of their care out-of-pocket, CDHC will address the biggest factor driving health care costs: "the perception that health care is free."[3]

This essay attempts to bring perspective to this issue. It questions the wisdom of relying on policies like CDHC that reduce the quantity of care in order to reduce national expenditures. Quantity-reducing policies have been tried in the past. Not only have such policies been ineffective in

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1. Mark V. Pauly & John C. Goodman, *Tax Credits for Health Insurance and Health Savings Accounts*, 14 HEALTH AFF. 125, 126 (1995). *See generally* JOHN C. GOODMAN & GERALD L. MUSGRAVE, PATIENT POWER: THE FREE ENTERPRISE ALTERNATIVE TO CLINTON'S HEALTH PLAN (1994).

2. NAT'L ECON. COUNCIL, REFORMING HEALTH CARE FOR THE 21ST CENTURY (2006); Robert Pear, *A More Impassioned Bush, on the Road, Delivers a State of the Union Encore*, N.Y. TIMES, Feb. 2, 2006, at A20; Christopher Lee, *Bush Seeks to Increase Health Savings Accounts*, WASH. POST, Feb. 6, 2006, *available at* 2006 WLNR 2070433.

3. CQ Healthbeat, Washington Health Policy Week in Review (Feb. 21, 2006) (quoting Allan Hubbard).

reducing health care expenditures, but they have been inefficient because they also discourage the purchase of some health care whose value to consumers exceeds their costs. Moreover, compared to a standard insurance policy, a savings account is an inefficient vehicle for increasing the resources available to consumers who become ill. Finally, this paper suggests that the fundamental reason for the growth in health care expenditures in the U.S. is not the consumption of too many services, but instead the high prices that we pay for care. CDHC is unlikely to be effective in reducing prices because it does not effectively address the issue of market power. First, CDHC is defined.

I. CONSUMER-DRIVEN HEALTH CARE

Consumer-driven health care is typically represented by a health savings (or spending) account (HSA) and a health insurance policy with a large deductible. These are often obtained by an employee from his or her employer. For example, an employer might make a payment (for example, $2,000) into an HSA that the employee can then spend on out-of-pocket health care costs or, possibly, on additional health insurance coverage. The employer also provides an insurance plan with a large deductible (for example, $5,000) to be paid out of the beneficiary's HSA or, after the HSA is depleted, directly out-of-pocket. Thus, a "doughnut hole" may exist representing the difference between the amount deposited in the HSA and the amount of the deductible (for example, health care spending that is greater than $2,000 but less than $5,000), where there is no coverage.[4]

The employer's payment to the employee can be a "defined contribution." If the employee is paid a defined contribution, he or she receives a certain amount annually that is intended to fund both the HSA and the health insurance premium. The employee can either contribute to any shortfall, or purchase less extensive coverage. Employees are sometimes presented with a list of options on an internet web site from which they may choose in order to customize their coverage.

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4. The current coverage parameters are that the deductible must be at least $1,050 but not greater than $5,100 for an individual, and at least $2,100 but not greater than $10,200 for a family. The maximum contribution that individuals can make to an HSA is the amount of their insurance deductible or $2,700, whichever is lower. For families, it is the amount of their insurance deductible or $5,450, whichever is lower. Michael F. Cannon, *Health Savings Accounts: Do the Critics Have a Point?*, *in* POLICY ANALYSIS, at 2 (Cato Inst., Policy Analysis No. 569, May 30, 2006).

The internet site may also supply information on physicians, hospitals and other types of providers. In theory, information is available on the quality of care provided by the various providers, but the information that consumers often desire is specific to their condition (for example, breast cancer), so there is a question regarding whether the general information on quality that is currently envisioned would be valuable to the consumer. Also in theory, information on unit prices of health care services and procedures may also be available on the web. The availability of comparative price information is an important component of CDHC and critical for this policy to work as envisioned.

HSA contributions are not taxed, just as the premiums paid to purchase health insurance policies by employers are also not taxed. The tax treatment of premiums represents an incentive that encourages employers and employees to purchase health insurance and contribute to the HSAs. The tax status of HSAs, however, also represents a vehicle for sheltering income from taxes because the amount of income that a person can contribute to these HSAs can vary, up to the legislated limit. Moreover, any money remaining in an HSA at the end of the year often can be rolled over and used next year, thus HSAs represent tax exempt savings accounts, especially for those who remain healthy. One report estimates that about 3 million Americans now have HSAs and suggests that this number is expected to grow to 15 million by 2010, representing about 10 percent of all those privately insured.[5]

II. MORAL HAZARD

The impetus behind the promotion of CDHC is to reduce health care spending by reducing "moral hazard." Moral hazard is a term coined by insurers to refer to the additional health care that a consumer purchases when he or she is insured, that would not have been purchased if not insured. According to conventional theory, all moral hazard is inefficient because it is caused by the price distortion that occurs when insurance pays for the health care of a beneficiary.[6] The price distortion arises because the beneficiary knows in advance that any health care will be paid for by the insurer and this acts like a reduction in the price that the beneficiary faces.

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5. Eric Dash, *Wall Street Senses Opportunities In Health Care Savings Accounts*, N.Y. TIMES, Jan. 27, 2006, at A1.

6. Mark V. Pauly, *The Economics of Moral Hazard: Comment*, 58 AM. ECON. REV. 531, 535 (1968).

Because insured consumers face unit prices that are artificially low, they consume "too much" health care. For example, a consumer with insurance might stay an extra day or two in the hospital or undergo a procedure that he would not have received without insurance. This additional health care is presumed to be worth less to the consumer than it costs to produce. Thus, according to conventional theory, *all* of moral hazard is inefficient.

Taken as a whole, health insurance that covers all of the consumer's health care expenditures is thought to reduce society's welfare because of moral hazard. For example, in an influential study, Martin Feldstein concluded that overall, "health insurance produces a very substantial welfare loss," and because of this, Feldstein recommended raising the coinsurance rate that patients pay to 67 percent in order to reduce moral hazard and the welfare loss that it generates.[7] Other studies have reached similar conclusions.[8] Since the 1970s, it would probably be fair to say that U.S. health care policy has been preoccupied with reducing moral hazard. Because of the inefficiencies associated with moral hazard, health insurance has been regarded by many U.S. policymakers as more of a problem than a solution.[9]

Because of this theory and preoccupation, policy recommendations over the past 35 years or so have focused on reducing health care expenditures by reducing the quantity of medical care consumed by those who are insured. In the 1970s, policy makers recommended that coinsurance payments and deductibles be imposed on health insurance contracts in order to discourage the purchase of health care. In the 1980s and 1990s, the imposition of managed care—utilization review programs, capitation of provider payments, and selection of panels of providers—became the preferred quantity-reducing policy solution. Now, CDHC arrangements are promoted as the preferred solution. Again, these are policies designed to make consumers bear more of the cost of care and, therefore, to reduce the quantity of health care that is purchased.

While these policies have no doubt reduced the quantity of health care consumed and the rate of health care expenditure growth from what they would have been without them, whether they have truly worked to limit

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7. Mark S. Feldstein, *The Welfare Loss of Excess Health Insurance*, 81 J. POL. ECON. 251 (1973).

8. *See, e.g.*, Willard G. Manning & M. Susan Marquis, *Health Insurance: The Tradeoff Between Risk Pooling and Moral Hazard*, 15 J. HEALTH ECON. 609 (1996).

9. Malcolm Gladwell, *The Moral Hazard Myth: Why Our Health-Care System Doesn't Work*, NEW YORKER, Aug. 28, 2005, *available at* http://www.newyorker.com/printables/fact/050829fa_fact.

health care expenditures depends upon how well they have worked compared to alternative policies. That is, are there other policies that would have reduced health care expenditures more than the quantity-reducing policies adopted in the U.S.? To better understand this, it is useful to compare the U.S. experience to the experience of another developed country with a completely different perspective on moral hazard: the United Kingdom.

The United Kingdom has a national health care system, the National Health Service (NHS), which spends about 7.3 percent of its GDP on health care, compared with our 13 percent.[10] If anything, the NHS is preoccupied with removing all financial obstacles and making health care free for every one of its citizens so that cost will never be a barrier to access to health care.[11] One of their core principles spells this out clearly:

> The NHS will provide a universal service for all based on clinical need, not ability to pay. Healthcare is a basic human right. Unlike private systems, the NHS will not exclude people because of their health status or ability to pay.[12]

Yet, in the U.K. per capita health care spending is less than half of what it is in the U.S.[13] While the U.K. may not use as much of the latest technology and their hospitals may not be quite as modern, the U.K. has a lower infant mortality rate and a higher life expectancy than we do.[14] Still,

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10. Gerard F. Anderson et al., *It's the Prices, Stupid: Why the United States Is So Different from Other Countries*, 22 HEALTH AFF. 89, 91 (2003).

11. PETER DAVIES, THE NHS IN ENGLAND 2005/06: A POCKET GUIDE (2005).

12. NHS England, NHS Core Principles, http://www.nhs.uk/England/AboutTheNhs/CorePrinciples.cmsx#a (last visited Sept. 21, 2006).

13. The U.S. spent $5,274 per person in 2004 compared to $2,160 per person in the U.K. These amounts represent the purchasing power parity equivalents, which take into account what the prices for similar goods and services are in the US and UK, rather than the exchange rate. The purchasing power parity values are generally considered the best measure of relative spending on health care in two countries. *See* U.N. DEVELOPMENT PROGRAMME, HUMAN DEVELOPMENT REPORT: INTERNATIONAL COOPERATION AT A CROSSROADS 236 (2005).

14. According to the Central Intelligence Agency, the UK ranked 38th highest in estimated 2006 life expectancy at 78.54 years while the US ranked 48th highest at 77.85 years. The U.K. ranked 198 out of 225 countries with regard to infant morality, with 5.08 deaths per 1,000 live births, compared to the US's ranking of 183 out of 225, with 6.43 deaths per 1,000 live births, both estimated for 2006. *See* U.S. CENTRAL INTELLIGENCE

a person in the U.K sees the doctor about as often as we do, and is admitted to the hospital more often, so the difference in spending is not due to better "control" of moral hazard.[15]

Indeed, not all moral hazard should be controlled. In *The Theory of Demand for Health Insurance*, I present an alternative model that shows that some moral hazard is actually efficient.[16] The efficient portion of moral hazard is the additional health care that is purchased because of the income that is implicitly being transferred to those consumers who have insurance and become ill. As an illustration of this beneficial income transfer, consider Elizabeth, who is just diagnosed with breast cancer. Without insurance, Elizabeth would purchase the $20,000 mastectomy procedure needed to rid her body of cancer. She would consider purchasing a breast reconstruction procedure for $20,000 to correct the disfigurement caused by the mastectomy and also consider staying 2 extra days in the hospital to recover, but without insurance, the other claims on her income and wealth make these additional purchases too expensive and, in that sense, unaffordable.

Fortunately, Elizabeth had purchased insurance for $4,000 that pays for all of her care. With this insurance, she responds by purchasing the $20,000 mastectomy, the $20,000 breast reconstruction, and the 2 additional days in the hospital to recover costing $4,000. Her total healthcare spending with insurance is ($20,000 + $20,000 + $4,000 =) $44,000. Because her total spending without insurance would have been $20,000, Elizabeth has incurred ($44,000 - $20,000 =) $24,000 of additional spending that would be considered moral hazard expenditures.

Whether the moral hazard is in fact inefficient or efficient, however, depends on what Elizabeth would have done if her insurer, instead of paying $44,000 for her care, had written her a cashier's check for $44,000 upon diagnosis. Assume that with this $44,000 income payment plus her original income and wealth (net of the $4,000 premium payment), she would have purchased the original mastectomy plus the $20,000 breast reconstruction, but not the extra 2 days in the hospital. This implies that, because she could have spent the additional income on anything she wanted and chose to purchase the breast reconstruction procedure for $20,000, the value of that procedure to her was at least as great as its $20,000 cost. Because of this, this portion of moral hazard spending is efficient. It also

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AGENCY, THE WORLD FACTBOOK - GUIDE TO COUNTRY PROFILES, https://www.cia.gov/cia/publications/factbook/docs/rankorderguide.html (last visited Sept. 25, 2006).

15. *See* Anderson et al., *supra* note 10, at 95-97.

16. JOHN A. NYMAN, THE THEORY OF DEMAND FOR HEALTH INSURANCE 102-03 (2003).

implies that the extra 2 days in the hospital (that she did not purchase with the additional income, but she did purchase with insurance that paid for her care) are inefficient because their $4,000 in costs apparently exceeds their value to Elizabeth. In other words, Elizabeth only purchased the extra days in the hospital because of the price distortion caused by insurance, therefore they represented a conventional moral hazard welfare loss. Thus, according to the new theory, some moral hazard is efficient because its value exceeds its costs, and some is inefficient because its costs exceed its value.

Policies that have attempted to reduce health care costs by reducing the quantity of medical care have not discriminated between efficient and inefficient moral hazard. For example, a $5,000 deductible might discourage the purchase of an inefficient cosmetic surgery, but it might also discourage a person of limited means who is suffering from breast cancer from purchasing the chemotherapy she needs. (Indeed, there may never be a need to apply a deductible or co-payment to such health care as chemotherapy: what healthy consumer would ever opt to endure a course in chemotherapy just because it is free?) Because coinsurance payments, deductibles, and the "doughnut holes" in CDHC do not distinguish between efficient and inefficient moral hazard, they inefficiently discourage those who are poor and ill from getting the care they need.

Fronstin and Collins investigated behavior changes caused by CDHC. The authors surveyed consumers and found that those with consumer-driven health plans had lower satisfaction, higher out-of-pocket costs and were more cost conscious that those with traditional plans.[17] They also found that consumers with CDHC were more likely to avoid, skip or delay health care than those with traditional plans, and that this was especially marked for those with chronic health problems and the poor.[18] Thus, there is evidence that CDHC reduces efficient as well as inefficient moral hazard.

Regardless of whether the quantity reduction would be efficient or inefficient, relying on a consumer response to CDHC is unlikely to result in significant cost reductions. In an early study based on the RAND Health Insurance Experiment data, Keeler and his colleagues estimated that if *all* insured non-elderly switched to a health savings account, that health care

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17. *See* Paul Fronstin & Sara R. Collins, *Early Experience with High-Deductible and Consumer-Driven Health Plans: Findings from the EBRI/Commonwealth Fund Consumerism in Health Care Survey*, 288 EMP. BENEFIT RES. INST. 1 (2005).

18. *Id.*

expenditures would decline by at most 13%, and might not decline at all.[19] If those most likely to switch switched, costs might fall by 1% or even rise by 2%.[20] Remler and Glied simulated the impact of CDHC on health care costs, and suggested that because cost-sharing is already pervasive in traditional health insurance plans, the portion of beneficiaries who are responsible for half of current health care spending would actually experience a decline in their cost sharing with CDHC. Thus, these authors questioned whether CDHC would reduce health care spending at all.[21]

III. EFFICIENCY OF INCOME TRANSFERS

According to the new theory, the intent of health insurance is to transfer income from those who purchase insurance and remain healthy, to those who purchase insurance and become ill.[22] This is a departure from the conventional theory of the demand for health insurance, which holds that consumers purchase fair insurance because they prefer a certain loss (the premium) to a larger uncertain loss (the cost of medical care that would occur only if the consumer became ill) that is of the same expected magnitude.[23] For example, conventional theory holds that people buy insurance because they would prefer incurring a $4,000 loss that is certain, rather than a 10% chance of incurring a $40,000 loss, the expected value of which is the same ($40,000 * 0.1 =) $4,000.

This "risk avoidance" motive for the demand for health insurance is problematic for at least two reasons. First, by limiting the insurance payoff to simply cover the loss that would have occurred without insurance, it does not recognize that this payoff might in fact generate additional expenditures. As has already been shown, an insured person who knows that they will be receiving a check for $44,000 if diagnosed with breast cancer may consume more health care than if they were uninsured and had to rely on their original income and wealth alone.

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19. Emmett B. Keeler et al., *Can Medical Savings Accounts for the Nonelderly Reduce Health Care Costs?*, 275 J. AM. MED. ASS'N 1666 (1996).

20. *Id.*

21. *See* Dahlia K. Remler & Sherry A. Glied, *How Much More Cost Sharing Will Health Savings Accounts Bring?*, 25 HEALTH AFF. 1070, 1076 (2006).

22. *See* NYMAN, *supra* note 16, at 30-31.

23. Although this theory is reproduced by many health economics text books, one of its earliest appearances is in Milton Friedman & L.J. Savage, *The Utility Analysis of Choices Involving Risk*, 66 J. POL. ECON. 279 (1948).

Second, the empirical evidence supporting "prospect theory" has shown that when consumers are given exactly the choice that is supposed to be the basis of the demand for insurance under conventional theory, they actually prefer an uncertain loss to a certain loss of the same expected magnitude.[24] This is just the opposite of the behavior that the conventional theory predicts would occur and that is consistent with the purchase of insurance. Indeed, in one study, when subjects were asked whether they preferred to purchase insurance for $50 that would cover completely a 0.25 chance of a $200 loss, or preferred to be without insurance for that loss, a majority preferred to purchase insurance. But when subjects were asked whether they preferred a $50 loss to a 0.25 chance of a $200 loss, a majority preferred the latter, that is, *the uncertain loss*.[25] These empirical studies suggest that if consumers purchase health insurance, it is not because of a preference for certainty.

The new theory holds that the demand for health insurance should be viewed as a demand for an income transfer in the event of illness.[26] Unlike conventional insurance theory, the new theory allows consumers to purchase more health care than they would have purchased if uninsured—the moral hazard—because of the additional income from the insurance payoff when they become ill. And, by not basing the demand for insurance on a fixed "loss," this theory is able to avoid the contradictions posed by the empirical studies supporting prospect theory.

If the demand for health insurance is a demand for an income transfer in the event of illness, the new theory then raises the question of whether CDHC, with its reliance on HSAs, is as efficient in increasing the resources of those who become ill as conventional health insurance would be. David de Meza has developed an economic model that informs this question.[27] De Meza was interested in whether saving for a future health problem or purchasing insurance coverage for that health problem would result in greater health care spending if ill. The health insurance that de Meza considered was of the type that would pay the beneficiary a cashier's check

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24. The initial paper in the prospect theory literature is Daniel Kahneman & Amos Tversky, *Prospect Theory: An Analysis of Decision Under Risk*, 47 ECONOMETRICA 263 (1979). Many other papers have followed, reaching similar conclusions.

25. PAUL SLOVIC ET AL., RESPONSE MODE, FRAMING AND INFORMATION-PROCESSING EFFECTS IN RISK ASSESSMENT, *reprinted in* DECISION MAKING: DESCRIPTIVE, NORMATIVE AND PRESCRIPTIVE INTERACTIONS 152-66 (David E. Bell et al., eds. 1988).

26. *See* NYMAN, *supra* note 16, at 30-31.

27. *See* David de Meza, *Health Insurance and the Demand for Medical Care*, 2 J. HEALTH ECON. 47 (1983).

for a certain amount of money upon diagnosis of an illness. This type of insurance cannot cause inefficient moral hazard, only efficient moral hazard, because there are no distorting price effects.

De Meza concludes that insurance provides greater income to the consumer who becomes ill than would a savings account. This is because insurance has a lower cost in terms of the present consumption forgone, since it relies on the fact that not everyone will become ill in any given year. For example, using a saving account, it is necessary to sacrifice $1 of consumption purchases in the present for every dollar contributed to the savings account. With insurance, however, it is necessary to pay less than $1 for insurance for every dollar available when ill because insurance takes advantage of the fact that not every purchaser of insurance will become ill in a given year. For example, if there is a 1 in 10 chance of becoming ill, for every $1 a consumer contributes to the insurance pool, the consumer who becomes ill would have access to transfer of $9, that is, $1 from each of the other 9 consumers who contribute to the pool but remain healthy. Therefore, an additional $9 of income when ill requires contributing only $1 when healthy, which represents a smaller cost in terms of present consumption forgone than does the use of a savings account. Insurance that pays for the ill consumer's care, has this same advantage. With de Meza's model, it is clear that insurance is a more efficient vehicle for providing resources to the ill consumer than a savings account would be.

This implies that consumers with CDHC would have less income if ill than they would have if they had purchased standard insurance. To see this, consider the employee who receives $5,000 from his employer and uses it to pay for a premium for an insurance policy that pays off with a cashier's check upon diagnosis. Assume that every employee has a 1 in 10 chance of becoming ill each year, and that the insurance contract is actuarially fair, meaning that whatever is paid into the insurance pool is paid out in benefits to those who become ill. For the $5,000 premium, this policy would be able to pay (to the 1 employee out of 10 who becomes ill during that year) a cashier's check of $50,000 upon diagnosis of illness (of the $50,000 payoff, $45,000 represents transfers of income from those 9 out of 10 who purchased insurance but remained healthy).

However, if the $5,000 were split so that $2,500 were placed in every employee's health savings account and $2,500 used to purchase insurance, the 1 employee out of 10 who becomes ill would have access to only $27,500 in income upon diagnosis, representing a payoff of $25,000 ($22,500 of which are income transfers) from his insurance policy and the $2,500 that was deposited in his own health savings account. The missing ($50,000 - $27,500 =) $22,500 represents what are now employer

contributions to the health savings accounts of those 9 employees out of 10 who remain healthy, each of whose $2,500 health saving account is only available for them to spend. In order for an employee to assure the same $50,000 income transfer upon diagnosis, he would have needed to contribute $2,250 out of his own income to purchase additional health insurance coverage.

This example illustrates the inefficiency of using savings accounts to pay for health care when ill. For those who remain healthy, the HSA contributions simply remain in the account and are not available to pay for the health care of those who become ill. As a result, there is less income available to those who become ill, assuming a fixed employer contribution. To obtain the same amount of income transfers, the employees' contribution would need to increase dramatically, or they would face income transfer shortfalls if ill, compared to their income if they had purchased a standard insurance policy with the same contribution.

Over time, the health savings accounts of those who remain healthy will grow, and their demand for standard health insurance coverage will fall, as their growing health savings accounts make the purchase of generous insurance policies increasingly unnecessary. But for those who become ill, they will face an increasingly larger burden on their income, as the ill disproportionately attempt to purchase the insurance policies in order to cover the shortfall in funds from their now depleted health savings accounts. The dynamic implications of CDHC represent both efficiency and equity issues.

IV. MARKET POWER

For the last 35 years or so, America has attempted to reduce health care costs by reducing the *quantity* of health care we consume, when the real culprit is the *prices*. In the U.K., by comparison, expenditures are low because they have a single monopsony buyer of health care services, the National Health Service, and the NHS determines the unit prices that it will pay.[28] In the U.S., the prices that physicians, hospitals, and pharmaceutical companies receive are determined by their considerable power in the market, and are higher. In recent years, health plans have used *their* market

28. Interestingly, in 2000, the Blair government committed to *raising* U.K. expenditures—mostly by raising physician salaries—from 8 percent of GDP in order to be more consistent with the average spending in the European Community. JOHN APPLEBY & ANTHONY HARRISON, SPENDING ON HEALTH CARE: HOW MUCH IS ENOUGH? (King's Fund 2006).

power—the fact that they purchase care for hundreds of thousands, even millions, of enrollees—to bargain down provider prices, but they have not passed these lower prices on to consumers in the form of lower premiums.[29] As a result, health care costs in the U.S. continue to rise as a percentage of GDP.

Economists generally regard prices as a useful source of information. For example, a high price in a competitive market means that a good or service is in short supply, and this causes a number of decentralized decisions to occur that will eventually result in more of that good or service being supplied on the market, and the price to fall. But in the U.S. health care sector, prices are almost always high, regardless of whether there is a shortage or surplus, causing some to observe that there is perhaps no sector of the economy where the prices convey as little information about the underlying demand and supply conditions as they do in the health care sector.[30]

Take, for example, hospital prices. Spending on hospital care represents about one third of total health care spending in the U.S., so the prices that hospitals receive are an important contributor to total health care spending in the U.S. They are also, in many ways, typical of the entire sector.[31] Over the past 25 years, the average ratio of hospital charges (its list prices) to costs has increased from 1.1 to 2.6.[32] This growing ratio reveals the emphasis that hospitals now place on establishing an initially high list price from which to negotiate prices with buyers, and the impact that relative market power plays in determining the price that buyers pay. It also implies that those consumers who purchase health care individually—the uninsured and those who rely on HSAs—are likely to pay dearly for their care. Most of all, it shows how the prices that are actually paid have come to reflect the relative market power of hospitals and purchasers, and no longer represent—if they ever did—the sort of information on relative supply and demand that is the economist's ideal.

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29. *See* David M. Cutler et al., *How Does Managed Care Do It?* 31 RAND J. ECON. 526, 526-48 (2000). These authors found that managed care reduces the payments to providers a great deal, but the premiums that they charge to enrollees falls by only a fraction of the decrease in payments.

30. Michael E. Porter & Elizabeth O. Teisberg, *Redefining Competition in Health Care*, HARV. BUS. REV., June 2004, at 65.

31. Cathy Cowan et al., *National Health Expenditures, 2002*, HEALTH CARE FIN. REV., Summer 2004, at 143, 143.

32. Christopher P. Thompkins et al., *The Precarious Pricing System for Hospital Services*, 25 HEALTH AFF. 45, 45, 49 (2006).

For physicians' services, the outlook for establishing and publishing a single, competitive price that would be available to every buyer is even bleaker. Physicians do not face the same level of underlying input costs that hospitals do, therefore their ability to discount from a list price is relatively unconstrained. Moreover, historically, the ability of physicians to price discriminate—that is, to charge different prices to different consumers for reasons not associated with costs—has been tenaciously defended because it is so profitable. [33] It has been relinquished reluctantly and only when other concessions have been made to compensate.[34] While it is possible that the government could intervene and require that a provider set a single price for each service that would prevail for all purchasers (for example, by passing a "most favored nation" law), such a law would likely be politically and economically very costly to enact. So, while knowledge of the list prices of various providers in a market is important, even more important for reducing health care expenditures is the knowledge that the list price is the same for every consumer who would purchase the service from that provider.[35]

To reduce health care expenditures in the U.S., proponents of CDHC envisage that consumers will shop around for health care, comparing quality and prices across various providers, and be parsimonious regarding their spending. But health care prices are not readily available. For example, a recent Minnesota Public Radio series explored CDHC in Minnesota and documented a number of cases where consumers were simply not able to obtain the information on prices they needed to make comparative decisions.[36] Of course, whether growth in CDHC would encourage more providers to make their prices known is not clear. But, even if prices are made available, it is unlikely that they would be the low prices that those with the greatest bargaining power obtain. Those prices

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33. Reuben A. Kessel, *Price Discrimination in Medicine*, 1 J.L. & ECON. 20 (1958).

34. For example, in order for Medicare to entice physicians to give up their ability to charge some Medicare patients more than the Medicare established fee, Medicare had to raise the established fees for "participating" physicians.

35. It should be noted that under standard microeconomic theory, perfect price discrimination, that is, charging each consumer a separate price equal to the maximum that each consumer would be willing to pay, would result in the greater access to services, compared to the establishment of a single competitive price. However, it would also result in the greatest profits to the physicians.

36. L. Benson, *"Prescription for Change,"* Minnesota Public Radio, http://news.minnesota.publicradio.org/projects/2006/01/healthcare (last visited Sept. 25, 2006).

will likely remain hidden and accessible only by a select number of powerful buyers.

The ability to pay low prices depends on the degree of market power that the consumer possesses. For example, VA hospital costs are low in part because of the VA's willingness and ability to use its market power to negotiate lower prices. Canadian drug prices are low because Canada's national health care system buys drugs for all Canadians, and has been able to bargain for low prices as a result. Martin Pfaff studied the relationship between government payments and healthcare spending in European countries and found that the greater the proportion of the health care purchases that are made by government, the lower the per capita spending in that country. He attributed this relationship to the comparatively greater market power that such governments have over suppliers of health care services.[37] In contrast, a person with an HSA who becomes ill has virtually no market power at all, so unless his health plan has already negotiated prices for him, it would be difficult for him to obtain bargain prices. As a result, without some additional mechanism, it is unlikely that CDHC will produce substantial reductions in health care prices.

If the present growth continues, health care expenditures in the U.S. are expected to reach 20 percent of GDP by 2015.[38] CDHC attempts to slow this increase by focusing on the reduction of health care quantity, despite the fact that it is not clear that a quantity reduction is desirable in all cases. What is missing from the CDHC concept is a focus on the use of market power to negotiate prices. As the evidence from the VA, Canada, and Europe suggests, this is where the real reductions in costs would come. If we would ever become truly serious about reducing the percentage of GDP we spend on health care, this is the direction that our policies will have to take us.

V. EQUITY ISSUES

Equity issues abound with CDHC. First, HSAs are more attractive to young, healthy workers than those with chronic conditions. Thus, there is likely to be selection of favorable risks into the HSAs and unfavorable risks into the conventional health insurance plans. This "fragmentation of the

37. Martin Pfaff, *Differences in Health Care Spending Across Countries: Statistical Evidence*, 15 J. HEALTH POL., POL'Y & L. 1, 21 (1990).

38. Christine Borger et al., *Health Spending Projections Through 2015: Changes on the Horizon*, HEALTH AFF., Feb. 22, 2006, at W61.

risk pool" will lead to increased insurance premiums and, if the employer is providing a defined premium, greater out-of-pocket expenditures (larger doughnut holes through greater deductibles and depleted HSA balances) for the high risks.

Second, HSA contributions are made with pretax income and can be rolled over to the next year (IRS Notice 2002-45, Revenue Ruling 2002-41). The untaxed nature of HSAs represents a tax shelter that those with high incomes are able to take advantage of, by making larger contributions (up to the statutory limits) into their HSAs. The poor, in contrast, will have smaller contributions, accruing a smaller tax advantage. This tax advantage does not make sense from a redistributive perspective (it is regressive because those with more income have a disproportionately larger tax subsidy because their marginal tax rates are higher), nor does it make sense from a macroeconomic policy perspective (tax policy stimulates the economy by favoring those who would be more likely to spend the tax savings on consumer goods, that is, by favoring people with low incomes). Consistent with this advantage, a recent GAO report found that HSAs were used disproportionately by those with higher incomes.[39]

Third, banks and other financial institutions will receive a fee—from $50 to $75 for setting the HSA up and about $40 per year for maintenance, according to one report.[40] So, financial institutions will push for HSAs, regardless of whether they work or make sense for consumers or the country.

CONCLUSION

Consumer-driven health care is yet another of the quantity-reducing policies that have attempted over the last 35 years to reduce health care expenditures, all the while the percentage of GDP devoted to health care in the U.S. has been steadily rising from 7 percent to 13 percent or greater. CDHC is unlikely to make more than a small dent in health care spending, and it would do this by increasing the portion of medical care that is paid for out of HSAs and out-of-pocket by consumers in order to reduce the quantity of care they consume. In doing this, CDHC does not distinguish

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39. GOV'T ACCOUNTABILITY OFFICE, CONSUMER DIRECTED HEALTH PLANS: EARLY ENROLLEE EXPERIENCES WITH HEALTH SAVINGS ACCOUNTS AND ELIGIBLE HEALTH PLANS 5 (Aug. 2006).

40. Eric Dash, *Savings Accounts for Health Costs Abstract Wall Street*, N.Y. TIMES, Jan. 26, 2006, at A1.

between efficient and inefficient moral hazard, so that those who are ill and poor will be discouraged from obtaining the care they need.

Moreover, HSAs are an inefficient method for increasing the resources available to those who become ill because HSAs do not take advantage of the fact that not all will become ill during a given period and that insurance uses this fact to transfer income from those who remain healthy to those who become ill, an efficiency that is especially useful for those with low incomes.

Furthermore, it does not address the issue of high health care prices—the most important cause of the high health care expenditures in the U.S.—even setting up a system where individual purchasers are constrained to have as little market power as possible.

And, perhaps, most importantly, it does not address the 46 million Americans who are uninsured. In contrast, as the experience of the U.K. and other developed countries illustrates, a national health insurance program would both insure the uninsured and generate sufficient purchasing power to reduce substantially the percentage of GDP that we Americans devote to health care.

THE RESTATEMENT (SECOND) OF CONTRACTS AS A USEFUL TOOL FOR ADDRESSING COMMON INSURANCE LAW ISSUES

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INTRODUCTION

When interpreting insurance policies, lawyers and courts will often avoid "re-inventing the wheel" where commonly used arguments are readily available. While the ease of this practice makes its appeal understandable, it is not always effective. Commonly employed arguments can have flaws and limitations that are accepted without critical analysis. This Article will attempt to shed new light on various problems that are present in insurance law cases by offering alternative approaches to those arguments that are frequently used by courts and litigators.

These alternative approaches will be drawn from careful consideration of various provisions of the *Restatement (Second) of Contracts* [hereinafter "*Restatement*"]. The approaches outlined in this Article are offered as different ways to address important recurring problems in insurance law cases. The alternative arguments proposed in this Article will seek to advance the same goals of the commonly used arguments, while also addressing some of their limitations.

This Article is composed of four substantive sections, each tackling an independently considered insurance law problem. The sections will each be structured in the same manner. First, each section will present a problem that is commonly found in insurance cases. Next, each section will present and explain the relevant provisions of the *Restatement* that will provide the framework for the alternative approach to the insurance law problem. Each section will then explain how, as a practical matter, the relevant provisions would be applied to the problem under consideration. Finally, each section will examine at least one decision that has adopted either the same or a similar approach.

In Part I, this Article will explain how the rules of interpretation in the *Restatement* can be used to address the "plain meaning" problem. Part II of this Article will address the "delayed notice" problem by drawing on the

Restatement's sections on conditions and promises, and how they relate to material breach. In Part III, this Article will consider the *Restatement*'s sections on remedies as a means to address the "consequential damages" problem. Finally, Part IV of this Article will examine how the *Restatement* could address the "additional insured" problem.

I. RULES OF INTERPRETATION IN THE *RESTATEMENT*

A. THE "PLAIN MEANING" PROBLEM

While insurance policies are generally subject to the same rules of interpretation as normal contracts, some doctrines have emerged that are specifically and frequently applied to insurance policies.[1] One such doctrine, considered one of the more important rules in insurance law, is *contra proferentum*, or the ambiguity rule, which compels judges to construe ambiguities against the party who drafted the insurance policy.[2] In the vast majority of insurance cases, the insurance company is the party who drafted the insurance policy.[3] Despite this doctrine's widespread

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1. *See* 16 SAMUEL WILLISTON & RICHARD A. LORD, A TREATISE ON THE LAW OF CONTRACTS § 49:14 (4th ed. 2000 & Supp. 2006).

2. *See* JEFFREY W. STEMPEL, INTERPRETATION OF INSURANCE CONTRACTS: LAW AND STRATEGY FOR INSURERS AND POLICYHOLDERS § 5.1 (1994 & Supp. 1998); PETER J. KALIS ET AL., POLICYHOLDERS GUIDE TO THE LAW OF INSURANCE COVERAGE § 20.02 (Supp. 2006) (stating that "[m]ost jurisdictions follow the time-honored doctrine of *contra proferentum* (literally, 'against the author or profferer'), which requires that ambiguous policy language be construed strictly against the insurer-drafter and liberally in favor of coverage for the policyholder").

3. ROBERT E. KEETON & ALAN I. WIDISS, INSURANCE LAW: A GUIDE TO FUNDAMENTAL PRINCIPLES, LEGAL DOCTRINES AND COMMERCIAL PRACTICES 628 (1988). Although a rule of general contract law, EUGENE R. ANDERSON ET AL., INSURANCE COVERAGE LITIGATION § 2.04 & n.82 (2d ed. Supp. 2004); Peter N. Swisher, *Judicial Rationales in Insurance Law: Dusting Off the Formal for the Function*, 52 Ohio St. L.J. 1037, 1058-59 (1991), *contra proferentum* has an almost transcendental place in insurance law, based largely on the bargaining and information inequalities between policyholders and insurance companies. James M. Fischer, *Why Are Insurance Contracts Subject to Special Rules of Interpretation?: Text Versus Context*, 24 ARIZ. ST. L.J. 995, 1008-30 (1992). *See also* Gaunt v. John Hancock Mut. Life Ins. Co., 160 F.2d 599, 602 (2d Cir. 1947) ("[T]he canon *contra proferentem* [sic] is more rigorously applied in insurance than in other contracts, in recognition of the difference between the parties in their acquaintance with the subject matter"); STEMPEL, *supra* note 2, § 5.2 ("Whatever the motivation, *contra proferentem* [sic] has a special place in insurance law"); *cf. id.* (enumerating six reasons for the doctrine's special place in insurance law); KALIS, *supra* note 2, § 20.02 (listing three justifications for contra proferentum in insurance law).

application,[4] it has not been employed in a uniform manner.[5] The most frequent variation in the use of the ambiguity rule has been in the admissibility of extrinsic evidence. This Part of the Article will examine the different ways that courts have applied the ambiguity rule, as well as explain how certain sections of the *Restatement* could offer an alternative approach to this area of insurance law.

There are some common and important stages in the application of the ambiguity rule. At an initial stage, the court determines whether the language of the insurance policy is ambiguous. In determining whether the language in the policy is ambiguous, some courts will consider extrinsic evidence, although many will not.[6] The question of whether an insurance policy is ambiguous at this initial stage, or "on its face," usually is one of law for the court.[7]

After that initial stage, if the language is found to be unambiguous, the policy will be interpreted and, in many jurisdictions, that interpretation will happen without the aid of any extrinsic or contextual evidence. It is rare when unambiguous policy language is interpreted in favor of policyholders.

If after that initial stage the language in the insurance policy is found to be ambiguous, some courts follow the more traditional use of the ambiguity rule that created a virtually *per se* rule against the insurance company.[8] Many courts, however, will not then automatically apply the ambiguity rule but instead will allow the introduction of extrinsic evidence after an

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4. *See* KEETON & WIDISS, *supra* note 3, at 629 (mentioning large number of insurance decisions that have employed ambiguity rule).

5. *See* STEMPEL, *supra* note 2, § 5.2 (describing decisions purportedly applying *contra proferentum* as "an unarticulated puree of the several contract interpretation approaches").

6. *See* Peter N. Swisher, *A Realistic Consensus Approach to the Insurance Law Doctrine of Reasonable Expectations*, 35 TORT & INS. L.J. 729, 736 (2000); *see also, e.g.*, 1010 Potomac Assoc. v. Grocery Mfrs. of Am., 485 A.2d 199 (D.C. App. 1984); Berry v. Fed. Kemper Life Assur. Co., 99 P.3d 1166 (N.M. App. 2004). A minority of courts will consider extrinsic evidence in all instances, irrespective of whether an ambiguity has been discovered in the insurance policy. *See, e.g.*, Miller v. Hehlen, 104 P.3d 193 (Ariz. App. Div. 2 2005); Walsh v. Nelson, 622 N.W.2d 499, 503 (Iowa 2001); Sunbeam Corp. v. Liberty Mut. Ins. Co. 781 A.2d 1189 (Pa. 2001).

7. *See, e.g.*, Burger King Corp. v. Horn & Hardart Co., 893 F.2d 525, 527 (2d Cir. 1990).

8. *See* Barry S. Levin & A. Mari Mazour, *Use of Extrinsic Evidence to Interpret Insurance Policy Language*, *in* ENVIRONMENTAL INSURANCE COVERAGE CLAIMS AND LITIGATION, at 379, 386 (PLI Commercial Law & Practice, Course Handbook Series No. A4-4477, 1995); David S. Miller, Note, *Insurance as Contract: The Argument for Abandoning the Ambiguity Doctrine*, 88 COLUM. L. REV. 1849, 1852 (1988).

ambiguity is found, and only after that extrinsic evidence is considered will they attempt to interpret the policy.[9]

As might be expected, the battle in most cases is reduced to whether the language is ambiguous. If the court determines that the language is unambiguous, the case is almost always immediately resolved in favor of the insurance company and generally that determination is based solely on the language of the insurance policy. The effect of this approach is that extrinsic evidence and basic rules of contract interpretation are largely ignored in favor of a fight over "plain meaning."[10]

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9. *See, e.g.*, Schering Corp. v. Home Ins. Co., 712 F.2d 4, 10 n.2 (2d Cir. 1983) (explaining that *contra preferentum* should only be used "as a matter of last resort, after all aids to construction have been employed but have failed to resolve the ambiguities in the written instrument").

10. *See* Richard A. Posner, *The Plain-Meaning Fallacy, in* THE PROBLEMS OF JURISPRUDENCE 262-85 (Richard A. Posner ed., 1990); *see also* STEMPEL, *supra* note 2, at 90 (observing that "[t]he text-centered, four-corners, plain-meaning approach still exerts strong influence on insurance contract construction even though it may at first glance seem inapt especially for consumer transactions"); *id.* at 89 & n.3 (noting "allure of objective and formal contract law [as having] driven much of contract interpretation, and [that] insurance law is no exception," and commenting that "[Professor] Samuel Williston, although having lost influence in the face of the more flexible [Professor] Arthur Corbin and other legal realists, continues to exert influence on thinking in the field [of contract interpretation]") (Grant Gilmore famously distinguished the Williston and Corbin traditions of contract interpretation in GRANT GILMORE, THE DEATH OF CONTRACT (1974)).

Professor Allan Farnsworth expressed overt criticism towards the concept of "plain meaning." He first noted its lack of any basis in semantics:

> Ordinary language simply has not got the "hardness," the logical hardness, to cut axioms in it. It needs something like a metallic substance to carve a deductive system out of it such a Euclid's. But common speech? If you begin to draw inferences it soon begins to go "soft" and fluffs up somewhere. You may just as well carve cameos on a cheese soufflé.

E. Allan Farnsworth, *"Meaning" in the Law of Contract*, 76 YALE L.J. 939, 952 (1967) (citation omitted). Borrowing from W.V.O. Quine, Farnsworth also found that, because of the different ways that people learn words, any single word can have different meanings to different people; hence, some people will say a red object is "red," and a crimson object is "red," without being able to distinguish between them. *Id.* at 952-53. Farnsworth continued:

> Quine has built upon Skinner's theory of language learning to explain the concept of vagueness. According to Quine, stimulations eliciting a verbal response, say 'red,' are best depicted as forming not a neatly bounded class but a distribution about a central norm. The idea of a central norm is useful in explaining the concept of vagueness, for a word is vague to the extent that it can apply to stimuli that depart from its central norm.

While it is possible that the various interpretations of the ambiguity doctrine have led and will continue to lead to fair and just results, this area of insurance law could benefit greatly from some alternative thinking. The *Restatement* provides a useful interpretive framework that would avoid some of the problems associated with attempting to ascertain "plain meaning."

B. THE RELEVANT *RESTATEMENT* SECTIONS

Many sections of the *Restatement* provide guidance for interpreting insurance policies. Some of those sections outline the basic rules of interpretation; other sections address specific problems that commonly arise in contract interpretation. One particularly relevant *Restatement* section is 202, which provides "Rules in Aid of Interpretation" that outline

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Id. at 953 (quoting W. QUINE, WORD AND OBJECT 85 (1960)), *quoted in* Nicholas M. Insua, *Dogma, Paradigm, and the Uniform Commercial Code:* Sons of Thunder v. Borden *Considered*, 31 RUTGERS L.J. 249, 290-91 n. 174 (1999).

Currently, however, the concept of "plain meaning" is in vogue and is closely related to the "new textualism" movement, which is most notably associated with the opinions and writings of Supreme Court Justice Antonin Scalia. *See* William N. Eskridge, Jr., *The New Textualism*, 37 UCLA L. REV. 621, 623 & n.11 (1990) (Eskridge describes this movement as new, "even though Justice Scalia's methodology is a return to the nineteenth century treatise approach to statutory interpretation. According to Eskridge, "[w]hat is 'new' about the new textualism is its intellectual inspiration: public choice theory, strict separation of powers, and ideological conservatism"). This movement also is associated with other prominent jurists such as Judge Frank H. Easterbrook of the United States Court of Appeals for the Seventh Circuit. *See* Frank H. Easterbrook, *Text, History, and Structure in Statutory Interpretation*, 17 HARV. J.L. & PUB. POL'Y 61 (1994).

As noted by Eskridge, one of the bases for the "new textualism" is public choice theory. Public choice theory is an economic theory that "view[s] statutes as commodities'sold' by the legislature to those special interest groups willing to pay the price demanded." Nicholas S. Zeppos, *Legislative History and the Interpretation of Statutes: Toward a Fact-Finding Model of Statutory Interpretation*, 76 VA. L. REV. 1295, 1304 (1990). From that perspective, because a statute is the final product of this political-market process, it follows that the end result is what the market was willing to pay for, nothing more, nothing less. As applied to statutory interpretation, the result is to exclude anything from consideration other than the text itself, which is the only item (as opposed to legislative history) that survived this political-market process through promulgation by the legislature. *Id.* at 1304-05. *See also* Posner, *supra* note 10, at 276-77. Whether a theory of contract interpretation should be premised on "public choice theory" is questionable, given that contracts generally do not have "public" reach but instead are private agreements. Mark L. Movsesian, *Are Statutes Really "Legislative Bargains?" The Failure of the Contract Analogy in Statutory Interpretation*, 76 N.C. L. REV. 1145, 1147-49 (1998).

the fundamental principles of contract interpretation.[11] According to these rules:

> (1) Words and other conduct are interpreted in the light of all the circumstances, and if the principal purpose of the parties is ascertainable it is given great weight.
> (2) A writing is interpreted as a whole, and all writings that are part of the same transaction are interpreted together.
> (3) Unless a different intention is manifested,
>
> (a) where language has a generally prevailing meaning, it is interpreted in accordance with that meaning;
>
> (b) technical terms and words of art are given their technical meaning when used in a transaction within their technical field.
>
> (4) Where an agreement involves repeated occasions for performance by either party with knowledge of the nature of the performance and opportunity for objection to it by the other, any course of performance accepted or acquiesced in without objection is given great weight in the interpretation of the agreement.
> (5) Wherever reasonable, the manifestations of intention of the parties to a promise or agreement are interpreted as consistent with each other and with any relevant course of performance, course of dealing, or usage of trade.[12]

The official comment explains that the rules in section 202 "*do not depend upon any determination that there is an ambiguity*, but are used in determining what meanings are reasonably possible as well as in choosing among possible meanings."[13]

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11. RESTATEMENT (SECOND) OF CONTRACTS § 202 (1981).

12. *Id.* "Course of dealing" is defined in section 223 of the *Restatement* as "a sequence of previous conduct between the parties to an agreement which is fairly to be regarded as establishing a common basis of understanding for interpreting their expressions and other conduct." *Id.* § 223. "Usage of trade" is defined in section 222 of the *Restatement* as "a usage having such regularity of observance in a place, vocation, or trade as to justify an expectation that it will be observed with respect to a particular agreement. It may include a system of rules regularly observed even though particular rules are changed from time to time." *Id.* § 222. General rules pertaining to both are found in sections 222 and 223, respectively, and the comments to those sections.

13. *Id.* § 202 cmt. a (emphasis added).

The *Restatement* supplements those rules in section 203 with a practical aid that establishes various "Standards of Preference in Interpretation."[14] These standards are to be used for "the interpretation of a promise or agreement *or a term thereof*."[15] The standards themselves establish a hierarchy of extrinsic evidence that gives the greatest weight to express terms, followed by course of performance, course of dealing, and usage of trade.[16]

In addition to creating a weighting system for evidence, section 203 provides that preference should be given to an interpretation that "gives a reasonable, lawful, and effective meaning to all the terms" rather than one that "leaves a part unreasonable, unlawful, or of no effect."[17] Greater weight is given to "specific terms and exact terms" over "general language,"[18] and, greater weight is given to "separately negotiated or added terms" rather than to "standardized terms or other terms not separately negotiated."[19]

That result is entirely logical because, while "[i]t is sometimes said that extrinsic evidence cannot change the plain meaning of a writing...meaning can almost never be plain except in a context."[20] Thus the *Restatement* requires consideration of not only the express terms of the contract, but extrinsic evidence as well.[21]

According to the *Restatement*, "[t]he interpretation of an integrated agreement is directed to the meaning of the terms of the writing or writings *in light of the circumstances*."[22] As the relevant comments explain, "the operative meaning is found *in the transaction and its context*,"[23] and "[a]ny determination of meaning or ambiguity should only be made in the light of the relevant evidence of the situation and relations of the parties, the

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14. *Id.* § 203.

15. *Id.* (emphasis added). It should be noted, however, that the Restatement limits the scope of these standards to "apply only in choosing among reasonable interpretations." *Id.* § 203 cmt. a.

16. *Id.* § 203(b).

17. RESTATEMENT (SECOND) OF CONTRACTS § 203(a) (1981).

18. *Id.* § 203(c).

19. *Id.* § 203(d).

20. *Id.* § 212 cmt. b; *see also* Infinity Ins. Co. v. Patel, 737 So. 2d 366, 369 (Miss. Ct. App. 1998) ("some of the surrounding circumstances always must be known before the meaning of the words can be plain and clear") (quoting 3 CORBIN ON CONTRACTS § 542, at 100-02 (1960)).

21. *See* RESTATEMENT (SECOND) OF CONTRACTS §§ 202-03 (1981).

22. *Id.* § 212(1) (emphasis added).

23. *Id.* § 212 cmt. a (emphasis added).

subject matter of the transaction, preliminary negotiations and statements made therein, usage of trade, and the course of dealing between the parties."[24] And, in the event that all of those rules and standards are insufficient to clarify meaning, the *Restatement*, in section 206, gives preference to the meaning that "operates against the party who supplies the words or from whom a writing otherwise proceeds."[25]

C. POTENTIAL APPLICATION OF THE *RESTATEMENT* TO ADDRESS THE "PLAIN MEANING" PROBLEM

The "plain meaning" problem associated with the use of the ambiguity rule could be avoided if courts used the relevant sections of the *Restatement* in their interpretive endeavors. As will be discussed below, some courts have followed the *Restatement*'s framework to interpret insurance policies.[26]

For example, under the *Restatement*, courts would not need to consider whether an insurance policy, or a term thereof, is ambiguous before considering extrinsic evidence.[27] Policyholders thus could "introduce evidence showing that policy language is ambiguous or has some other meaning, whether or not that language appears unambiguous at first glance."[28] Rather than having a claim summarily dismissed based on purportedly unambiguous language, policyholders could introduce extrinsic evidence to show that their interpretation is the proper one. A *Restatement*-based approach would thus skip as an initial step determining ambiguity, moving straight to consideration of all the relevant evidence and circumstances.

The process of interpretation summarized in the *Restatement* does not, however, ignore the importance of the express terms of the agreement. Section 203 gives them greater weight than extrinsic factors in the interpretive hierarchy of the *Restatement*.[29] But express terms would no longer be the sole source of meaning. For example, if the course of

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24. *Id.* § 212 cmt. b. Indeed, comment b to section 212 provides the best summary of the rules of interpretation of the *Restatement*.

25. *Id.* § 206.

26. *See* discussion *infra* Part I.D.

27. RESTATEMENT (SECOND) OF CONTRACTS § 202 cmt. a (1981).

28. Levin & Mazour, *supra* note 8, at 381 (advocating use of extrinsic evidence to interpret policy language).

29. *See* RESTATEMENT (SECOND) OF CONTRACTS §§ 203(b), 212 cmt. b (1981) ("But after the transaction has been shown in all its length and breadth, the words of an integrated agreement remain the most important evidence of intention").

performance, course of dealing, and usage of trade all weighed against the express terms, a meaning supported only by the express terms might not prevail.[30] In fact, section 202 addresses this potential conflict by advocating consistency between these four important factors.[31]

Further, by following the *Restatement*'s rules of interpretation, the ambiguity rule would still be upheld, because Section 206 would ensure that, when consideration of all the evidence cannot resolve an ambiguity, the meaning "which operates against the [drafter]" will be preferred.[32] In other words, if after working through the *Restatement*'s interpretive rules, the meaning of a policy term is still unclear, the traditional ambiguity rule would continue to safeguard the interests of the policyholder.

D. PRACTICAL EXAMPLE

One useful insurance coverage decision that follows the *Restatement*'s rules of interpretation is *Sunbeam Corp. v. Liberty Mutual Insurance Co.*[33] That decision considered the obligation to defend and indemnify policyholders for the costs of environmental liabilities that they had incurred.[34] At issue in *Sunbeam* was whether the terms "sudden and accidental," included in the exception to the qualified pollution exclusion, allowed coverage for pollution that occurred gradually and over a long period of time.[35] The insurance company argued, and the trial court and intermediate appellate court agreed, that the terms "sudden and accidental" were unambiguous and therefore no extrinsic evidence would be admitted to alter the asserted plain meaning of those terms.[36] Pursuant to that "plain" meaning, those lower courts held that the term "sudden" had a temporal connotation, which precluded coverage for a gradual release.[37]

To rebut that interpretation, the policyholders in *Sunbeam* attempted to introduce statements made by the insurance industry when it sought regulatory approval for the qualified pollution exclusion with its "sudden and accidental" language. The policyholders argued that the

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30. *See* Nanakuli Paving & Rock Co. v. Shell Oil Co., 664 F.2d 772 (9th Cir. 1981) (analyzing seeming conflict between express terms and usage of trade and finding that usage of trade controlled).

31. *See* RESTATEMENT (SECOND) OF CONTRACTS § 202(5) (1981).

32. *Id.* § 206.

33. 781 A.2d 1189 (Pa. 2001).

34. *Id.* at 1191.

35. *Id.* at 1192.

36. *Id.*

37. *Id.*

representations made by the insurance industry, concerning the scope of insurance coverage available under the "sudden and accidental" pollution exclusion, may evidence a "usage of trade"[38] in the insurance industry regarding the meaning of the phrase "sudden and accidental."[39]

The Supreme Court of Pennsylvania agreed with the policyholders, holding that "[i]n the law of contracts, custom in the industry or usage in trade is always relevant and admissible in construing commercial contracts and does not depend on any obvious ambiguity in the words of the contract."[40] Citing the *Restatement*, the court explained that the manifestations of intention of the parties should be interpreted as consistent with each other and with "any relevant course of performance, course of dealing, or usage of trade."[41] Further, the court relied on the *Restatement* to dispel the notion that ambiguity must be shown before extrinsic evidence, such as usage of trade, could be considered.[42] After considering relevant extrinsic evidence, the court ultimately held that the policyholders had provided sufficient evidence to show that the policy might provide coverage for both gradual and abrupt pollution incidents.[43] The court therefore remanded the case for further discovery concerning whether the terms "sudden and accidental" have a usage of trade in the insurance industry that does not carry with it a temporally abrupt meaning.

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38. For an overview of the concept of "usage of trade," see generally Roger W. Kirst, *Usage of Trade and Course of Dealing: Subversion of the UCC Theory*, 1977 U. ILL. L. REV. 811 (1977).

39. *See generally* Thomas Reiter, *The Pollution Exclusion Under Ohio Law: Staying the Course*, 59 U. CIN. L. REV. 1165, 1187-1203 (1991); Nancy Ballard & Peter Manus, *Clearing Muddy Waters: Anatomy of the Comprehensive General Liability Pollution Exclusion*, 75 CORNELL L. REV. 610, 622-27 (1990); Robert Chesler, *Patterns of Judicial Interpretation of Insurance Coverage for Hazardous Waste Site Liability*, 18 RUTGERS L.J. 9, 31-38 (1986); Richard Hunter, *The Pollution Exclusion in the Comprehensive General Liability Insurance Policy*, 1986 U. ILL. L. REV. 897, 903-06 (1986); E. Joshua Rosenkranz, Note, *The Pollution Exclusion Through the Looking Glass*, 74 GEO. L.J. 1237, 1241-53 (1986) (For more detailed discussions concerning the history of the adoption of the so-called "sudden and accidental" pollution exclusion).

40. Sunbeam Corp. v. Liberty Mut. Ins. Co., 781 A.2d 1189, 1193 (Pa. 2001).

41. *Id.* (citing RESTATEMENT (SECOND) OF CONTRACTS § 202(5) (1981)).

42. *Id.* (citing RESTATEMENT (SECOND) OF CONTRACTS § 220 cmt. d (1981)).

43. *Id.* at 1195. Notably, the dissent attacks this decision by implicitly relying on the traditional use of the ambiguity rule, explaining that "the words of an insurance policy are to be interpreted in their natural, plain, and ordinary sense, and only if the policy language is ambiguous is resort to be made to extrinsic evidence." *Id.* (Saylor, J., dissenting).

II. CONDITIONS AND PROMISES IN THE *RESTATEMENT*

A. THE "DELAYED NOTICE" PROBLEM[44]

The vast majority of insurance policies contain a provision that requires the policyholder to give notice to the insurance company of any claim or occurrence that is purported to be covered by the policy.[45] These provisions generally require notice to be given to the insurance company within a reasonable period of time from when the occurrence happens.[46]

Many courts and litigants assume that notice provisions are conditions precedent[47] to coverage and that strict compliance with them is required before coverage will obtain.[48] Under that view, any notice that is given beyond what a court construes to be "as soon as practicable," would be considered deficient and the insurance company would be completely excused from liability under the policy.

In general, most of the conditions in insurance policies are considered conditions precedent, and "the fulfillment of the condition by the

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44. Although this article focuses on notice provisions as alleged conditions precedent, other provisions, such as those requiring that a policyholder cooperate with an insurance company and those requiring a policyholder to provide a proof of loss, are also almost uniformly treated as conditions precedent and would similarly be subject to the within analysis; indeed, the "practical example" discussed below analyzes a proof-of-loss provision. For a thorough discussion of cooperation clauses as conditions, see KEETON & WIDISS, *supra* note 3, at 779-88. For a treatment of proof-of-loss provisions as conditions, see RICHARD L. LEWIS & NICHOLAS M. INSUA, BUSINESS INCOME INSURANCE DISPUTES § 8.02[C] (2006).

45. 16 SAMUEL WILLISTON & RICHARD A. LORD, A TREATISE ON THE LAW OF CONTRACTS § 49:109 (4th ed. 2000 & Supp. 2006); KALIS, *supra* note 2, § 24.02[A]. This discussion focuses only on occurrence-based insurance policies, as opposed to claims-made policies. In general, an occurrence-based policy requires notice of an occurrence, while a claims-made policy requires notice of claims made against the policyholder during a particular policy period.

46. WILLISTON & LORD, *supra* note 45, § 49:109.

47. The *Restatement* does not use the term "condition precedent," but instead uses the universal term "condition." RESTATEMENT (SECOND) OF CONTRACTS §§ 224 cmt. e, 230 cmt. a (1981). This terminology change has not yet taken hold, but in this Part of the Article both "conditions" and "conditions precedent" will have the same meaning. *See* Weiss v. Northwest Broad, Inc., 140 F. Supp. 2d 336, 343 n.4 (D. Del. 2001) (commenting on the change in the *Restatement*).

48. *See, e.g.*, Janjer Enterprises., Inc. v. Executive Risk Indem., Inc., 97 F.App'x 410 (4th Cir. 2004) (holding that a notice provision was a condition precedent which had to be strictly enforced despite the resultant denial of a policyholder's insurance coverage who had given notice of the claim within the policy period but outside the 60-day provision).

policyholder must occur before the insurance company becomes legally liable on the policy."[49] That general principle has not always been strictly applied to notice provisions, which is to say, courts will sometimes give a fair and functional interpretation to the "as soon as practicable" requirement. In fact, the majority of jurisdictions have interpreted notice provisions in occurrence-based insurance policies to require "reasonable notice under the circumstances," irrespective of any stated time limit.[50] When determining whether notice was reasonable, moreover, these courts consider only two factors: "the length of the delay in giving notice and the reasons."[51]

An additional requirement imposed by many jurisdictions is for the insurance company to prove that it was prejudiced by the delay from the late notice.[52] Some courts, however, do not require the insurance company to demonstrate this prejudice from the lack of timely notice.[53]

While the different approaches adopted by many jurisdictions can lead to equitable results, an analysis of the *Restatement* reveals a different framework. As this Section will discuss, the *Restatement* presents a variety of factors to be considered in determining whether notice under the policy was adequate, rather than simply considering the length of the delayed notice and the reason for it.[54] A thorough application of the *Restatement*'s

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49. WILLISTON & LORD, *supra* note 45, § 49:87.

50. *Id.* § 49:109.

51. *Id.*; *see, e.g.*, U.S. Fid. & Guar. Co. v. Baldwin County Home Builders Ass'n, Inc., 770 So. 2d 72 (Ala. 2000).

52. WILLISTON & LORD, *supra* note 45, § 49:109; *see also* ALLAN D. WINDT, INSURANCE CLAIMS AND DISPUTES § 1.4 (4th ed. 2001) (noting split in authority between jurisdictions not requiring prejudice, those requiring policyholders to demonstrate prejudice, and jurisdictions requiring insurance companies to demonstrate prejudice, noting that "[t]his latter rule is followed in most states"); JEFFREY W. STEMPEL, STEMPEL ON INSURANCE CONTRACTS § 9.01[I] (3d ed. 2006) (discussing how prejudice rules for notice provisions sometimes vary in respect of what party bears the burden to demonstrate prejudice, but observing that "in a nontrivial number of cases, allocation of the burden of proof probably has little practical effect"); KALIS ET AL., *supra* note 2, § 24.02[G]. The prejudice requirement as applied to cooperation clauses is discussed in KEETON & WIDISS, *supra* note 3, § 7.3(b) & (c).

53. WILLISTON & LORD, *supra* note 45, § 49:109. *See generally* ANDERSON ET AL., *supra* note 3, § 5.04 (listing jurisdictions that apply the "modern rule," which requires showing of prejudice, versus the "old rule," which does not in all circumstances require prejudice). As of its 2006 supplement, Anderson counts eleven jurisdictions in which some form of the "old rule" persists: Alabama, Arkansas, Colorado, District of Columbia, Georgia, Illinois, Nevada, New York, Ohio, Virginia, and Wisconsin. *Id.*

54. *See infra* Part II.B-C.

framework to a particular set of facts can thereby avoid the harsh results of failing strictly to comply with conditions precedent.

B. THE RELEVANT *RESTATEMENT* SECTIONS

Under section 224 of the *Restatement*, a condition precedent "is an event, not certain to occur, which must occur, unless its non-occurrence is excused, before performance under a contract becomes due."[55] In other words, a condition precedent must be satisfied before one of the parties is required to render its performance. Rather than mandating strict compliance with such conditions, the *Restatement* counsels courts to "excuse the non-occurrence" of a condition to the extent that it "would cause disproportionate forfeiture...unless its occurrence was a material part of the agreed exchange."[56]

The *Restatement* also describes promises to exchange performance, which "are often called constructive conditions of exchange."[57] Courts have applied the "flexible requirement of substantial performance" to constructive conditions of exchange, and that requirement stands in sharp contrast to the requirement of strict compliance" with express conditions.[58] The principle of substantial performance is articulated in the *Restatement (Second) of Contracts* as the converse of an "uncured material failure... to render... such performance."[59] Thus, "[t]he considerations in determining whether performance is substantial are those listed in [*Restatement (Second) of Contracts*] § 241 for determining whether a failure is

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55. RESTATEMENT (SECOND) OF CONTRACTS § 224 (1981).

56. *Id.* § 229.

57. E. ALLAN FARNSWORTH, CONTRACTS 579 (1982) (emphasis omitted). Farnsworth traces constructive conditions back to the decision of Lord Mansfield in "the great case of *Kingston v. Preston*, [99 Eng. Rep. 437 (K.B. 1773)]." *Id.* at 577. *See also* RESTATEMENT (SECOND) OF CONTRACTS § 237 cmt. a (1981) (describing exchange of promises to perform in the Second Restatement § 237 as "constructive conditions of exchange"). As another commentator put it, "prior to *Kingston v. Preston*, decided by King's Bench in 1773, the law evidently lacked a constructive conditions doctrine and instead treated the parties' promises as independently enforceable." MARVIN A. CHIRLESTEIN, CONCEPTS AND CASE ANALYSIS IN THE LAW OF CONTRACTS 104 (1990).

58. FARNSWORTH, *supra* note 57, at 590-91.

59. RESTATEMENT (SECOND) OF CONTRACTS § 237 (1981); *see also id.* § 237 cmt. d (stating that the rule of substantial performance is substantively identical to the rule set forth in section 237 of the Second Restatement).

material."[60] Substantial performance of a promise *per se* cannot be a material failure of such performance.[61]

When determining whether an insurance policy, or contract, contains a condition precedent, the *Restatement* explains that "[a]n intention to make a duty conditional may be manifested by the general nature of an agreement, as well as by specific language."[62] One must answer a basic question of interpretation, and consideration is given to the language of the parties' agreement and the context in which their agreement was made.[63] Although there are no rigid rules for determining whether a contract provision creates a condition precedent,[64] there is a preference of interpretation to resolve doubts about whether a provision creates a duty or condition in favor of finding that the event imposes a duty "on an obligee that an event occur," rather than a condition.[65]

There are, however, some practical and common-sense methods of drafting provisions to be conditions precedent. Words such "as 'on condition that,' 'provided that' and 'if' are often used" to create a condition.[66] Some contracts explicitly label a provision a "condition

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60. RESTATEMENT (SECOND) OF CONTRACTS § 237 cmt. d (1981).

61. For an excellent discussion of constructive conditions of exchange and the concomitant doctrine of substantial performance in the law of contracts generally, see FARNSWORTH, *supra* note 57, at 576-96. *See also* JOHN D. CALAMARI & JOSEPH M. PERILLO, CONTRACTS 455-85 (3d ed. 1987) (discussing constructive conditions and substantial performance).

62. RESTATEMENT (SECOND) OF CONTRACTS § 226 (1981).

63. Blitz v. Subklew, No. CV187171T, 2001 WL 1002714, at *2 (Conn. Super. Ct. Aug. 9, 2001); Am. Original Corp. v. Legend, Inc., 689 F. Supp. 372, 378 (D. Del. 1988); Marker v. United States, 646 F. Supp. 433, 436 (D. Del. 1986).

64. *See* SLMSoft.com, Inc. v. Cross Country Bank, No. Civ. A. 00C09163JRJ, 2003 WL 1769770, at *12 (Del. Super. Ct. Apr. 2, 2003) (quoting RESTATEMENT (SECOND) OF CONTRACTS § 226 cmt. a (1981)) (stating that whether language creates condition "is determined by the process of interpretation"); Feinberg v. Berglewicz, 632 A.2d 709, 711 (Conn. App. 1993) (citing RESTATEMENT (SECOND) OF CONTRACTS § 226 (1981)); Blitz v. Subklew, 810 A.2d 841, 845 (Conn. App. 2002) (stating that "[w]hether a provision in a contract is a condition the nonfulfilment of which excuses performance depends upon the intent of the parties, to be ascertained from a fair and reasonable construction of the language used in the light of all the surrounding circumstances when they executed the contract"). Thus, "the purpose of the parties is given great weight . . .and, in choosing between reasonable meanings, that meaning is generally preferred which operates against the draftsman." RESTATEMENT (SECOND) OF CONTRACTS § 226 cmt. a (1981).

65. RESTATEMENT (SECOND) OF CONTRACTS § 227(2)(a) (1981) *quoted in SLMSoft.com*, 2003 WL 1769770, at *13.

66. *SLMSoft.com*, 2003 WL 1769770, at *12 n.80 (quoting RESTATEMENT (SECOND) OF CONTRACTS § 226 cmt. a (1981). *Accord* Munson v. Strategis Asset Valuation & Mgmt., Inc., 363 F. Supp. 2d 1377, 1382 (N.D. Ga. 2005) (stating that "[i]n the absence of an

precedent."[67] If the parties' contract contains a part or section entitled "Conditions," the parties might express their intent to make an event a condition precedent by placing any language or provisions concerning that event in that "Conditions" part or section. Still other contracts may combine some of these methods, such as in an insurance policy, by delineating a separate section entitled "Notice," and in it asserting that reporting a claim within a certain period of time is a "condition precedent" to coverage. Although "there is no requirement that such phrases be utilized, their absence is probative of the parties' intention that a promise be made rather than a condition imposed."[68]

Section 237 of the *Restatement* then states that the key difference between promises to exchange performance and conditions precedent is the concept of substantial performance:

> [I]f...the parties have made an event a condition of their agreement, there is no mitigating standard of materiality or substantiality applicable to the non-occurrence of that event. If, therefore, the agreement makes full performance a condition, substantial performance is not sufficient and if relief is to be had under the contract, it must be through excuse of the non-occurrence of that condition to avoid forfeiture.[69]

As the *Restatement* explains, "[t]he considerations in determining whether performance is substantial are [the same as] those listed in § 241 for determining whether a failure is material."[70] Accordingly, section 241 of the *Restatement* enumerates the factors to be considered in determining whether a failure of performance is substantial:

> (a) the extent to which the injured party will be deprived of the benefit which he reasonably expected;

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indication to the contrary, words such as 'provided,' 'if,' and 'on condition that' in a contract create a condition precedent") (citation omitted).

67. *Cf. SLMSoft.com*, 2003 WL 1769770, at *12 (stating that conditions precedent also can be created by "some other phrase that conditions performance").

68. *Id.*

69. RESTATEMENT (SECOND) OF CONTRACTS § 237 cmt. d (1981).

70. *Id.*

> (b) the extent to which the injured party can be adequately compensated for the part of that benefit of which he will be deprived;
> (c) the extent to which the party failing to perform or to offer to perform will suffer forfeiture;
> (d) the likelihood that the party failing to perform or to offer to perform will cure his failure, taking account of all the circumstances including any reasonable assurances;
> (e) the extent to which the behavior of the party failing to perform or to offer to perform comports with standards of good faith and fair dealings.[71]

The *Restatement* further provides, in section 227, a preference for resolving doubts about whether a provision creates a duty or condition in favor of finding that the event imposes a duty "on an obligee that an event occur," rather than a condition.[72] This means that in situations where it is a close question, a provision will be interpreted to create a promise to exchange performance rather than a condition precedent.

C. POTENTIAL APPLICATION OF THE *RESTATEMENT* TO ADDRESS THE "DELAYED NOTICE" PROBLEM

Courts could benefit greatly from adopting the *Restatement*'s approach for use in interpreting insurance policy notice provisions. As a first step in the analysis, the *Restatement* would aide a court's determination regarding whether the notice provision was a condition precedent or a promise to exchange performance.[73] In addition to providing the general methodology for making that determination, the *Restatement* further provides a preference of interpretation, in section 227, that courts could employ for close questions.[74]

Once a determination is made regarding whether the notice provision is a condition precedent or a promise to exchange performance, the interpretive analysis branches off into two paths. On the first of those paths, if the provision is determined to be a condition precedent, then the court should make a determination concerning whether the failure to

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71. *Id.* § 241.
72. *Id.* § 227(2)(a).
73. *See id.* § 226.
74. *See id.* § 227.

comply with that provision is excused in accordance with section 229 of the *Restatement.* The court should decide whether strict compliance with the condition precedent would result in "disproportionate forfeiture."[75] If the result is not "disproportionate forfeiture," the condition might be strictly enforced, supporting a denial of coverage for the policyholder.[76] This path is especially dangerous to policyholders in jurisdictions that do not apply the notice-prejudice rule or in courts that, despite the notice-prejudice rule, will find prejudice "as a matter of law" based not on whether actual prejudice was sustained but on whether a specific time period of delayed notice is just too much for the court to stomach.

The second path presents itself when the provision is determined to be a promise to exchange performance. In that situation, the court should consider the factors outlined in section 241 of the *Restatement*[77] and determine whether the obligation in the notice provision has been "substantially performed."[78] Unlike conditions precedent, however, a policyholder could prevail on a promise to perform without demonstrating that a "disproportionate forfeiture" would result from its failure technically to comply with the notice provision.

D. PRACTICAL EXAMPLE

In *Hartford Fire Insurance Co. v. Himelfarb*, the policyholders sought coverage under a first-party property policy for loss arising from the theft of personal property in which the policyholders had a security interest.[79] Although not a decision concerning a notice provision, *Himelfarb* did address another common provision frequently considered a condition by courts and litigators – the provision requiring the policyholder to file a proof of loss within a particular time period.

In *Himelfarb*, the policyholders leased a warehouse and, as part of the transaction, loaned $100,000 to the tenants for tenant improvements and to

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75. *See* RESTATEMENT (SECOND) OF CONTRACTS § 229 (1981). As the *Restatement* explains, the rule is "a flexible one, and its application is within the sound discretion of the court." *Id.* § 229 cmt. b.

76. This outcome would comport with the expressed written intentions of the parties, while at the same time permitting consideration of external factors.

77. *See supra* text accompanying note 71.

78. RESTATEMENT (SECOND) OF CONTRACTS § 237 cmt. d (1981).

79. 736 A.2d 295, 295 (Md. 1999). Although not insurance decisions, both *Luttinger v. Rosen*, 316 A.2d 757 (Conn. 1972) and *Burger King Corp. v. Family Dining, Inc.*, 426 F. Supp. 485 (E.D. Pa. 1977) deal with this issue as well, with each coming to the opposite conclusion – *Luttinger* found a condition, while *Burger King* found a promise to perform.

purchase equipment. The loan was secured by certain contents of the tenants in the warehouse.[80]

The tenants thereafter went bankrupt, but before the policyholders could move on their secured property, it was stolen.[81] The theft occurred on November 19, 1994. The policyholders gave notice of a claim in late 1994 or early 1995.[82]

The policy in *Himelfarb* required the policyholders to provide a proof of loss, among other things, in the event of a loss as follows:

> E. LOSS CONDITIONS
> The following conditions apply in addition to the Common Policy Conditions and the Commercial Property Conditions.
> ....
> 3. Duties In The Event Of Loss Or Damage
> a. You must see that the following are done in the event of loss or damage to Covered Property:
> ....
> (7) Send us a signed, sworn proof of loss containing the information we request to investigate the claim. You must do this within 60 days after our request. We will supply you with the necessary forms.
> 4. Loss Payment
> ....
> (f) We will pay for covered loss or damage within 30 days after we receive the sworn proof of loss, if:
> (1) You have complied with all of the terms of this Coverage Part; and
> (2)(a) We have reached agreement with you on the amount of loss; or
> (b) An appraisal award has been made.[83]

In November 1995, the policyholders provided a "Compliance Proof" to the insurance company, in compliance with the policy's requirement to provide a proof of loss, and reserved their right to submit an amended proof as new information became available.[84] The insurance company stated that

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80. *Himelfarb*, 736 A.2d at 297.
81. *Id.* at 298.
82. *Id.*
83. *Id.*
84. *Id.* at 298.

the Compliance Proof was deficient, and did not pay the claim.[85] The policyholders disagreed, stating that the Compliance Proof complied with both the 60-day timing requirement of the policy and provided all information that was available at that time.[86] The policyholders supplemented their Compliance Proof with additional information in June 1996.[87] When the insurance company continued to refuse to pay, the policyholders sued on the claim.[88]

The insurance company argued that the original proof did not have the required information, and the subsequent proof was late.[89] The court rejected the insurance company's argument, and its crisp reasoning is worth excerpting in detail:

> Provisions in insurance policies are to be interpreted like those of any other contract....Looking first to the language of the Policy, Hartford relies on the introduction of Part E in the Personal Property Coverage form, headed, "LOSS CONDITIONS." It introduces seven subparts with this language: "The following conditions apply in addition to the Common Policy Conditions and the Commercial Property Conditions." The seven subparts are: "1. Abandonment," "2. Appraisal," "3. Duties In The Event Of Loss Or Damage," "4. Loss Payment," "5. Recovered Property," "6. Vacancy," and "7. Valuation." In our view Hartford undertakes to read too much into the introduction to Part E. Each provision in Part E is not a condition precedent to Hartford's performance. For example, included in Part E is subpart 4 dealing with loss payments. Paragraph 4.a. provides that Hartford at its option either will pay the value of lost or damaged property or the cost of repair or replacement. Payment by Hartford clearly is not a condition precedent to Hartford's obligation to pay. Similarly in ¶ 4.e the policy provides that Hartford, at its expense, "may elect to defend [the insured] against suits arising from claims of owners of property." Surely the obligation of Hartford to pay an otherwise proper claim is not extinguished unless a

85. Hartford Fire Ins. Co. v. Himelfarb, 736 A.2d 295, 299 (Md. 1999).
86. *Id.*
87. *Id.*
88. *Id.*
89. *Id.*

claim is made against the insured by an owner and unless Hartford elects to defend that claim. The use of the term "conditions" in the introduction to Part E of the policy is ambiguous.

> "The question whether a stipulation in a contract constitutes a condition precedent is one of construction dependent on the intent of the parties to be gathered from the words they have employed and, in case of ambiguity, after resort to the other permissible aids to interpretation. Although no particular form of words is necessary in order to create an express condition, such words and phrases as 'if' and 'provided that,' are commonly used to indicate that performance has been expressly made conditional as have the words 'when,' 'after,' 'as soon as,' or 'subject to.'"

Chirichella v. Erwin, 270 Md. 178, 182, 310 A.2d 555, 557 (1973) (citations omitted).

Under ordinary rules of construction the use of the term "conditions" in the introduction to Part E must be read compatibly with Part E in its entirety. To do so, "conditions" must be read as "terms" or "provisions," any one of which, in turn, may be either an express condition or may be a covenant. If the latter, the provision makes the obligation of Hartford to perform subject to the implied condition of substantial performance.

Directing attention to whether ¶ E.3.a(7) is a condition or a covenant, it is first to be noted that the provision does not contain any of the words ordinarily used to create an express condition. Nor does it expressly effect a forfeiture for failure of the condition. The language of ¶ E.3.a(7) imposes a duty on the insured. Under these circumstances construction of ¶ E.3.a(7) as a covenant, rather than an express condition, is the preferred construction. *See Beckenheimer's Inc. v. Alameda Assocs. Ltd. Partnership,* 327 Md. 536, 554-55, 611 A.2d 105, 113-14 (1992); *New York Bronze Powder Co. v. Benjamin Acquisition Corp.,* 351 Md. 8, 17, 716 A.2d 230, 234 (1998) (applying New York law); Restatement (Second) of Contracts § 227(2) (1981).

In *Beckenheimer's* we quoted comment *d* to Restatement § 227(2) in explanation of the preference:

> "'*Condition or duty.* When an obligor wants the obligee to do an act, the obligor may make his own duty conditional on the obligee doing it and may also have the obligee promise to do it. Or he may merely make his own duty conditional on the obligee doing it. Or he may merely have the obligee promise to do it...It may not be clear, however, which he has done. The rule in Subsection (2) states a preference for an interpretation that merely imposes a duty on the obligee to do the act and does not make the doing of the act a condition of the obligor's duty. The preferred interpretation avoids the harsh results that might otherwise result from the non-occurrence of a condition and still gives adequate protection to the obligor under the rules ... relating to performances to be exchanged under an exchange of promises. Under those rules ... the obligee's failure to perform his duty has, if it is material, the effect of the non-occurrence of a condition of the obligor's duty. Unless the agreement makes it clear that the event is required as a condition, it is fairer to apply these more flexible rules. The obligor will, in any case, have a remedy for breach.'"

327 Md. at 555, 611 A.2d at 114.

An express condition precedent to Hartford's obligation to pay is found in ¶ E.4.f, reading in part: "[Hartford] will pay for covered loss ... after we receive the sworn proof of loss, if ... [the insured has] complied with all of the terms of this Coverage Part." Thus, Hartford is under no obligation to pay until it has received the sworn proof of loss. But, if the Himelfarbs "have complied with all of the terms of" Part E, then Hartford "will pay for covered loss." With respect to the sole issue before us, the effect of the time limit in ¶ E.3.a(7), it suffices that compliance within that time be substantial.[90]

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90. *Id.* at 300-01.

The court then surveyed other Maryland decisions that generically held that substantial performance satisfied proof-of-loss requirements; however, its analysis of the *Restatement*'s distinction between conditions and promises is one of the more rigorous found in insurance jurisprudence and would apply with equal force to any asserted "conditions precedent" to coverage, such as notice provisions.

III. REMEDIES IN THE *RESTATEMENT*

A. THE "CONSEQUENTIAL DAMAGES" PROBLEM

When a company without insurance coverage suffers a catastrophe, that company may lose customers and profits, and even could go out of business altogether. That disastrous possibility is most likely one of the main reasons why many companies purchase insurance coverage in the first place.

In many cases, courts and litigants assume that the only recovery available when an insurance company breaches an insurance policy is the face amount of the policy (*i.e.*, the policy limit).[91] In those cases, while the affected policyholder holds a valid insurance policy that should be paid, some insurance companies try to force a settlement, or deny payment on the policy outright.[92] Such insurance companies reason that if the damages cannot exceed the face amount of a policy with interest, it is far more financially advantageous for the insurance company to engage in abusive delay rather than prompt payment.[93] Indeed, if commercial interest rates are higher than the legal interest rate, the insurance company will profit

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91. *See, e.g., In re* Payroll Express Corp., 921 F. Supp. 1121, 1125 (S.D.N.Y. 1996) ("Damages for a first party claim by an insured against its own insurer are generally limited to the face amount of the policy, plus appropriate interest"); Spencer v. Aetna Life & Cas. Ins. Co., 611 P.2d 149, 151 (Kan. 1980) (explaining that traditional rule limited policyholder to remedies at face amount of policy plus interest).

92. *See, e.g.*, Fletcher v. W. Nat'l Life Ins. Co., 10 Cal. App. 3d 376, 392 (Cal. Ct. App. 1970) (finding that defendant insurance company conceded that its "malicious and bad faith refusal to pay plaintiff's legitimate claim" was "deplorable" and "outrageous," and yet when asked by court whether insurance company would conduct same routine in the future the answer was unequivocally affirmative); Reichert v. Gen. Ins. Co., 442 P.2d 377 (Cal. 1968).

93. *See* Phyllis Savage, *The Availability of Excess Damages for Wrongful Refusal to Honor First Party Insurance Claims – An Emerging Trend,* 45 FORDHAM L. REV. 164, 166 (1972) ("At best, the company may be able to avoid the payment entirely. At worst, it will have to pay its original obligation plus interest"); Earth Scientists (Petro Services) Ltd. v. U.S. Fid. & Guar. Co., 619 F. Supp. 1465 (1985).

from the difference.[94] The possibility is particularly acute in jurisdictions where awards of prejudgment interest are discretionary.[95]

An insurance company's decision to breach its contract, and "run for cover rather than coverage,"[96] generates the same loss of customers, profits, or even business, to an affected company as when that company is uninsured.[97] To combat these practices, many jurisdictions have "[permitted] insurance claimants to recover amounts in excess of policy limits plus interest."[98] However, in the "majority of jurisdictions, the policyholder cannot recover consequential damages for breach of a first-party insurance policy where there has been no finding that the insurance company acted in bad faith."[99]

The determination of what constitutes bad faith varies by jurisdiction, but could include "(1) an insurance company's rejection of a claim even though it clearly has a legal obligation to pay, (2) an insurance company's failure to properly investigate a claim and refusal to pay a claim without a reasonable basis for doing so, and (3) deliberate and abusive conduct by an insurance company in an attempt to force the policyholder to settle for an amount far below what is reasonable."[100] As this part of the Article will explain, the *Restatement* can aid the analysis of such claims by providing

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94. Savage, *supra* note 93, at 167. *See also* Bibeault v. Hanover Ins. Co., 417 A.2d 313, 318 (R.I. 1980) ("when the legal rate of interest is lower than the commercial rate, an unscrupulous insurance company would be wise to delay payment for the maximum period of time").

95. *See, e.g.*, Tupelo Redevelopment Agency v. Abernathy, 913 So. 2d 278, 286 (Miss. 2005) (stating that "where there is no provision in the parties' contract concerning payment of interest, the law in Mississippi regarding an award of prejudgment interest is clear. Such an award is discretionary with the trial judge but is available only if the money due was liquidated and there was no legitimate dispute that the money was owed").

96. This phrase comes from the case of *Sandoz, Inc. v. Employer's Liab. Assurance Corp.*, 554 F. Supp. 257, 258 (D.N.J. 1983).

97. *See* Indiana Ins. Co. v. Plummer Power Mower & Tool Rental, Inc., 590 N.E.2d 1085, 1092 (Ind. Ct. App. 1992) (explaining that "[d]elayed payment, whether as a result of good or bad faith, will undoubtedly result in the failure of the owner's business. He cannot generate sufficient income to pay his bills because he has no business").

98. *Id.*

99. George J. Kenny & John H. Denton, *First-Party Actions: Loss Suffered by a Policyholder – Nature of Action: Recovery for Breach of Contract*, 2 LAW & PRAC. INS. COVERAGE LITIG. § 27:2 (2005).

100. Chris M. Kallianos, *Bad Faith Refusal to Pay First-Party Insurance Claims: A Growing Recognition of Extra-Contract Damages*, 64 N.C. L. REV. 1421, 1437 n.19 (1986).

an invaluable tool for arguing that consequential damages may be available even without a showing of bad faith conduct.[101]

B. THE RELEVANT *RESTATEMENT* SECTIONS

Section 344 of the *Restatement* details the three interests that contract remedies are designed to protect:

> Judicial remedies under the rules stated in this Restatement serve to protect one or more of the following interests of a promisee:
>
> (a) his "expectation interest," which is his interest in having the benefit of his bargain by being put in as good a position as he would have been in had the contract been performed,
>
> (b) his "reliance interest," which is his interest in being reimbursed for loss caused by reliance on the contract by being put in as good a position as he would have been in had the contract not been made, or
>
> (c) his "restitution interest," which is his interest in having restored to him any benefit that he has conferred on the other party.[102]

The most commonly protected is the expectation interest.[103] According to the official comment to section 344, the expectation interest protects a non-breaching party by "attempting to put him in as good a position as he

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101. The *Restatement* is not the only source that supports the recovery of consequential damages for breaches of contract. *See, e.g.*, 5 ARTHUR CORBIN, CONTRACTS § 1076; Richard J. Faletti, *Breach, Repudiation and Damages in Contract Litigation: Legal and Economic Theory*, 1954 U. ILL. L. REV. 615, 632-36; KEETON & WIDISS, *supra* note 3, § 7.9(d)-(e); FARNSWORTH, *supra* note 57, at 858-88.

102. RESTATEMENT (SECOND) OF CONTRACTS § 344 (1981); *see also* ATACS Corp. v. Trans World Commc'ns., Inc., 155 F.3d 659, 669 (3d Cir. 1998) (explaining that "[i]n general, contract law espouses three distinct, yet equally important, theories of damages to remedy a breach of contract: 'expectation' damages, 'reliance' damages, and 'restitution' damages"). As stated in the Reporter's Note, section 344 of the Restatement is new and is based on a seminal article dividing remedies for breach of contract into those that protect the expectation, reliance and restitution interest. *See* L.L. Fuller & William R. Perdue, *The Reliance Interest in Contracts Damages: 1*, 46 YALE L.J. 52, 53-54 (1936).

103. *See ATACS Corp.*, 155 F.3d at 669.

would have been in had the contract been performed, that is, had there been no breach."[104] It is from the expectation interest that consequential damages flow. According to section 347:

> Subject to the limitations stated in §§ 350-53, the injured party has a right to damages based on his expectation interest as measured by
>
> (a) the loss in the value to him of the other party's performance caused by its failure or deficiency, plus
> (b) any other loss, including incidental or consequential loss, caused by the breach, less
> (c) any cost or other loss that he has avoided by not having to perform.[105]

The official comment to section 347 explains that the calculation of the expectation interest "requires a determination of the values...to the injured party himself, and not their values to some hypothetical reasonable person or on some market."[106]

Despite the inherently subjective nature of expectation damages, their determination relies on objective criteria and the *Restatement* sets forth several requirements that limit their applicability. The first of these requirements, that of mitigation, is outlined in section 350 of the *Restatement* and requires a non-breaching party to avoid any loss caused by the breach that could be mitigated by reasonable efforts.[107] A second requirement, that of forseeability, is outlined in section 351 of the *Restatement*:

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104. RESTATEMENT (SECOND) OF CONTRACTS § 344 cmt. a (1981).
105. *Id.* § 347.
106. *Id.* § 347 cmt. b.
107. *Id.* § 350 cmt b. Section 350 of the *Restatement* provides:

> (1) Except as stated in Subsection (2), damages are not recoverable for loss that the injured party could have avoided without undue risk, burden or humiliation.
> (2) The injured party is not precluded from recovery by the rule stated in Subsection (1) to the extent that he has made reasonable but unsuccessful efforts to avoid loss.

Farnsworth calls this requirement the "limitation of avoidability." FARNSWORTH, *supra* note 57, § 12.12, at 868; *see also id.* at 859 (stating that limitation of avoidability is sometimes conceived as placing on "the injured party . . . a 'duty' to take appropriate steps to mitigate damages").

> (1) Damages are not recoverable for loss that the party in breach did not have reason to foresee as a probable result of the breach when the contract was made.
> (2) Loss may be foreseeable as a probable result of a breach because it follows from the breach
>
> (a) in the ordinary course of events, or
>
> (b) as a result of special circumstances, beyond the ordinary course of events, that the party in breach had reason to know.
>
> (3) A court may limit damages for foreseeable loss by excluding recovery for loss of profits, by allowing recovery only for loss incurred in reliance, or otherwise if it concludes that in the circumstances justice so requires in order to avoid disproportionate compensation.[108]

The requirement of foreseeability requires damages to be reasonably foreseeable as a probable result of breach at the time the contract is made.[109] Finally, a third requirement of certainty mandates that, in addition

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108. RESTATEMENT (SECOND) OF CONTRACTS § 351 (1981).

109. *See id.* The foreseeability requirement stems from the classic rule of *Hadley v. Baxendale*, 156 Eng. Rep. 145 (1854). *See* FARNSWORTH, *supra* note 57, § 12.14, at 873 (calling *Hadley* "[t]he fountainhead of the limitation of foreseeability"). In *Hadley*, the plaintiffs were millers whose mill stopped because "of a breakage [of the shaft] by which the mill was worked." *Hadley*, 156 Eng. Rep. at 147. The defendants contracted to carry the broken shaft to the engineers of the mill to be used as a pattern for the replacement. The plaintiffs advised the defendants that the shaft was needed for the mill to run, but the defendants did not deliver the broken shaft at the time promised; as a result, the plaintiffs could not open their mill and "thereby lost the profits they would otherwise have received." *Id.*

On appeal, the court held that the damages that a non-breaching party should receive are those that naturally flow from the breach, or that reasonably were in the contemplation of the parties are the time the contract was made:

> Where two parties have made a contract which one of them has broken, the damages which the other party ought to receive in respect of such breach of contract should be such as may fairly and reasonably be considered either arising naturally, i.e. according to the usual course of things, from such breach of contract itself, or such as may reasonably be supposed to have been in the contemplation of both parties at the time they made the contract, as the probable result of the breach of it.

Id. at 151. The court opined that whether damages were reasonably within the contemplation of the parties at the time of contracting depended, in part, on whether, at that time, special circumstances of the non-breaching party were communicated to the breaching

to being reasonably foreseeable, the damages resulting from the breach must be established with reasonable certainty from the evidence.[110]

C. POTENTIAL APPLICATION OF THE *RESTATEMENT* TO ADDRESS THE "CONSEQUENTIAL DAMAGES" PROBLEM

The *Restatement* addresses the "consequential damages" problem in several important ways. First, the application of the *Restatement* dispels the notion that the measure of damages would be limited to the face amount of an insurance policy.[111] The remedies envisioned by the *Restatement*

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party. If such special circumstances were not known to the breaching party, damages corresponding to such circumstances could not be obtained:

> Now, if the special circumstances under which the contract was actually made were communicated by the plaintiffs to the defendants, and thus known to both parties, the damages resulting from the breach of such contract, which they would reasonably contemplate, would be the amount of injury which would ordinarily follow from a breach of contact under these special circumstances. But, on the other hand, if these special circumstances were wholly unknown to the party breaking the contract, he, at the most, could only be supposed to have had in his contemplation the amount of injury which would arise generally, and in the great multitude of cases not affected by any special circumstances, from such a breach of contract. For, had the special circumstances been known, the parties might have specially provided for the breach of contract by special terms as to the damages in that case; and of this advantage it would be very unjust to deprive them.

Id.; see also CHIRELSTEIN, *supra* note 57, at 153 (stating that "the foreseeability doctrine creates what has been described as 'an implicit duty to premitigate' because the non-breaching party often "[i]s in the best position (prospectively) to minimize damages") (citations omitted); CALAMARI & PERILLO, *supra* note 61, at 594 (remarking that *Hadley* "was cleary based on the policy of protecting enterprises in the then burgeoning industrial revolution").

110. See RESTATEMENT (SECOND) OF CONTRACTS § 352 (1981), which provides that "[d]amages are not recoverable for loss beyond an amount that the evidence permits to be established with reasonable certainty." *Accord* FARNSWORTH, *supra* note 57, at 881-88; CHIRELSTEIN, *supra* note 57, at 158-60. For cases addressing the certainty requirement, see *Locke v. United States*, 283 F.2d 521 (Ct. Cl. 1960) and *Kenford Co., Inc. v. County of Erie*, 493 N.E.2d 234 (N.Y. 1986).

111. Even insurance industry commentators agree that consequential damages are always potentially available for breach of an insurance policy, and that the decisions holding that the only damages allowed for a breach of an insurance policy are the amount of the recovered loss, plus interest, are incorrect:

> The general measure of damages available for breach of a contract to pay money is the amount due, plus interest. There is language in a few cases, therefore, indicating that an insurer, following its breach of

attempt to put a non-breaching party in as good a position as if the contract had not been breached.[112] If a policyholder's business suffers a catastrophe, its insurance company refuses to pay the claim, and the business consequently becomes bankrupt, the payment of the face amount of the insurance policy may not return the policyholder to as good of a position as it would have enjoyed had the policy not been breached.

Second, the *Restatement* provides a useful framework for courts to employ when calculating a non-breaching party's expectation interest.[113] For all intents and purposes, section 347 of the *Restatement* reads like a mathematical formula, detailing precisely how the expectation interest should be calculated.[114] When using section 347, courts would add together the loss in value of the breaching party's performance and "any other loss, including incidental or consequential loss, caused by the breach."[115] The courts would then subtract from the resulting amount the value of any cost or other loss that the non-breaching party no longer had to perform.[116] While those values will not always be easily ascertainable, the *Restatement* assists courts by providing the formula in which they will be included once they have been determined.

The formula itself is explained by the several sections of the *Restatement* that have been quoted above.[117] Following those sections, a court that adopted the *Restatement* in its analysis would need to consider whether the non-breaching party had made sufficient efforts to mitigate the

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> contract, is liable only for the amount of policy benefits owed, plus interest. The dicta in those cases, however, do not accurately represent the law. *Absent a statute to the contrary, consequential damages are, in fact, always available in contract actions if they arise naturally from the breach and are such that they may reasonably be supposed to have been in the contemplation of the parties at the time the contract was made.* The courts that have expressly considered the issue, therefore, have consistently recognized that, under certain circumstances, the foregoing test might be met in an action against the insurance company.

WINDT, *supra* note 52, at 374-75 (emphasis added) (citations omitted). *See also* ANDERSON, *supra* note 3, at 11-102 (discussing recovery of consequential damages as "breach-of-contract damages, distinct from any bad-faith recovery, and without regard to policy limits"); *id.* § 11.13[I] n.391 (collecting cases).

112. *See* RESTATEMENT (SECOND) OF CONTRACTS § 344 cmt. a (1981).

113. *See id.* § 347.

114. *Id.*

115. *Id.*

116. *Id.*

117. RESTATEMENT (SECOND) OF CONTRACTS §§ 350-2 (1981). *See supra* Part III.B.

damages resulting from a breach.[118] The requirement of mitigation would be helpful to ensure that the policyholders took reasonable steps to minimize the damages that resulted from the breach. This requirement offers the dual benefit of avoiding needless compounding of damages, while protecting the interests of the non-breaching party by only requiring efforts that do not cause "undue risk, burden, or humiliation."[119]

The *Restatement* would also be used to determine whether the consequential damages claimed by the policyholder were reasonably foreseeable at the time the insurance contract was formed.[120] As guidance in this determination, the *Restatement* explains that losses are foreseeable if they follow from the breach in either "the ordinary course of events," or from special circumstances that the breaching party had reason to know.[121] If either of those conditions were met, the damages would be foreseeable and therefore recoverable by the non-breaching party.

The *Restatement*'s final requirement is that the damages sought be demonstrated "with reasonable certainty" from the evidence.[122] If the evidence does not prove the amount of damages with certainty, the non-breaching party will be unable to recover. On the other hand, if the evidence is sufficiently certain, it will serve the purpose of the expectation interest by placing the policyholder in the position it would have been in but for the breach.

D. PRACTICAL EXAMPLE

The case of *Royal College Shop, Inc. v. Northern Insurance Company of New York* provides an excellent example of how some of the *Restatement*'s principles for consequential damages could be applied in practice.[123] In *Royal College*, after the plaintiffs suffered a fire loss that closed their shoe store, they filed a timely proof of loss with their insurance company.[124] The insurance policy covered loss of the building, personal property, and inventory, *as well as* the "loss of earnings resulting from the

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118. *See* RESTATEMENT (SECOND) OF CONTRACTS § 350 (1981).
119. *Id.*
120. *See id.* § 351.
121. *Id.*
122. *Id.* § 352.
123. *See* Royal Coll. Shop, Inc. v. Northern Ins. Co. of NY, 895 F.2d 670 (10th Cir. 1990).
124. *Id.* at 672.

interruption of business."[125] Unfortunately for the policyholders, their insurance company refused to pay the claim and that "refusal resulted in the permanent closure of [the shoe store]."[126]

Among many issues, the Tenth Circuit Court of Appeals analyzed the policyholders' potential recovery for the "going concern value" of the shoe shop. The insurance company argued, *inter alia*, that "consequential damages allegedly resulting from the loss of the business as a going concern are not recoverable under Kansas law."[127] In particular, the insurance company argued "that consequential damages are not recoverable ... for breach of an insurance contract."[128] The court found that the authority on which the insurance company relied dealt with whether "Kansas should recognize the tort of bad faith; it did not take away any traditional contract remedies in an insurance contract case,"[129] such as consequential damages.[130] The court therefore held that consequential damages were recoverable for breach of an insurance policy.[131]

The court then went on to discuss several issues that parallel those set forth in the *Restatement*, such as (1) whether the alleged damages were within the contemplation of the parties, and (2) whether the policyholders failed to prove the loss with sufficient certainty.[132] In fact, the Tenth Circuit's consideration of those issues mirrored the analysis of the *Restatement*.

When considering the first of those arguments, the court noted that "damages recoverable for breach of contract are limited to those which may fairly be considered as arising, in the usual course of things, from the breach itself, or as may reasonably be assumed to have been within the contemplation of both parties as the probable result of the breach."[133] Applying this standard to the case before it, the Tenth Circuit reasoned that a business obtains insurance against fire loss to restore itself to the *status quo ante* in the event that a fire loss occurs.[134] According to the court, if a fire occurs and the insurance company refuses to pay the claim, the

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125. *Id.*
126. *Id.*
127. *Id.*
128. *Id.* at 677.
129. Royal Coll. Shop, Inc. v. N. Ins. Co. of NY, 895 F.2d 670, 678 (10th Cir. 1990).
130. *Id.*
131. *Id.*
132. *Id.*
133. *Id.* at 679.
134. *Id.*

business might have to close down due to insufficient finances.[135] Making the final inferential step, the court then held that it would be reasonable for the jury to conclude that the parties to the insurance contract would have anticipated such a consequence.[136]

On the second argument, the court considered whether the plaintiffs had proven their alleged loss of the "going concern value" with reasonable certainty.[137] The court noted that both the plaintiff and the insurance company had offered expert testimony and analysis from certified public accountants who were experienced in the valuation of businesses.[138] According to the court: "The jury apparently found the policyholders' expert more persuasive."[139]

Under the *Restatement,* although damages cannot be recovered for any loss that the evidence does not establish with "reasonable certainty," the result in *Royal College* does not violate the certainty requirement.[140] As the official comment to section 352 of the *Restatement* explains, the requirement of certainty does not mean that damages must be calculable with "mathematical accuracy."[141] The *Restatement* explicitly notes that "[t]his is especially true for items such as loss of good will as to which great precision cannot be expected."[142] The Tenth Circuit's determination therefore fits squarely within the reasoning of the *Restatement.*

IV. THE LAW OF THIRD PARTY BENEFICIARIES IN THE *RESTATEMENT*

A. THE "ADDITIONAL INSURED" PROBLEM

The best way to describe this problem is by reference to one of the most common situations in which it arises – a construction project. When a business undertakes a construction project, it customarily accepts a bid from a general contractor to complete the project. The general contractor may then accept bids from sub-contractors to undertake various specialized aspects of the project. If all goes well, the general contractor and the sub-

135. Royal Coll. Shop, Inc. v. N. Ins. Co. of NY, 895 F.2d 670, 679 (10th Cir. 1990).
136. *Id.*
137. *Id.*
138. *Id.*
139. *Id.* at 678.
140. *See* RESTATEMENT (SECOND) OF CONTRACTS § 352 cmt. a (1981).
141. *Id.*
142. *Id.*

contractors complete their work and the project is finished without incident.[143]

Unfortunately, things very rarely go perfectly well. Apart from delays, mistakes, and other problems with the construction itself, in some instances the employees of either the general or sub-contractor are injured during the construction project. When such an injury occurs, the employee could potentially sue either the sub-contractor, the contractor, and/or the company that initially commissioned the project. To address the liability and indemnity problems that arise from such a situation, the general contractor can procure separate insurance coverage on behalf of the sub-contractor, which is generally referred to as a "protective liability" policy.[144] The most common method for addressing this problem, however, is to have the insuring party modify its own insurance coverage to cover the other party as well as an "additional insured."[145] Such "additional insured" coverage is usually required in the contract between the company commissioning the project and the general contractor.[146]

In most situations, "additional insured" coverage is required by companies for all parties working on a project, to ensure that if someone sues because of the negligence of a sub-contractor or the general contractor, the commissioning company will have insurance protection.[147] In some situations, however, the "additional insured" coverage is either omitted from the policy, or deficient in some respect.[148] In those circumstances, because it can be said that the creation of "additional

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143. *See generally* KALIS ET AL., *supra* note 2, § 19.07[B][1] (discussing typical additional insured scenario).

144. David R. Hendrick, *Insurance Law: Understanding the Basics Regarding "Additional Insureds," in* INSURANCE LAW 2003: UNDERSTANDING THE ABC'S, at 591, 603-04 (PLI LITIG. & ADMIN. PRACTICE, COURSE HANDBOOK SERIES No. HO-00LJ, 2003).

145. *Id.* at 604.

146. *Id.; see also* DONALD S. MALECKI ET AL., THE ADDITIONAL INSURED BOOK 55-57 (5th ed. 2004).

147. Harold K. Watson, *Exercising Subrogation Rights Against Subcontractors Isn't Easy, But It's Not Impossible,* 68 DEF. COUNS. J. 458, 459 (2001); *see also* Hendrick, *supra* note 144, at 609 ("Additional insured" endorsements "can either specifically name the additional insured or designate a general category of persons entitled to such coverage under a 'blanket endorsement'").

148. *See* KALIS ET AL., *supra* note 2, § 19.07[B][3] ("Action, or inactions, by the named insured may directly affect the additional insured in numerous ways. For example, the named insured could fail to pay the premium due for the additional insured endorsement resulting in the cancellation of the endorsement. Or, the named insured may simply fail to procure the promised insurance coverage").

insured" status was not "generally conferred by the basic insurance policy language," most courts refuse to extend coverage.[149]

Although that result seemingly comports with the express terms of the policy, it may run contrary to the intent of the contracting parties. In some instances, the insurance company and the policyholder intended to provide protection for the actions of others, but neglected or otherwise failed to expressly provide "additional insured" coverage. In those instances, if the court decides solely on the basis of the express terms of the policy, the true intentions of the parties are frustrated. As this Part of the Article will explain, in such cases the *Restatement*'s third-party beneficiary rules[150] offer a useful avenue to effectuate the intentions of the parties in respect of "additional insured" protection, even if there is a technical deficiency or omission in the express terms of the policy.[151]

B. THE RELEVANT *RESTATEMENT* SECTIONS

Several sections of the *Restatement* can be used to address the "additional insured" problem. Section 302 of the *Restatement* provides a framework for the analysis of this problem by elucidating the distinction between intended and incidental beneficiaries[152] and setting up the criteria for determining whether a given party is an intended beneficiary:

> (1) Unless otherwise agreed between promisor and promisee, a beneficiary of a promise is an intended beneficiary if recognition of a right to performance in the beneficiary is appropriate to effectuate the intention of the parties and either

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149. Hendrick, *supra* note 144, at 615.

150. A concise and extremely lucid treatment of the rules of third-party beneficiaries in contract law generally can be found in CHIRELSTEIN, *supra* note 57, at 177-86. *See also* FARNSWORTH, *supra* note 57, § 10.3; CALAMARI & PERILLO, *supra* note 61, § 17-3, at 693-94, § 17-4, at 701. One of the few insurance treatises to even mention the rules of third-party beneficiaries is WINDT, *supra* note 52, § 9:16; however, Windt's discussion is limited to the situation in which an injured third party seeks insurance under the tortfeasor's insurance policy.

151. In addition, the *Restatement*'s rules of interpretation provide useful help when facing this problem. *See supra* Part I. Those rules might combat what one commentator has observed in this area as a fondness for the strictures of classical contract law. Melvin A. Eisenberg, *Third Party Beneficiaries*, 92 COLUM. L. REV. 1358, 1428 (1992).

152. The nomenclature of "intentional beneficiary" was new in the *Restatement*. FARNSWORTH, *supra* note 57, § 10.3, at 716.

> (a) the performance of the promise will satisfy an obligation of the promisee to pay money to the beneficiary; or
> (b) the circumstances indicate that the promisee intends to give the beneficiary the benefit of the promised performance.
> (2) An incidental beneficiary is a beneficiary who is not an intended beneficiary.[153]

A potentially crucial component of third-party beneficiary status is whether the alleged beneficiary relied to its detriment on becoming a third-party beneficiary of the contract. Such reliance must be "both reasonable and probable."[154] However, "[i]n such cases, if the beneficiary would be reasonable in relying on the promise as manifesting an intention to confer a right on him, he is an intended beneficiary."[155] The *Restatement* provides an example of how such reliance may trigger third-party beneficiary status:

> A, a corporation, contracts with B, an insurance company, that B shall pay to any future buyer of a car from A the loss [the buyer] may suffer by the burning or theft of the car within one year after sale. Later A sells a car to C, telling C about the insurance. C is an intended beneficiary.[156]

It is important to note that in the illustration, the insurance company does not need to advise the prospective buyer of anything. Furthermore, the buyer's third-party beneficiary status obtains even without an express term in the insurance policy or other language conferring that status in writing.

Lastly, as the official comment to section 302 explains, the "[p]erformance of a contract will often benefit a third person. But unless the third person is an intended beneficiary as here defined, no duty to him

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153. RESTATEMENT (SECOND) OF CONTRACTS § 302 (1981); *see also* CHIRELSTEIN, *supra* note 57, at 180 (noting that intentional beneficiaries are defined in § 302 "somewhat tautologically . . . as anyone intended by the promise to be benefited by the promisor's performance and the latter [incidental beneficiaries] as anyone who is not the former").

154. RESTATEMENT (SECOND) OF CONTRACTS § 302 cmt. d (1981).

155. *Id.*

156. *Id.* § 302 cmt. d, illus. 11.

is created."[157] Accordingly, it is essential to determine whether the beneficiary of the promise is an intended or incidental beneficiary.

The *Restatement* then supplements this framework with two contrasting sections, 304 and 315. Section 315 mirrors the official comment to section 302 by denying incidental beneficiaries any right of recovery against the promisor or promisee.[158] Section 304, however, provides that "[a] promise in a contract creates a duty in the promisor to any intended beneficiary to perform the promise, and the intended beneficiary may enforce the duty."[159] That creates a right of recovery for intended beneficiaries against the promisor or promisee. In addition to creating that right of recovery, the *Restatement* explains that "[i]t is not essential to the creation of a right in an intended beneficiary that he be identified when a contract containing the promise is made."[160]

The *Restatement* places some important limitations on the creation of a right to recovery in an intended beneficiary. As section 309 of the *Restatement* explains:

> (1) A promise creates no duty to a beneficiary unless a contract is formed between the promisor and the promisee; and if a contract is voidable or unenforceable at the time of its formation the right of any beneficiary is subject to the infirmity.
> (2) If a contract ceases to be binding in whole or in part because of impracticability, public policy, non-occurrence of a condition, or present or prospective failure of performance, the right of any beneficiary is to that extent discharged or modified.
> (3) Except as stated in Subsections (1) and (2) and in § 311 or as provided by the contract, the right of any beneficiary against the promisor is not subject to the promisor's claims or defenses against the promisee or to the promisee's claims or defenses against the beneficiary.

157. *Id.* § 302 cmt. e.
158. *Id.* § 315.
159. *Id.* § 304.
160. RESTATEMENT (SECOND) OF CONTRACTS § 308 (1981).

> (4) A beneficiary's right against the promisor is subject to any claim or defense arising from his own conduct or agreement.[161]

Accordingly, the *Restatement* provides an effective means by which a party might obtain rights as an additional insured notwithstanding any technical failure to achieve that result through the policy's express terms.

C. POTENTIAL APPLICATION OF THE *RESTATEMENT* TO ADDRESS THE "ADDITIONAL INSURED" PROBLEM

In some cases there is either a technical deficiency, or an outright omission, in the naming of additional insureds on an insurance policy. It is tempting to quickly dismiss such cases by confining one's interpretation to the four corners of the policy. That methodology can lead to inequitable results, particularly when it ignores the intent of the parties involved. The "additional insured" problem could be avoided if courts used the relevant sections of the *Restatement* outlined above in their analyses. As stated, section 302 in particular provides a useful means for courts to come to a more appropriate and equitable determination regarding whether a party should be considered an intended beneficiary of an insurance policy even if that party was not specifically named as an "additional insured" under the policy.

Like the rules of interpretation discussed in Part I, *supra*, section 302 of the *Restatement* eschews the formalism of the plain meaning rule in favor of a more wholistic approach, considering all the relevant factors in the formation of the insurance policy. In effect, section 302 creates a two-pronged standard for determining whether a given party is an intended beneficiary of the policy as an additional insured. The first prong of this standard requires that the recognition of a beneficiary's right to performance is "appropriate to effectuate the intention of the parties."[162] This means that recognizing a given party's rights as an additional insured must be what the contracting parties intended. The second prong of this standard requires consideration of all the circumstances surrounding the formation of the insurance policy, to ensure that the promisee intended to

161. *Id.* § 309.
162. *Id.* § 302(1).

give the beneficiary the benefit of the policy,[163] including whether the would-be beneficiary reasonably relied on becoming a beneficiary.[164]

When considering all the circumstances surrounding the formation of an insurance policy, courts can first use section 308 of the *Restatement* to forestall any prompt dismissal under the plain meaning rule.[165] Once a court is satisfied that a party is an intended beneficiary under section 302, the court could then use section 304 to grant the party a right of recovery against the promisee, which in the insurance transaction is the insurance company.[166] On the other hand, if the court determines that a party is an incidental beneficiary, as described under section 302, then the court could use section 315 to deny the party a right of recovery.[167]

Although it can be argued that permitting "additional insured" coverage to be read into a policy that is silent on the issue contravenes the *expressed* intention of the parties, the *Restatement* does not require additional insured status to be conferred. The *Restatement* does nothing more than direct courts to consider all of the circumstances surrounding the formation of the insurance policy.[168] The omission of specific designations in an insurance policy need not necessarily be dispositive of whether a party is an additional insured.

D. PRACTICAL EXAMPLE

A decision that provides an excellent example of the practical application of the *Restatement* to address the "additional insured" problem is *Cordero Mining Co. v. United States Fidelity & Guarantee Insurance Company.*[169] In *Cordero*, the Cordero mining company contracted with a

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163. *Id.* § 302(1)(b).

164. *Id.* § 302 cmt. d, illus. 11 (1981).

165. *See id.* § 308. Section 308 of the *Restatement* does not require, however, that an unnamed beneficiary be automatically granted a right of recovery. In some cases, courts have initially cited section 308 to explain that a beneficiary need not be named in an agreement to have a right of recovery, only to then deny recovery because the facts showed that the parties did not contract for the direct and primary benefit of the third party. *See, e.g.*, Goldberg v. R.J. Longo Constr. Co., Inc., 54 F.3d 243, 247 (1995) (denying recovery where the agreement explicitly identified intended beneficiaries but did not include the plaintiff in that identification).

166. RESTATEMENT (SECOND) OF CONTRACTS § 304 (1981).

167. *See id.* § 315.

168. *See id.* § 302(1)(b).

169. 67 P.3d 616 (Wyo. 2003). For non-insurance decisions addressing questions about contract beneficiaries, see *Bain v. Gillespie*, 357 N.W.2d 47 (Iowa Ct. App. 1984) (holding that disgruntled fans of Iowa's basketball team were not third-party beneficiaries of

general contractor, Production Industries Corporation [hereinafter PICOR], for the construction of a coal loading system.[170] The Cordero-PICOR contract required PICOR to obtain insurance that named the "Company Group," which included Cordero, Kennecott, and each of their respective subsidiaries, as an additional insured.[171] The contract also required PICOR to ensure that all subcontractors hired to work on the project obtained insurance naming the Company Group as an additional insured.[172]

PICOR obtained the additional insured coverage from Transcontinental Insurance Company and Continental Casualty Company [together hereinafter CNA], and appropriately named Cordero as an additional insured.[173] PICOR later subcontracted with L & T Fabrication & Construction, Inc. [hereinafter L & T] to construct platforms for the coal loading system.[174] The PICOR-L & T purchase order mandated that L & T obtain the requisite additional insured coverage outlined above.[175] L & T attempted to comply with the requirement by procuring insurance from United States Fidelity and Guarantee Insurance Company [hereinafter USF & G] through its agent, the Barlow Agency [hereinafter Barlow].[176] Unfortunately, when Barlow issued the certificates they named PICOR and Kennecott, but not Cordero as additional insureds.[177]

L & T knew its contract with PICOR required it to procure the additional insured coverage for Cordero but, instead of contacting the insurance company to correct the mistake, L & T accepted the certificates as written and transmitted them to PICOR.[178] Indeed, no one contacted L & T or Barlow to point out the mistake until an employee of L & T was seriously injured after a co-worker dropped a steel handrail on his head nearly four months after the certificates were issued.[179] When the employee later filed a negligence claim against Cordero and PICOR, USF

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referee's contact with league, where referee called foul that led to foul shots that gave Purdue University win over University of Iowa); *See also* Lonsdale v. Chesterfield, 662 P.2d 385, 386 (Wash. 1983) (finding that petitioners were intended beneficiaries of contract).

170. Cordero Mining Co. v. U.S. Fid. & Guar. Ins. Co., 67 P.3d 616, 619 (Wyo. 2003).
171. *Id.* at 620.
172. *Id.*
173. *Id.*
174. *Id.*
175. *Id.*
176. Cordero Mining Co. v. U.S. Fid. & Guar. Ins. Co., 67 P.3d 616, 620 (Wyo. 2003).
177. *Id.*
178. *Id.*
179. *Id.*

& G refused to defend Cordero because it was not named as an additional insured on L & T's policy.[180] Ultimately PICOR's insurance company, CNA, paid Cordero's defense and settled the claims against Cordero.[181] Cordero eventually assigned its claims against USF & G to CNA and CNA then filed suit against USF & G.[182]

In deciding the case, the Supreme Court of Wyoming first considered Barlow's alleged promise to obtain insurance for L & T that would cover Cordero as an additional insured.[183] On this issue, the court cited the *Restatement* as the appropriate analytical tool for determining whether Cordero was an intended beneficiary of the policy. According to the court:

> CNA was required to demonstrate that, (1) under paragraph (1) of § 302 of the Restatement, recognition of Cordero's alleged right to benefits as an additional insured was appropriate to effectuate the intent of L & T and Barlow; and, (2) under subparagraph (1)(b) of that section, the circumstances indicate L & T intended to give Cordero the direct benefit of being named as an additional insured on the policy.[184]

The court further explained that the intent of the parties could be demonstrated by both "the language of the insurance policy and the circumstances surrounding the parties at the time of its execution."[185]

The court declined to limit the consideration to the four corners of the contract, as argued by USF & G, explaining that in some contracts where the third-party beneficiary is not identified the court must look to the surrounding circumstances to determine intent.[186] Applying this standard, the court concluded that Barlow's promise to procure insurance for L & T should be considered together with the contracts that gave rise to the request.[187] After considering the record, the court concluded that Barlow and L & T "clearly intended" to name Cordero as an additional insured.[188]

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180. *Id.*

181. *Id.*

182. Cordero Mining Co. v. U.S. Fid. & Guar. Ins. Co., 67 P.3d 616, 620 (Wyo. 2003).

183. *Id.* at 622.

184. *Id.* (footnote omitted).

185. *Id.*

186. *Id.* at 623 (according to the court, "doing so is not an improper extension of the terms of the contract but rather is a necessary step in effectuating the intent of the parties").

187. *Id.*

188. Cordero Mining Co. v. U.S. Fid. & Guar. Ins. Co., 67 P.3d 616, 623 (Wyo. 2003).

The court then applied this determination to the *Restatement*'s standard, and determined that "recognition of Cordero as a third-party beneficiary is appropriate to effectuate the intent of L & T and Barlow, thus satisfying the first prong of § 302 of the Restatement."[189] The court further concluded that the second prong of the *Restatement* was also met because the record demonstrated L & T's clear intent to give Cordero the direct benefit of being named an additional insured.[190]

The court then considered, however, whether L & T's acceptance of the policy naming only Kennecott and PICOR defeated the third-party beneficiary and negligence claims.[191] The District Court had dismissed the negligence claims because L & T had a duty to review and reject the insurance policy if it did not comply with the coverage requested; and Cordero did nothing to ensure that proper coverage was in place before allowing PICOR and L & T to commence work on the project.[192] When reviewing that decision, the Wyoming Supreme Court agreed that "Wyoming recognizes a policyholder's duty to read his insurance policy and reject or renegotiate if it fails to conform to the coverage requested," and that the same principle applies to third-party beneficiary claims.[193] Since the undisputed facts indicated that L & T knew that Kennecott, not Cordero, was designated as an additional insured, the court determined that USF & G was entitled to summary judgment on the third-party beneficiary claim.[194] Although seemingly harsh, the court's conclusion really was just another way of enforcing the requirement that a third-party beneficiary's reliance be reasonable;[195] in essence, the court found that it was not reasonable for Cordero to rely on its additional insured status without inspecting the appropriate documents before the project went forward.

CONCLUSION

The alternative approaches discussed in this Article are intended to provide insurance purchasers, and insurance law practitioners, with a full range of options when litigating insurance recovery cases. These approaches offer a way to achieve some of the same goals as commonly

189. *Id.*
190. *Id.* at 622.
191. *Id.* at 625.
192. *Id.*
193. *Id.* at 626 (citing Small v. King, 915 P.2d 1192, 1194 (Wyo. 1996)).
194. Cordero Mining Co. v. U.S. Fid. & Guar. Ins. Co., 67 P.3d 616, 626 (Wyo. 2003).
195. *See* RESTATEMENT (SECOND) OF CONTRACTS § 302(d) (1981).

used tests and doctrines, while offering additional benefits of their own. One of the key benefits we perceive is a doctrinally based means to break free of the dogma that strangles much of insurance jurisprudence. More ink is spilled in insurance law decisions on string cites to authorities supporting one side or the other of the same, stale debates than should be. In the age of Westlaw and Lexis, those string cites are much less impressive, are frequently inaccurate and misleading, and do not advance insurance jurisprudence in a productive direction. More time should be spent thinking about different ways to look at old problems, and searching for better ways to resolve them.

Another benefit we perceive to bringing the *Restatement* more into the fold of insurance law is that it offers a familiar backdrop for many jurists and litigators (and certainly for judicial law clerks). Contract law is on every bar exam, while insurance law is probably on none. By providing a known body of doctrine when presenting an argument, the advocate can skip over, or through, a lot of insurance jargon and clutter to submit a clear and ultimately more efficient and effective claim.[196] In this vein, it has been our goal to show that the paths discussed in this Article are not novel, but instead derive from the (forgotten) mainstream of contract law doctrine, doctrine explicated by Corbin, Farnsworth, and others, as well as in the *Restatement*. Those are familiar sources. They should be critical resources for insurance law practitioners.

Our only hope for this Article is that it may have contributed something of value to the consideration of some commonly faced insurance law problems. By trying the avenues explored in this Article, jurists and lawyers may be able to break free from the hollow arguments and purple language endemic to insurance law practice.[197]

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196. Knowing your audience, and crafting arguments that will resonate with it, is one of the primary messages of Aristotle's *Rhetoric*. According to Aristotle, "you compose your speech for an audience, and the audience is the 'judge.' As a rule . . . the term 'judge' means simply and solely one of the persons who decide the issue in the disputes of civil life." ARISTOTLE, THE RHETORIC OF ARISTOTLE 141 (Lane Cooper trans., 1932).

197. For a practical example of the jurisprudence animating the thesis of this Article, see the discussion of Justice Blackmun's concurring opinion in *United Steelworkers of America v. Weber*, 443 U.S. 193 (1979) in DENNIS M. PATTERSON, LAW AND TRUTH 67-68 (1996).

BUSS STOP: A POLICY LANGUAGE BASED ANALYSIS

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INTRODUCTION

Insurers and policyholders have been waging a state-by-state battle over a newly-recognized right of recoupment. Guided by a desire to avoid what it viewed as possible unjust enrichment in an extreme set of facts in which only one of 27 claims against an insured was potentially covered, the California Supreme Court recognized this right a decade ago in *Buss v. Superior Court.*[1] *Buss* held that a liability insurer can agree to defend an action against its insured while reserving a right to recoup the defense costs the insurer pays if some or all of the case is later held to be outside of policy coverage.[2] For a time, courts considering the issue readily followed *Buss*. More recently, however, a so called "minority" view is taking hold that rejects this right of recoupment.[3] Courts in this "minority" have, among other things, adopted an approach based on the language of the insurance contract that refuses recoupment absent specific authorization for reimbursement in the applicable policy. This policy language based

1. 939 P.2d 766 (Cal. 1997).

2. *Id.* at 776.

3. Attached as an appendix to this article is a survey of the states that have taken a position on the issue decided in *Buss*, or on the major decisions that followed or refused to follow *Buss*.

approach is exemplified by the Illinois Supreme Court's 2005 decision in *General Agents Insurance Co. of America v. Midwest Sporting Goods Co.*[4]

This article traces the history of the reimbursement issue. It recounts the reasoning of the *Buss* opinion and the courts that have ruled in accordance with it. It also describes decisions that extended the *Buss* holding to require recoupment of settlements. The article then explains the contrary view against recoupment, with particular attention paid to the policy language based reasoning of the *General Agents* court.

Ultimately, the article advocates adopting the policy language based approach but explains that the argument against *Buss* is even stronger than the contrary courts have framed it. Courts on both sides of the issue have debated reimbursement from the premise that standard general liability policies are silent as to reimbursement, allowing the *Buss* court and others following it to imply the right for various reasons. Courts ruling to the contrary, on the other hand, have been unwilling to imply the missing right. This article shows that both sides have failed to recognize that standard liability policies are not silent on the matter at all. Instead, those policies contain supplementary payment provisions that expressly promise that the insurer will bear all of the costs of cases it defends. These express terms preclude implying a right of reimbursement as recognized by *Buss*.

I. THE *BUSS* ARRIVES: THE CARRIER'S RIGHT TO RECOUP DEFENSE COSTS

In *Buss*, the California Supreme Court affirmed rulings that an insurer who issued a standard commercial general liability ("CGL") insurance policy has a right of reimbursement of defense costs for claims not even potentially covered under its policy.[5] This right is implied in law as quasi-contractual under the theory of unjust enrichment.[6] The *Buss* court held that in a "mixed action," *i.e.*, a case against an insured involving some claims that are potentially covered plus others that are not, an insurer seeking recoupment must prove by a preponderance of the evidence which claims are not even potentially covered and which defense costs can be allocated *solely* to those non-covered claims.[7]

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4. 828 N.E.2d 1092 (Ill. 2005).
5. *Buss*, 939 P.2d at 776.
6. *Id.* at 770.
7. Buss v. Superior Court, 939 P.2d 766, 778 (Cal. 1997).

A. THE EXTREME FACTS OF *BUSS*

The *Buss* case arose out of an underlying lawsuit in which only one of 27 claims was potentially within coverage.[8] This underlying action was a suit by H&H Sports, Inc. alleging that Jerry Buss, the owner of various Los Angeles sports teams (including the L.A. Lakers), breached contractual obligations with H&H by unilaterally terminating a relationship.[9] H&H's suit pleaded 27 causes of action against Buss and Buss-related persons and entities, including one count for defamation.[10]

Buss tendered defense of the H&H action to his insurers and all but Transamerica denied coverage.[11] Transamerica's CGL policies provided coverage for "personal injury," a term defined to include various forms of defamation. Transamerica accepted the tender of defense on the premise that the defamation count was the only potentially covered claim in the action. Transamerica reserved all of its rights, however, including a right to have the defense attorney fees it was to pay reimbursed in full or in part if it was later determined that there was no coverage for the suit. Buss and Transamerica thereafter entered into an agreement "supported by consideration that provided, among other things, that '[i]f a court . . . orders that defense costs be shared pro rata by . . . Buss . . . and Transamerica, . . . Buss . . . shall reimburse Transamerica for the appropriate pro rata share of the fees and costs paid to that date.'"[12]

After paying defense counsel just over $1 million, Buss settled the H&H action for $8.5 million. Of the defense costs incurred, Transamerica's expert maintained that approximately $21,720 to $55,767.50 was associated with defending the defamation cause of action. Transamerica refused to contribute anything toward the settlement.[13]

Buss eventually sued Transamerica, alleging that Transamerica breached its contractual obligations when it denied a duty to defend the H&H action in its entirety and refused to contribute to the settlement. Transamerica filed a cross-complaint alleging, *inter alia*, that Buss himself was guilty of breaching contractual obligations by denying Transamerica's right to defense cost reimbursement. Transamerica then moved for

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8. *Id.* at 770.
9. *Id.* at 769.
10. *Id.*
11. *Id.* at 769.
12. *Id.* at 770.
13. Buss v. Superior Court, 939 P.2d 766, 770 (Cal. 1997).

summary judgment against Buss on its indemnity obligations. The trial court granted that motion, determining that Transamerica owed nothing for the settlement.[14]

Buss then moved for summary judgment on the reimbursement of defense costs issue,[15] relying primarily on *Hogan v. Midland National Insurance Co.*[16] In that case, the California Supreme Court held that an insurer that breached its duty to defend an insured could not avoid liability for the full total of the insured's defense costs on the basis that some of the claims defended were not potentially covered unless "the insurer produces undeniable evidence of the allocability of specific expenses" to the uncovered claims.[17] Buss asserted this "undeniable evidence" burden of proof was controlling and dispositive.[18] The trial court again ruled for Transamerica, however, and denied Buss's motion. The trial court distinguished *Hogan* on the basis that its burden of proof applies only when an insurer wrongfully refuses its duty to defend an action and that Transamerica did not do that as to the H&H suit.[19]

The California Court of Appeals found no error in the trial court's rulings.[20] The appellate court recognized that the duty to defend in California, as in other states, is triggered for any claim that is at least potentially covered by an insurer's policy, though an insurer does not have a duty to defend cases pleading allegations that are not even potentially within coverage; it held:

> [A]n insurer may not seek reimbursement from an insured for defense costs as to claims that are at least potentially covered – in the H&H Sports action, the defamation cause of action against Buss; it may, however, seek reimbursement for costs as to those that are not – in that action, all of the others; it may obtain reimbursement for the costs that can be allocated solely to those claims; to do so, it must carry the burden of proof; the burden it must carry is proof by a preponderance of the evidence; *Hogan's* "undeniable evidence" language only applies when the insurer has

14. *Id.* at 770-71.
15. *Id.*
16. 476 P.2d 825 (Cal. 1970).
17. *Id.* at 831.
18. Buss v. Superior Court, 939 P.2d 766, 771 (Cal. 1977).
19. *Id.*
20. *Id.*

> wrongfully refused to defend the insured, which was not the case here.[21]

The Supreme Court of California agreed to review the Court of Appeals' decision.

B. THE CALIFORNIA SUPREME COURT'S HOLDING

The California Supreme Court began its *Buss* decision by affirming the scope of the duty to defend in mixed actions and it held that in such a case, the insurer owes a duty to defend the action in its entirety.[22] This is an obligation imposed by law in support of the policy. "To defend meaningfully," the court stated, "the insurer must defend immediately. To defend immediately, it must defend entirely. It cannot parse the claims, dividing those that are at least potentially covered from those that are not."[23]

Because an insurer's duty to defend extends to any claims at least potentially covered, the insurer is not entitled to seek reimbursement of defense costs for potentially covered claims.[24] The insurer bargained to bear these costs and was paid premiums for this responsibility.[25] The court cautioned, however, "[t]his would not be the case if the policy itself provided for reimbursement: such a policy would qualify itself. It would also not be the case if there were a separate contract supported by separate consideration: such a contract would supersede the policy pro tanto."[26]

On the other hand, the court held that the insurer may seek reimbursement of defense costs for claims that were not even potentially covered.[27] According to the California Supreme Court:

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21. *Id.* at 771-72.

22. *Id.* at 774.

23. *Id.* at 775 (citations omitted). If the insurer breaches this duty by failing to fully defend in a mixed action, it cannot then rely upon the reimbursement rights contained in *Buss*. Instead, a breaching insurer must look to the California Supreme Court's decision in *Hogan v. Midland National Insurance Co.*, 476 P.2d 825 (Cal. 1970), which sets out a standard of proof much stricter than the one established in *Buss*. *See infra* note 31 and accompanying text.

24. Buss v. Superior Court, 939 P.2d 766, 775 (Cal. 1977).

25. *Id.*

26. *Id.* at 776.

27. *Id.*

> The reason is this. Under the policy, the insurer does not have a duty to defend the insured as to the claims that are not even potentially covered. With regard to defense costs for these claims, the insurer has not been paid premiums by the insured. It did not bargain to bear these costs. To attempt to shift them would not upset the arrangement. . . . The insurer therefore has a right of reimbursement that is implied in law as quasi-contractual, whether or not it has one that is implied in fact in the policy as contractual. As stated, under the law of restitution such a right runs against the person who benefits from "unjust enrichment" and in favor of the person who suffers loss thereby. The "enrichment" of the insured by the insurer through the insurer's bearing of unbargained-for defense costs is inconsistent with the insurer's freedom under the policy and therefore must be deemed "unjust." It is like the case of *A* and *B*. *A* has a contractual duty to pay *B* $50. He has only a $100 bill. He may be held to have a prophylactic duty to tender the note. But he surely has a right, implied in law if not in fact, to get back $50. Even if the policy's language were unclear, the hypothetical insured could not have an objectively reasonable expectation that it was entitled to what would in fact be a windfall.[28]

In a related footnote the court further explained:

> That the insurer does not have a right of reimbursement express in the policy does not mean that it does not have one implied in law. Rather, that it has an implied-in-law right helps explain why it does not have an express-in-policy one. The former renders the latter unnecessary. This is proved by the fact that, with an implied-in-law right and without an express-in-policy one, insurers have sought, and obtained, reimbursement–and have done so, on the evidence of reported decisions, for much more than a decade. . . . To be sure, an express right could have been introduced into the policy. . . . But that it was not is not dispositive.

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28. *Id.* at 776-77.

> By stating that the insurer has a right of reimbursement that is implied in law, *whether or not it has one that is implied in fact in the policy,* we should not be taken to imply that the unresolved issue set out in the italicized clause should indeed be resolved in the negative.[29]

The court next held that an insurer can obtain reimbursement of defense costs in a "mixed action" for costs that can be allocated solely to claims not potentially covered by the policy, reasoning that the insured never paid premiums for such costs.[30] However, the court found that the insurer must carry the burden of proof on this point by a preponderance of the evidence.[31]

Finally, the *Buss* court held that in order to obtain a reimbursement of defense costs, an insurer must reserve its rights on this basis. It is not necessary that the insured agree with the insurer's reservation of rights to obtain a reimbursement of defense costs for it to be valid; "[b]ecause the right is the insurer's alone, it may be reserved by it unilaterally."[32]

C. JUSTICE KENNARD'S DISSENT

Justice Joyce L. Kennard filed a dissent in the *Buss* case. In it, she pointed specifically to the policy language in the standard CGL policies, including those at issue, wherein the insurer is obligated to defend "suits" rather than individual "claims." The justice reasoned that it is settled law that "clear and explicit provisions of insurance policies should be enforced as written."[33] Justice Kennard further pointed to the insurers' freer hand and enhanced control obtained in the defense of the claims that are potentially covered in exchange for the added expense of defending claims not potentially covered.[34] Last, she noted that insurers could certainly

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29. *Id.* at 776-77 n.13.

30. Buss v. Superior Court, 939 P.2d 766, 776 (Cal. 1977).

31. *Id.* at 778. The burden of proof is much higher, and likely unattainable, for an insurer who breaches its defense obligations by failing to fully defend and still seeks to recover some noncovered portion of its defense costs. *See* Hogan v. Midland Nat'l Ins. Co., 476 P.2d 825, 831 (Cal. 1970) (the insurer must produce "undeniable evidence of the allocability of specific expenses; the insurer having breached its contract to defend should be charged with a heavy burden of proof of even partial freedom from liability for harm to the insured which ostensibly flowed from the breach").

32. *Buss*, 939 P.2d at 784 n.27.

33. *Id.* at 784 (Kennard, J., dissenting).

34. *Id.* at 785.

change the standard CGL language to narrow the defense obligation to claims if they chose to do so. They could use, for example, the language in the standard title insurance policy (which contains a defense obligation for particular causes of action rather than entire suits).[35]

Stressing that the policy language alone should control, Justice Kennard concluded:

> Insurance policies are written contracts governed by the rules of contract law, not equity or quasi-contract. "The rules governing policy interpretation require us to look first to the language of the contract in order to ascertain its plain meaning or the meaning a layperson would ordinarily attach to it." When a CGL policy uses language obligating the insurer to defend "any suit" seeking potentially covered damages, without reserving a right to reimbursement from the insured, the insurer at its own cost must defend the entirety of any action against the insured seeking potentially covered damages. Because the majority holds otherwise, I dissent.[36]

D. CALIFORNIA DECISIONS AFTER *BUSS*

After deciding *Buss*, the California Supreme Court spoke several more times on related issues. In 2001, the court in *Blue Ridge Insurance Co. v. Jacobsen*[37] applied the *Buss* rationale to an insurer seeking reimbursement of a settlement payment after reserving its right to do so, notwithstanding the insured's vehement refusal to agree to such a term at the time of settlement. The supreme court stated: "[A]pplying *Buss*'s reasoning regarding reimbursement of defense costs to reimbursement of reasonable settlement costs, the insurer only has a duty to indemnify the insured for covered claims, and no duty to pay for noncovered claims because the insured did not pay premiums for such coverage." [38] Most recently, in *Scottsdale Insurance Co. v. MV Transportation*,[39] the California Supreme Court applied its *Buss* holding and rationale to a non-mixed action. The

35. *Id.* at 785-86.

36. Buss v. Superior Court, 939 P.2d 766, 787 (Cal. 1977) (Kennard, J. dissenting) (citation omitted).

37. 22 P.3d 313 (Cal. 2001).

38. *Id.* at 321.

39. 115 P.3d 460 (Cal. 2005).

Scottsdale court allowed an insurer that timely and properly reserved its rights to obtain reimbursement for all of the defense fees it ever paid to the insured upon a finding of no coverage. The insurer was allowed to recoup the fees paid before that finding–thereby avoiding any duty to defend both prospectively and retroactively.[40]

E. OTHER COURTS FOLLOWING *BUSS*

The decision in *Buss* created quite a stir in the coverage world. After *Buss*, virtually every insurer reserved a right to obtain a reimbursement of its defense costs, whether or not California law had any chance of applying to the particular case. Several courts ruled in accordance with the *Buss* holding, including courts applying the law of the following states:

1) Alaska,[41]
2) Arkansas,[42]
3) Colorado,[43]
4) Delaware,[44]
5) Florida,[45]
6) Minnesota,[46]

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40. *Id.* at 467-68.

41. *See, e.g.*, Unionamerica Ins. Co. v. Gen. Star Indem. Co., No. A01-0317-CV, 2005 WL 757386, at *8 (D. Alaska Mar. 7, 2005).

42. *See, e.g.*, Nobel Ins. Co. v. Austin Powder Co., 256 F. Supp. 2d 937, 940 (W.D. Ark. 2003) (holding that an insurer who defends a claim for which coverage did not exist is entitled to reimbursement costs for both the settlement amount and litigation expenses only if the insurer timely and explicitly reserved its right to recoup the costs and provided specific and adequate notice of the possibility of reimbursement).

43. *See, e.g.*, First Fed. Sav. & Loan Ass'n of Fargo N.D. v. Transamerica Title Ins. Co., 793 F. Supp. 265, 269 (D. Colo. 1992), *aff'd*, 19 F.3d 528 (10th Cir. 1994). *But see* Farmington Cas. Co. v. United Educators Ins. Risk Retention Group, Inc., 117 F. Supp. 2d 1022, 1029 (D. Colo. 1999) (stating in dicta "Colorado law is not clear on whether it would allow an insurer to recover defense costs from the insured in a 'mixed' action....").

44. *See, e.g.*, Nationwide Mut. Ins. Co. v. Flagg, 789 A.2d 586, 597 (Del. Super. Ct. 2001).

45. *See, e.g.*, Colony Ins. Co. v. G&E Tires & Serv., Inc., 777 So. 2d 1034 (Fla. Dist Ct. App. 2000) (defense costs). *But see* Steadfast Ins. Co. v. Sheridan Children's Healthcare Serv., Inc., 34 F. Supp. 2d 1364, 1367 (S.D. Fla. 1998) (no reimbursement allowed as to settlement costs).

46. *See, e.g.*, Knapp v. Commonwealth Land Title Ins. Co., 932 F. Supp. 1169, 1172 (D. Minn. 1996). *But see* Employers Mut. Cas. Co. v. Indus. Rubber Prods., Inc., No. Civ. 04-3839, 2006 WL 453207, at *5 (D. Minn. Feb. 23, 2006) (refused to allow reimbursement).

7) Montana,[47]
8) Nevada,[48]
9) New Mexico,[49]
10) New York,[50]
11) Ohio,[51]
12) Oklahoma,[52] and
13) Texas.[53]

For a while at least, it appeared that every court would jump on the *Buss*.

II. WHY SOME COURTS HAVE JUMPED ON THE *BUSS* AND PERMITTED REIMBURSEMENT OF DEFENSE OR SETTLEMENT COSTS

A. RESERVATION OF RIGHTS CREATES CONTRACT, QUASI-CONTRACT AND/OR IMPLIED-IN-FACT CONTRACT OR AGREEMENT

Courts have often allowed an insurer to obtain reimbursement of defense costs if that insurer specifically reserved a right to obtain reimbursement in the event a court found there was no coverage, and the policyholder accepted payment of defense costs without objecting to this reservation.[54] These courts have reasoned that the reservation of rights

47. *See, e.g.*, Travelers Cas. & Sur. Co. v. Ribi Immunochem Research, Inc., 108 P.3d 469, 480 (Mont. 2005) (Travelers was entitled to recoup insurance costs because notice was found).

48. *See, e.g.*, Forum Ins. Co. v. County of Nye, No. 91-16724, 1994 WL 241384, at *3 (9th Cir. June 3, 1994) (the insured may be held responsible for costs incurred as long as they had unambiguous notice).

49. *See, e.g.*, Resure, Inc. v. Chem. Distribs., Inc., 927 F. Supp. 190 (M.D. La. 1996), *aff'd*, 114 F.3d 1184 (5th Cir. 1997) (table case).

50. *See, e.g.*, Gotham Ins. Co. v. GLNX, Inc., No. 92 Civ. 6415, 1993 WL 312243, at *5 (S.D.N.Y. Aug. 6, 1993).

51. *See, e.g.*, United Nat'l Ins. Co. v. SST Fitness Corp., 309 F.3d 914 (6th Cir. 2002).

52. *See, e.g.*, Melton Truck Lines, Inc. v. Indem. Ins. Co. of N. Am., No. 04-CV-263-JHP-SAJ, 2006 WL 1876528 (N.D. Okla. June 26, 2006) (held insurer properly reserved its rights to obtain reimbursement of settlement amounts paid).

53. *See, e.g.*, St. Paul Fire & Marine Ins. Co. v. Compaq Computer Corp., 377 F. Supp. 2d 719, 723 (D. Minn. 2005) (predicting Texas law), *aff'd*, 457 F.3d 766 (8th Cir. 2006).

54. *See* Travelers Cas. & Sur. Co. v. Ribi Immunochem Research, Inc., 108 P.3d 469, 480 (Mont. 2005); Grinnell Mut. Reinsurance Co. v. Shierk, 996 F. Supp. 836, 839 (S.D. Ill.

letter itself constituted an offer to create a new contract that the policyholder could accept, if by no other means, than by accepting the insurer's payment of defense costs. Courts generally held that the insurer had to meet two specific requirements to obtain reimbursement. It had to: "(1) specifically reserve the right to seek reimbursement from the insured; and (2) provide the insured with adequate notice of this potential reimbursement."[55]

As further support for this conclusion, courts also have relied on section 69 of the *Second Restatement of Contracts*, which states that "a party cannot accept tendered performance while unilaterally altering the material terms on which it is offered."[56]

Many courts decided it does not matter whether the insured objects to the reservation of rights letter or is silent after receiving it. They held that as long as the insurer reserves a right of recoupment and the insured accepts payment of defense costs, a new "implied" contract is created. Some have held that this new contractual agreement even binds an insured that expressly objects to the reservation while continuing to accept defense cost payments.[57] Courts have reasoned that the policyholder's objection "is

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1998), *rejected by* Gen. Agents Ins. Co. of Am., Inc. v. Midwest Sporting Goods Co., 828 N.E.2d 1092, 1098, 1101 (Ill. 2005); United Nat'l Ins. Co. v. SST Fitness Corp., 309 F.3d 914, 921 (6th Cir. 2002); Underwriters at Lloyds London v. STD Enters., Inc., 395 F. Supp. 2d 1142, 1150-51 (M.D. Fla. 2005); Jim Black & Assoc., Inc. v. Transcon. Ins. Co., 932 So. 2d 516, 518 (Fla. Dist. Ct. App. 2006); Colony Ins. Co. v. G&E Tires & Serv., Inc., 777 So. 2d 1034, 1039 (Fla. Dist. Ct. App. 2000). *But see* NCMIC Ins. Co. v. Dailey, No. 267801, 2006 WL 2035597, at *5-6 (Mich. Ct. App. July 20, 2006) (in rescission case, court held insurer entitled to reimbursement of defense costs paid as restitution to prevent unjust enrichment notwithstanding that insurer failed to specifically reserve its rights to recoup same after court upheld trial court's ruling that policy was successfully rescinded based on material misrepresentations in application).

55. *Ribi*, 108 P.3d at 479-80 (quoting *Grinnell*, 996 F. Supp. at 839 and *United Nat'l Ins.*, 309 F.3d at 921); *see also* Resure, Inc. v. Chem. Distrib., Inc., 927 F. Supp. 190, 194 (M.D. La. 1996) (applying New Mexico law), *aff'd*, 114 F.3d 1184 (5th Cir. 1997) (table case); United Nat'l Ins. Co. v. SST Fitness Corp., 309 F.3d 914, 920 (6th Cir. 2002) (applying Ohio law); Unionamerica Ins. Co. v. Gen. Star Indem. Co., No. A01-0317-CV, 2005 WL 757386, *8 (D. Alaska Mar. 7, 2005); Capital Indem. Corp. v. Blazer, 51 F. Supp. 2d 1080, 1090-91 (D. Nev. 1999); Nobel Ins. Co. v. Austin Powder Co., 256 F. Supp. 2d 937, 940 (W.D. Ark. 2003).

56. *Ribi*, 108 P.3d at 480; *Colony Ins. Co.*, 777 So. 2d at 1039.

57. *See, e.g.*, Forum Ins. Co. v. County of Nye, No. 91-16724, 1994 WL 241384 (9th Cir. June 3, 1994); Walbrook Ins. Co. v. Goshgarian & Goshgarian, 726 F. Supp. 777, 784 (C.D. Cal. 1989); *see also* Blue Ridge Ins. Co. v. Jacobsen, 22 P.3d 313, 314 (Cal. 2001) (holding that insurer who reserved rights was entitled to reimbursement of settlement payment notwithstanding insured's objection to same at the time of settlement).

properly dismissed as inconsistent with their acceptance of defense costs; they may not 'refus[e] to accept the agreement yet retain[] the fruits of it.'"[58] Other courts allow an insured to reject the insurer's reservation of rights, and they punish a policyholder that fails to expressly do so.[59]

In *United National Insurance Co. v. SST Fitness Corp.*,[60] for example, the Sixth Circuit predicted that Ohio law would find that a new "implied in fact" contract was created by a reservation of rights letter and the policyholder's silent acceptance of the defense by the insurer. The court noted that under Ohio law, an implied in fact contract may be found where one party provides another party with services when a payment generally is made for such services.[61] To establish that an implied in fact contract exists "'the plaintiff must prove that the defendant either requested or assented to such conduct under conditions precluding an inference that the plaintiff acted gratuitously.'"[62] The court concluded that this standard required United National to prove that SST accepted its defense with the reservation of rights to seek reimbursement "under conditions disallowing an inference that United National acted gratuitously" or that it is "reasonably certain that the parties intended to agree that United National

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58. *Forum Ins. Co.*, 1994 WL 241384, at *3 (citing *Walbrook*, 726 F. Supp. at 784).

59. *Resure*, 927 F. Supp. at 194 (applying New Mexico law) ("There is nothing in the record to suggest CDI objected to the reservation. Accordingly, Resure is entitled to reimbursement for all costs of defense"); *see also* Gotham Ins. Co. v. GLNX, Inc., No. 92 Civ. 6415, 1993 WL 312243, at *4-5 (S.D.N.Y. Aug. 6, 1993) (finding insurer entitled to reservation of rights for defense costs of all uncovered claims given that it reserved its rights to do so and "GLNX offered no evidence that it expressly refused to consent to Gotham's reservation of rights as to reimbursement..."); Omaha Indem. Ins. Co. v. Cardon Oil Co., 687 F. Supp. 502, 505 (N.D. Cal. 1988) (finding adequate reservation of rights where insured offered no evidence of express refusal to consent), *aff'd*, 902 F.2d 40 (9th Cir. 1990) (table case); Knapp v. Commonwealth Land Title Ins. Co., 932 F. Supp. 1169, 1172 (D. Minn. 1996) ("Under these circumstances, the Court finds it appropriate to determine that Knapp's silence in response to Commonwealth's reservations of rights letter, and subsequent acceptance of the defense provided by Commonwealth, constitutes an implied agreement to the reservation of rights."). *But see* Employers Mut. Cas. Co. v. Indus. Rubber Prods., Inc., No. Civ. 04-3839, 2006 WL 453207, at *5-6 (D. Minn. Feb. 23, 2006); First Fed. Sav. & Loan Ass'n of Fargo N.D. v. Transamerica Title Ins. Co., 793 F. Supp. 265, 269 (D. Colo. 1992) (holding that because insured did not object to the insurer's reservation of rights, the insurer was entitled to reimbursement), *aff'd*, 19 F.3d 528 (10th Cir. 1994).; N. Atl. Cas. & Sur. Ins. Co. v. William D., 743 F. Supp. 1361, 1367 (N.D. Cal. 1990) (where insurer reserved its rights to recoup costs and insured accepted payment without comment, insurer was entitled to reimbursement from insured).

60. 309 F.3d 914 (6th Cir. 2002).

61. *Id.* at 919.

62. *Id.* at 920 (citation omitted).

would recoup defense costs if United National had no duty to pay the costs."[63] The court found that United National met that burden.

The Sixth Circuit rejected SST's arguments that United National did not create an implied in fact contract because (1) there was no consideration to modify the contract; (2) United National cannot unilaterally modify the insurance contract; and (3) there was no acceptance of a new contract because silence and inaction cannot amount to acceptance. Specifically, the court decided that United National did not modify the existing insurance contract with SST, but rather, created a new contract in which the insurer offered to pay defense costs subject to potential reimbursement, which SST allegedly accepted by accepting the defense.[64]

In a strong dissent, Sixth Circuit Judge Eric Clay pointed out that there is a difference of opinion on whether an insurer can reserve its rights to seek reimbursement by a unilateral letter. He cited the Couch treatise, which states: "Under one view, an insurer has no right to payment for such costs under a policy, and the creation of such a right [by way of a unilateral reservation of rights letter] . . . amount[s] to a pro tanto supersession of the policy without separate agreement and separate consideration."[65]

Judge Clay also pointed out that silence generally does not constitute an acceptance under contract law.[66] He noted that while there are exceptions to this general rule, "strong policy considerations militate against allowing an insurer to unilaterally declare that it can recoup the costs of defending an insured where it is later determined that the underlying insurance policy did not cover the claim(s) asserted against the insured."[67] In any event, the judge held that given the litigation involved in this issue, it was clear that there was no meeting of the minds about whether a new contract was formed by the reservation of rights letter.[68]

In an opinion issued in May 2005, but now being reconsidered on rehearing, the Texas Supreme Court followed the lead of the California

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63. *Id.*

64. *Id.* A recent district court decision concluded, however, that "it is unlikely that the Ohio courts would extend the framework of *United National*...even further to encompass an insurer's right to seek reimbursement for the payment of a judgment, based solely on a unilateral reservation of rights." *See* American Motorist Ins. Co. v. Custom Rubber Extrusions, Inc., No. 1:05cv2331, 2006 U.S. Dist. LEXIS 59436 (N.D. Ohio Aug. 23, 2006).

65. United Nat'l Ins. Co., v. SST Fitness Corp., 309 F.3d 914, 925 (Clay, J., dissenting) (citing Couch on Insurance § 202:40, 3d ed. 1999) (alterations in the original).

66. *Id.* at 926.

67. *Id.*

68. *Id.* at 927.

Supreme Court's decision in *Blue Ridge*,[69] which as discussed above expanded the *Buss* rationale to allow reservation of a right to recoup a settlement payment. In *Excess Underwriters at Lloyd's, London v. Frank's Casing Crew & Rental Tools* ("*Frank's Casing*"), the Texas Supreme Court held that an insured's agreement to reimburse its liability insurer for the settlement of a suit against the insured can be implied in law if the insured demands that the insurer accept a settlement offer within policy limits or expressly agrees to accept the offer.[70] The court held that express agreement to seek reimbursement is not the only circumstance in which the insurer could obtain reimbursement, and recovery could be had under a quasi-contract theory.[71] It ruled this way despite having decided five years earlier in *Texas Association of Counties County Government Risk Management Pool v. Matagorda County*,[72] that an insurer's letter reserving a right to obtain reimbursement of a settlement did not justify recovery without the insured's express agreement. The *Matagorda* opinion decided that an insured's silence in response to a reservation of rights letter reserving a right to recoupment, coupled with a stipulation by the insured that the proposed settlement was reasonable, was not enough to permit reimbursement.[73]

Purporting to "clarify" any misunderstanding flowing from statements in *Matagorda*, the *Frank's Casing* court said there were "additional circumstances that will give rise to a right of reimbursement" beyond express agreement by the insured.[74] It concluded that an insurer can obtain reimbursement of a settlement when there is no coverage if, after the insurer has timely asserted its reservation of rights notifying the insured that it intends to seek reimbursement, the insured (1) demanded that the insurer accept a within limits settlement demand (*i.e.*, as occurs in a *Stowers* letter) or (2) expressly agreed that the settlement offer should be

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69. Blue Ridge Ins. Co. v. Jacobsen, 22 P.3d 313, 321 (Cal. 2001) ("Indeed, the right to reimbursement is implied by the terms of the insurance policy. Here, Blue Ridge agreed that as to 'bodily injury or property damage caused by an occurrence to which this coverage applies,' the insurer would indemnify the insured. By implication, Blue Ridge had no obligation to pay for noncovered claims").

70. Excess Underwriters at Lloyd's, London v. Frank's Casing Crew & Rental Tools, 48 Tex. Sup. Ct. J. 735, 737-39 (Tex. 2005) (as of the writing of this article the opinion has not been released for publication in the permanent law reports. Until released, it is subject to revision or withdrawal).

71. *Id.* at 739, 741.

72. 52 S.W.3d 128, 135 (Tex. 2000).

73. *Id.* at 131, 133.

74. *Frank's Casing*, 48 Tex. Sup. Ct. J. at 741.

accepted.[75] The court reasoned that in the first circumstance, the insured is not prejudiced by having to reimburse because its demand shows it considered the settlement demand reasonable, and "[i]f the offer is one that a reasonable insurer should accept, it is one that a reasonable insured should accept if there is no coverage."[76] The court also felt that allowing reimbursement may encourage insurers to settle questionable coverage cases.[77] It further echoed the California Supreme Court's sentiment that "reimbursement should be available because the insurer had not bargained to bear these costs and the insured had not paid the insurer premiums for the risk."[78]

The court deemed the second situation, when the insured expressly agreed the offer should be accepted, distinguishable from the situation in *Matagorda*.[79] It noted that in *Matagorda*, the insurer had the right to, and did, settle without the insured's consent, even though the insured agreed that the settlement amount was reasonable.[80] In *Frank's Casing*, on the other hand, the insured had the option to continue the litigation and decided to settle knowing the excess insurers intended to pursue coverage issues for the amount they paid in settlement.[81] The court concluded, "[a]n insured who agrees to the settlement and benefits by having claims against it extinguished cannot complain that it must reimburse its insurer if the claims against the insured were not covered by its policy."[82] It remains to

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75. *Id.* at 737-38. Such a demand to accept a within limits settlement demand is typically made by means of a *Stowers* letter. *See* G.A. Stowers Furniture Co. v. Am. Indem. Co., 15 S.W.2d 544 (Tex. Comm'n App. 1929).

76. Excess Underwriters at Lloyd's, London v. Frank's Casing Crew & Rental Tools, 48 Tex. Sup. Ct. J. 735, 738 (Tex. 2005).

77. *Id.* at 738-39.

78. *Id.* at 739 (quoting Blue Ridge Ins. Co. v. Jacobsen, 22 P.3d 313, 320 (Cal. 2001)).

79. *Id.* However, in the interest of calling a spade a spade, in Justice Nathan L. Hecht's concurring opinion he claimed that the distinctions the court pointed to are immaterial, stating that "the rule in *Matagorda County* cannot survive today's decision for the reasons *Matagorda County* was wrongly decided. . . . Since the present case cannot be distinguished from *Matagorda County* on any ground that matters, this case effectively overrules *Matagorda County*, as it should." *Id.* at 742 (Hecht, J., concurring). The dissenting opinion in *Matagorda County*, written by Justice Priscilla R. Owen and joined by Justice Hecht, was largely adopted in the majority decision of *Frank's Casing*, also delivered by Justice Owen. *See* Texas Ass'n of Counties County Gov't Risk Mgmt. Pool v. Matagorda County, 52 S.W.3d 128, 136 (Tex. 2000) (Owen, J., dissenting); *Frank's Casing*, 48 Tex. Sup. Ct. J. at 737-41.

80. *Frank's Casing*, 48 Tex. Sup. Ct. J. at 739.

81. *Id.*

82. Excess Underwriters at Lloyd's, London v. Frank's Casing Crew & Rental Tools, 48 Tex. Sup. Ct. J. 735, 739 (Tex. 2005).

be seen whether the Texas Supreme Court will ultimately adhere to these rulings when it issues a final opinion in the *Frank's Casing* case.

B. EQUITABLE THEORIES OF UNJUST ENRICHMENT AND QUANTUM MERUIT

Many courts that follow *Buss* have allowed insurers reimbursement of fees for uncovered claims to prevent the insured from being "unjustly enriched in benefiting by, without paying for, the defense of a non-covered claim."[83] A minority of courts have explicitly rejected this argument.[84]

Similarly, following up on the rationale of *Frank's Casing* and the Texas appellate court decision in the *Matagorda* case, the U.S. District Court for Minnesota in *St. Paul Fire & Marine Insurance Co. v. Compaq Computer Corp.*, recently predicted that Texas would also allow for reimbursement of defense costs based on the doctrine of quantum meruit.[85] This doctrine "is an equitable theory of recovery which is based on an implied agreement to pay for benefits received."[86] The elements of quantum meruit include: "(1) valuable services or materials were furnished, (2) to the party sought to be charged, (3) which were accepted by the party sought to be charged, (4) under such circumstances as reasonably notified the recipient that the plaintiff, in performing, expected to be paid by the recipient."[87] Based on the doctrine of quantum meruit, a finding of no coverage for the underlying claim, and a reservation of rights letter reserving its rights to obtain recoupment of its defense costs, the *Compaq* court awarded St. Paul its defense costs.[88]

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83. Hebela v. Healthcare Ins. Co., 851 A.2d 75, 86 (N.J. Super. Ct. App. Div. 2004) (citing Buss v. Superior Court, 939 P.2d 766, 776-78 (Cal. 1997)); *see also* Blue Ridge Ins. Co. v. Jacobsen, 22 P.3d 313, 321 (Cal. 2001) (applying *Buss* unjust enrichment reasoning to reimbursement of reasonable settlement payment situation).

84. *See, e.g.*, Terra Nova Ins. Co. v. 900 Bar, Inc., 887 F.2d 1213, 1219-20 (3d Cir. 1989); LA Weight Loss Ctrs., Inc. v. Lexington Ins. Co., No. 1560, 2006 WL 689109, at *7 (Pa. Ct. C.P. Philadelphia County Ct. Mar. 1, 2006).

85. St. Paul Fire & Marine Ins. Co. v. Compaq Computer Corp., 377 F. Supp. 2d 719, 723 (D. Minn. 2005), *aff'd*, 457 F.3d 766 (8th Cir. 2006).

86. *Id.* (quoting Matagorda County v. Texas Ass'n of Counties County Gov't Risk Mgmt. Pool, 975 S.W.2d 782, 785 (Tex. App. 1998)).

87. *Id.* (citing Matagorda County v. Texas Ass'n of Counties County Gov't Risk Mgmt. Pool, 975 S.W.2d 782, 785 (Tex. App. 1998)).

88. *Id.* at 723, 725.

C. GOOD SENSE/EQUITY/PUBLIC POLICY

Courts have reasoned that it is just and fair to allow reimbursement of defense costs after a court finds that there is no coverage when an insurer has clearly reserved its right to recover such costs. They hold that "a payor should be allowed to recover for payments made for others in good faith where, because of the relationship, the payor had reason to believe it would be reimbursed."[89]

The California Supreme Court in *Blue Ridge* determined that public policy considerations supported a rule allowing an insurer to unilaterally reserve its right to seek a reimbursement of settlement payments for claims not covered.[90] "In particular," the court stated, "it encourages insurers to defend and settle cases for which insurance coverage is uncertain. In so doing, it transfers from the injured party to the insurer the risk that the insured may not be financially able to pay the injured party's damages."[91] The court further noted the inequity inherent in placing the insurer in the "Catch-22" dilemma of either being forced to indemnify noncovered claims or facing the risk of bad faith allegations for failure to settle a claim within policy limits.[92]

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89. Util. Serv. & Maint., Inc. v. Noranda Aluminum, Inc., No. ED 82504, 2004 WL 1877916, at *5 (Mo. Ct. App. Aug. 24, 2004) (citing Ticor Title Ins. Co. v. Mundelius, 887 S.W.2d 726, 728 (Mo. Ct. App. 1994), *rev'd on other grounds*, 163 S.W.3d 910 (Mo. 2005)).

90. Blue Ridge Ins. Co. v. Jacobsen, 22 P.3d 313, 321 (Cal. 2001).

91. *Id.*

92. *Id.* However, a concurring opinion filed by Justice Mosk noted an interesting third option for addressing this alleged Catch-22 situation without placing an undue burden on the insured in a situation where the policyholder refuses to consent to a settlement within policy limits with a reservation of rights by the insurer to seek reimbursement of the settlement payment, but offers the insured the chance to defend on its own and settle the claim itself. That third option would be to allow the insured to retain the defense and refuse the settlement, but require that it waive any right to assert a bad faith claim against the insurer for failing to settle within limits. *Id.* at 324 (Mosk, J., concurring). Justice Mosk observed, "Without this option, the insured is forced to choose between accepting an unfair settlement for which it may be liable and having to pay its own legal expenses up front." *Id.*

III. WHY OTHER COURTS HAVE STOPPED THE *BUSS* AND REFUSED REIMBURSEMENT OF DEFENSE OR SETTLEMENT COSTS

Although a good number of courts have chosen to follow *Buss* on this issue, a growing number have not, including courts applying the laws of the following states:

1) Alabama,[93]
2) Illinois,[94]
3) Iowa,[95]
4) Louisiana,[96]
5) Maryland,[97]
6) Massachusetts,[98]
7) Minnesota,[99]
8) Mississippi,[100]

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93. *See, e.g.*, Mt. Airy Ins. Co. v. Doe Law Firm, 668 So. 2d 534, 537 (Ala. 1995) (reimbursement of settlement payment not allowed).

94. *See, e.g.*, Gen. Agents Ins. Co. of Am., Inc. v. Midwest Sporting Goods Co., 828 N.E.2d 1092, 1104 (Ill. 2005) (no reimbursement of defense costs).

95. Pekin Ins. Co. v. Tysa, Inc., No. 3:05-cv-00030-JEG, 2006 U.S. Dist. LEXIS 93525 (S.D. Iowa Dec. 27, 2006) (insurer not entitled to reimbursement of defense costs incurred prior to a determination of coverage under its policy).

96. *See, e.g.*, Yount v. Maisano, 627 So. 2d 148, 153 (La. 1993); Riley Stoker Corp. v. Fid. & Guar. Ins. Underwriters, Inc., 26 F.3d 581, 589 (5th Cir. 1994). *But see* Excess Underwriters at Llyod's, London v. Frank's Casing Crew & Rental Tools, Inc., No. 02-07306, 2005 WL 1252321, at *10 (Tex. May 27, 2005), *reh'g granted*, 2006 Tex. LEXIS 1 (Tex. Jan. 26, 2006) (holding Louisiana court would allow settlement reimbursement based on Louisiana Civil Code and state supreme court decision providing remedy when person was "enriched without cause at the expense of another person").

97. *See, e.g.*, Perdue Farms, Inc. v. Travelers Cas. & Sur. Co. of Am., 448 F.3d 252, 258, 259 (4th Cir. 2006) (no reimbursement of defense costs); Am. Modern Home Ins. Co. v. Reeds at Bayview Mobile Home Park, LLC, No. 05-1149, 2006 WL 994573, at *3 (4th Cir. Apr. 14, 2006) (no reimbursement of settlement payment).

98. *See, e.g.*, Millipore Corp. v. Travelers Indem. Co., 115 F.3d 21, 35 (1st Cir. 1997) (defense costs); Dash v. Chicago Ins. Co., No. Civ. A. 00-11911-DPW, 2004 WL 1932760, at *10 (D. Mass. Aug. 23, 2004) (defense costs); Med. Malpractice Joint Underwriting Ass'n of Mass. v. Goldberg, 680 N.E.2d 1121, 1128 (Mass. 1997) (no reimbursement of settlement payments).

99. *See, e.g.*, Employers Mut. Cas. Co. v. Indus. Rubber Prods., Inc., No. Civ. 04-3839, 2006 WL 453207, at *6 (D. Minn. Feb. 23, 2006) (no reimbursement of defense costs prior to the determination of coverage). *But see* Knapp v. Commonwealth Land Title Ins. Co., 932 F. Supp. 1169, 1172 (D. Minn. 1996) (allowing reimbursement of defense costs).

9) Missouri,[101]
10) Pennsylvania,[102]
11) Virginia,[103] and
12) Wyoming.[104]

These courts have relied on various rationales for their refusal.

A. BROAD DEFENSE OBLIGATIONS ARISE IMMEDIATELY WHEN SUITS ARE FILED WHEREAS NARROWER INDEMNITY OBLIGATIONS ARISE ONLY WHEN DAMAGES ARE FIXED

Some courts have determined recoupment to be inconsistent with the scope of the duty to defend. They have recognized that it is generally accepted that when a complaint is made against a policyholder that clearly alleges facts potentially within coverage, an insurer owes a duty to defend that claim until a court determines that no coverage exists for it. The Eighth Circuit employed this rationale in ruling on Missouri law in *Liberty Mutual Insurance Co. v. FAG Bearings Corp.*[105] There, the court refused recoupment of defense costs incurred in defending an environmental action after it was held that a pollution exclusion, which precluded coverage for contamination as long as it did not involve a "sudden and accidental" discharge of contaminants, applied to avoid coverage. The Eighth Circuit reasoned:

> Liberty remained obligated to defend FAG so long as there remained any question as to whether the underlying claims were covered by the policies. Upon determination that the pollution was not "sudden and accidental" and that the

100. *See, e.g.*, Mobile Telecomm. Techs. Corp. v. Aetna Cas. & Sur. Co., 962 F. Supp. 952, 956 (S.D. Miss. 1997) (no reimbursement of legal fees and costs).

101. *See, e.g.*, Liberty Mut. Ins. Co. v. FAG Bearings Corp., 153 F.3d 919, 924 (8th Cir. 1998) (defense costs).

102. *See, e.g.*, Terra Nova Ins. Co. v. 900 Bar, Inc., 887 F.2d 1213, 1219-20 (3d Cir. 1989) (no reimbursement of defense costs); LA Weight Loss Ctrs., Inc. v. Lexington Ins. Co., No. 1560, 2006 WL 689109 (Pa. Ct. C.P. Philadelphia County Ct. Mar. 1, 2006) (reimbursement of defense costs refused).

103. *See, e.g.*, Med. Protective Co. v. McMillan, No. Civ. A. 501CV00073, 2002 WL 31990490, at *7 (W.D. Va. Dec. 16, 2002) (no reimbursements of defense costs).

104. *See, e.g.*, Shoshone First Bank v. Pac. Employers Ins. Co., 2 P.3d 510, 513-14 (Wyo. 2000).

105. 153 F.3d 919 (8th Cir. 1998).

> claims against FAG were therefore excluded from coverage, the district court properly concluded that Liberty's duty to defend FAG in this action expired. Because we conclude that Liberty had a duty to defend FAG until such determination was made, we reject Liberty's argument that it is entitled to reimbursement of defense costs.[106]

Most recently, the Fourth Circuit, applying Maryland law in *Perdue Farms, Inc. v. Travelers Casualty & Surety Co. of America*,[107] held that the insurer was not entitled to reimbursement of defense costs for the non-covered claims (despite not being required to pay indemnity for these same non-covered claims) because the duty to defend is broader than the duty to indemnify. The court stated:

> While jurisdictions differ on the soundness of an insurer's right to reimbursement of defense costs, . . . Travelers has not identified a single Maryland case that extends this right to insurers. Under Maryland's comprehensive duty to defend, if an insurance policy potentially covers any claim in an underlying complaint, the insurer, as Travelers did here, must typically defend the entire suit, including non-covered claims. . . . *Properly considered, a partial right of reimbursement would thus serve only as a backdoor narrowing of the duty to defend, and would appreciably erode Maryland's long-held view that the duty to defend is broader than the duty to indemnify.*[108]

The Fourth Circuit stressed that refusing reimbursement in a mixed action case is necessary to keep the delicate balance of the bargain reached between the insurer and insured.[109] The court observed that in the typical CGL policy, the insurer has both the "duty" and the "right" to defend its insured, an arrangement that benefits both parties. The duty to defend

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106. *Id.* at 924. *But see* Util. Serv. & Maint., Inc. v. Noranda Aluminum, Inc., No. ED 82504, 2004 WL 1877916, at *5 (Mo. Ct. App. 2004), *rev'd*, 163 S.W.3d 910 (Mo. 2005) (appellate court holding of no coverage for indemnity agreement and granting insurer reimbursement of defense costs was reversed by Missouri Supreme Court which found coverage for indemnity agreement and thus did not reach issue of defense reimbursement).

107. 448 F.3d 252 (4th Cir. 2006).

108. *Id.* at 258 (emphasis added).

109. *Id.* at 258-59.

primarily benefits the insured because it receives a full defense and acts as "litigation insurance" by protecting the insured from having to bear the costs associated with the defense of litigation. The insurer receives the benefit of the "right" to defend, thereby protecting and minimizing its indemnity obligations. However,

> allowing a partial recoupment of defense costs would significantly tip the scales in favor of the insurer. Under Travelers's proposed rule, liability insurance would all but cease to function as 'litigation insurance' . . . , instead merely providing insureds with an up-front defense whose line-item costs would then be the subject of litigation. In the absence of any contrary indication from the Maryland courts, we are unwilling to grant insurers a substantial rebate on their duty to defend."[110]

Other courts have held similarly and therefore denied insurers' requests for reimbursement.[111]

B. INSURERS' PAYMENTS ARE VOLUNTARY

In *Medical Protective Co. v. McMillan*,[112] a federal district court sitting in Virginia upheld a magistrate judge's factual finding that an insurer voluntarily undertook the defense of insureds under a reservation of rights

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110. *Id.* at 259.

111. *See, e.g.*, Yount v. Maisano, 627 So. 2d 148, 153 (La. 1993) (ordered insurer to pay defense costs notwithstanding court's finding that no coverage existed for claim because of applicability of exclusion); Riley Stoker Corp. v. Fid. & Guar. Ins. Underwriters, Inc., 26 F.3d 581, 589-90 (5th Cir. 1994) (citing *Yount*, court rejected insurer's request to apportion defense costs for uncovered claims); Millipore Corp. v. Travelers Indemn. Co., 115 F.3d 21, 35-36 (1st Cir. 1997) (no reimbursement allowed despite finding of no coverage because duty to defend possibility existed when complaint filed). It is also worth noting that some courts that allowed reimbursement did so after specifically determining that there was no duty to defend from the start of the underlying case. *See, e.g.*, Scottsdale Ins. Co. v. Sullivan Prop., Inc., No. Civ. 04-00550HGBMK, 2006 WL 505170, at *2, 12 (D. Haw. Feb. 28, 2006) (insurer entitled to reimbursement of defense costs, after insurer timely reserved such rights, because court held insurer had no duty to defend insured, noting no Hawaii precedent and citing California law, *Scottsdale* and *Buss*); Scottsdale Ins. Co. v. MV Transp., 115 P.3d 460 (Cal. 2005) (same).

112. No. Civ. A. 501CV00073, 2002 WL 31990490 (W.D. Va. Dec. 16, 2002).

and also upheld the dismissal of that insurer's motion for reimbursement of attorney's fees.[113]

Similarly, in refusing to allow reimbursement of defense fees, the Alabama Supreme Court squarely decided that an insurer's payment of such funds was completely voluntary, despite having been made under protest and with the pending threat of a bad faith suit by the policyholder if the insurer failed to settle the claim within policy limits.[114] The court rejected the insurer's argument that the doctrine of subrogation applied to the reimbursement of settlement funds sought, because the settlement payments were not paid to compensate the policyholder for an injury caused by a third party, but rather, to settle a third party's claim against the policyholder.[115]

The United States District Court for the Southern District of Mississippi held likewise, also basing its decision upon the volunteer doctrine.[116] In *Mobile Telecommunications*, the court denied the insurer's requests for reimbursement of $1 million paid in defense costs, notwithstanding that the carrier timely reserved its rights to recover such fees, because the court held the fees were voluntarily paid.[117]

In a related analysis, in *Terra Nova Insurance Co. v. 900 Bar, Inc.*,[118] the Third Circuit observed that an insurer that assumes the defense does so to protect its own interests as much as the insured's, and thus there is no inequity in requiring the insurer to bear its costs. Predicting that the Pennsylvania Supreme Court would preclude an insurer who defends an action under a reservation of rights from recouping its defense costs from its insured if it is later found that there is no coverage, the court stated:

> A rule permitting such recovery would be inconsistent with the legal principles that induce an insurer's offer to defend under a reservation of rights. Faced with uncertainty as to its

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113. *Id.* at *5-8.

114. Mt. Airy Ins. Co. v. Doe Law Firm, 668 So. 2d 534, 538 (Ala. 1995).

115. *Id.* at 537. Citing that decision, Pennsylvania and Florida district courts held similarly. *See, e.g.*, Coregis Ins. Co. v. Law Offices of Carole F. Kafrissen, 140 F. Supp. 2d 461, 465-66 (E.D. Pa. 2001) (denying insurer's request for reimbursement of settlement payment because it found payment was voluntarily made, citing Alabama's decision in *Mount Airy*); Steadfast Ins. Co. v. Sheridan Children's Healthcare Servs., Inc., 34 F. Supp. 2d 1364, 1367 (S.D. Fla. 1998).

116. Mobile Telecomm. Techs. Corp. v. Aetna Cas. & Sur. Co., 962 F. Supp. 952 (S.D. Miss. 1997).

117. *Id.* at 953, 956.

118. 887 F.2d 1213 (3d Cir. 1989).

> duty to indemnify, an insurer offers a defense under reservation of rights to avoid the risks that an inept or lackadaisical defense of the underlying action may expose it to if it turns out there is a duty to indemnify. At the same time, the insurer wishes to preserve its rights to contest the duty to indemnify if the defense is unsuccessful. Thus, such an offer is made at least as much for the insurer's own benefit as for the insured's. If the insurer could recover defense costs, the insured would be required to pay for the insurer's action in protecting itself against the estoppel to deny coverage that would be implied if it undertook the defense without reservation.[119]

The voluntary payment defense was raised and rejected in several other cases, however. For example, in *Utility Service & Maintenance, Inc. v. Noranda Aluminum, Inc.*,[120] the court did not agree that the insurer acted as a volunteer payor in defending its insured, but, rather, acted under duress.[121] The same result occurred in *United National Insurance Co. v. SST Fitness Corp.*,[122] in which the Sixth Circuit reversed the Ohio District Court's holding on the same basis. The court held that "[t]he volunteer defense applies if the paying party has not been asked for the payment. SST requested the defense costs from United National by tendering the underlying litigation for defense. . . ."[123] The U.S. District Court for Minnesota, applying Texas law, similarly dismissed this defense, holding that a payment made under reservation of a right to seek recovery is not a voluntary payment.[124] Finally, the California Supreme Court rejected this argument in *Blue Ridge* as well.[125]

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119. *Id.* at 1219-20; LA Weight Loss Ctrs., Inc. v. Lexington Ins. Co., No. 1560, 2006 WL 689109, at *6-7 (Pa. Ct. C.P. Philadelphia County Ct. Mar. 1, 2006).

120. No. ED 82504, 2004 WL 1877916 (Mo. Ct. App. Aug. 24, 2004), *rev'd*, 163 S.W.3d 910 (Mo. 2005).

121. *Id.* at *5.

122. 309 F.3d 914 (6th Cir. 2002).

123. *Id.* at 922.

124. St. Paul Fire & Marine Ins. Co. v. Compaq Computer Corp., 377 F. Supp. 2d 719, 725 (D. Minn. 2005) (citing H.S. Res., Inc. v. Wingate, 327 F.3d 432, 442 (5th Cir. 2003), *aff'd*, 457 F.3d 766 (8th Cir. 2006)).

125. Blue Ridge Ins. Co. v. Jacobsen, 22 P.3d 313, 322 (Cal. 2001) ("It is not apparent how an insurer that has been precluded from earlier resolving the question of coverage, and that is obligated to accept a reasonable settlement or risk excess exposure, acts as a

C. A RESERVATION OF RIGHTS DOES NOT CREATE A NEW CONTRACT

Many courts have concluded that a unilateral reservation of rights letter "cannot create rights not contained in the insurance policy"[126] or "relieve the insurer of the costs incurred in defending its insured where the insurer was obligated, in the first instance, to provide such a defense. . . ."[127] A Pennsylvania court recently agreed with the minority of courts on this issue and found that a "reservation of rights letter does not create a contract allowing an insurer to recoup defense costs from its insured, but rather, is a means to assert defenses and exclusions which are already set forth in the policy."[128]

Further, even courts that accept the proposition that a reservation of rights can create a contract generally hold insurers must both: (1) specifically reserve the right to seek reimbursement; and (2) provide the insured with adequate notice of this potential reimbursement.[129] "The terms and conditions of a reservation of rights letter are strictly construed and an [insurer] must indicate its intent to seek reimbursement for defense costs in clear and unambiguous language."[130] A general reservation of rights does not accomplish this task.[131] An insurer's failure to prove that it

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volunteer in accepting that settlement merely because its insured objects to its reservation of the right to seek reimbursement.").

126. Texas Ass'n of Counties County Gov't Risk Mgmt. Pool v. Matagorda County, 52 S.W.3d 128, 131 (Tex. 2000), *holding modified by*, Excess Underwriters at Lloyd's, London v. Frank's Casing Crew & Rental Tools, Inc., No. 02-0730, 2005 WL 1252321 (Tex. May 27, 2005); *see also* Shoshone First Bank v. Pac. Employers Ins. Co., 2 P.3d 510, 515-16 (Wyo. 2000) (rejecting notion that insurer could base right of reimbursement of defense costs on a letter stating "we will not permit the contract to be amended or altered by a reservation of rights letter," citing America States Insurance Co. v. Ridco, Inc., Riddles Jewelry, Inc. & Ken B. Berger, Civ. No. 95CV158D (D. Wyo. 1999)); LA Weight Loss Ctrs., Inc. v. Lexington Ins. Co., No. 1560, 2006 WL 689109, at *5 (Pa. Ct. C.P. Philadelphia County Ct. Mar. 1, 2006).

127. First Ins. Co. of Haw., Inc. v. State, 665 P.2d 648, 654 (Haw. 1983) (cited and adopted by *Shoshone*, 2 P.3d at 515-16).

128. *LA Weight Loss Ctrs.*, 2006 WL 689109, at *6.

129. Travelers Cas. & Sur. Co. v. Ribi Immunochem Research, Inc, 108 P.3d 469, 479-80 (Mont. 2005) (citing Grinnell Mut. Reinsurance Co. v. Shierk, 996 F. Supp. 836, 839 and United Nat'l Ins. Co. v. SST Fitness Corp., 309 F.3d 914, 921 (6th Cir. 2002)); *see also* Resure, Inc. v. Chem. Distrib., Inc., 927 F. Supp. 190, 194 (M.D. La. 1996) (applying New Mexico law), *aff'd*, 114 F.3d 1184 (5th Cir. 1997) (table case); Nobel Ins. Co. v. Austin Powder Co., 256 F. Supp. 2d 937, 940 (W.D. Ark. 2003).

130. *Nobel*, 256 F. Supp. 2d at 940 (citing 16 Couch on Insurance § 226:128 (3d Ed.)).

131. *Id.*

has met either requirement is enough for a court to deny reimbursement of defense costs.[132]

Absent a new contract arising through a reservation of rights, courts have held insurers to policy terms and have pointed to standard CGL policies' lack of a provision granting the insurer a right of defense or settlement cost reimbursement as a reason to deny an insurer's reimbursement request.[133] For example, in the dissent in *United National v. SST*, Judge Clay stated:

> However, United National admits that the underlying insurance contract that United National entered into with SST contains no provision allowing it to recoup attorneys fees where United National elects to accept the tender of a defense and then later discovers that it had no duty to do so. Thus, the right United National seeks to assert in this case, the right to reimbursement under the applicable policy of

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132. Capitol Indemn. Corp. v. Blazer, 51 F. Supp. 2d 1080, 1090-91 (D. Nev. 1999); Terra Nova Ins. Co. v. 900 Bar, Inc., 887 F.2d 1213, 1217-19 (3d Cir. 1989) (insurer not entitled to reimbursement because reservation of rights letter was too general); *In re* Hansel, 160 B.R. 66, 70 (Bankr. S.D. Tex. 1993) (same, letter "fail[ed] to put the reader on notice that such a right [of reimbursement] is claimed"); Med. Protective Co. v. McMillan, No. Civ. A. 501CV00073, 2002 WL 31990490, at *6 (W.D. Va. Dec. 16, 2002) (same); *Nobel Ins. Co.*, 256 F. Supp. 2d at 940 (insurer not entitled to reimbursement of defense or settlement costs because reservation of rights letter did not "mention of the possibility" that the insurer would seek reimbursement if no coverage and additional letter specifically stating same did not come until after claim was settled and therefore was not timely); Underwriters at Lloyds, London v. STD Enters., Inc., 395 F. Supp. 2d 1142, 1150-51 (M.D. Fla. 2005). *But see* NCMIC Ins. Co. v. Dailey, No. 267801, 2006 WL 2035597, at *5-6 (Mich. Ct. App. July 20, 2006) (in rescission case, court held insurer entitled to reimbursement of defense costs paid as restitution to prevent unjust enrichment notwithstanding that insurer failed to specifically reserve its rights to recoup same, but instead gave insured general notice that it would seek restitution).

133. *See, e.g.*, Texas Ass'n of Counties County Gov't Risk Mgmt. Pool v. Matagorda County, 52 S.W.3d 128 (Tex. 2000), *holding modified by*, Excess Underwriters at Lloyd's, London v. Frank's Casing Crew & Rental Tools, Inc., No. 02-0730, 2005 WL 1252321 (Tex. May 27, 2005); LA Weight Loss Ctrs., Inc. v. Lexington Ins. Co., 2003 No. 1560, 2006 WL 689109 (Pa. Ct. C.P. Philadelphia County Ct. Mar. 1, 2006); *United Nat'l Ins. Co.*, 309 F.3d at 925 (Clay, J., dissenting); *In re Hansel*, 160 B.R. at 70; *Med. Protective Co.*, 2002 WL 31990490, at *5-6; Shoshone First Bank v. Pac. Employers Ins. Co., 2 P.3d 510 (Wyo. 2000); Flannery v. Allstate Ins. Co., 49 F. Supp. 2d 1223, 1232 (D. Colo. 1999); Employers Mut. Cas. Co. v. Indust. Rubber Prods., Inc., No. Civ. 04-3839, 2006 WL 453207, at *5-6 (D. Minn. Feb. 23, 2006); Med. Malpractice Joint Underwriting Ass'n of Mass. v. Goldberg, 680 N.E.2d 1121, 1128 (Mass. 1997).

> insurance, is not a right to which it is entitled based on noncoverage under the policy.[134]

In *Shoshone First Bank v. Pacific Employers Insurance Co.*,[135] the Wyoming Supreme Court rejected the California Supreme Court's *Buss* holding and held that an insurer cannot be reimbursed for uncovered claims in a mixed action case, in part because the policy language did not make such a distinction or allow for any sort of allocation in its duty to defend requirement.[136]

The Massachusetts Supreme Court and the Fourth Circuit Court of Appeals, applying Maryland law, ruled similarly in refusing to allow an insurer reimbursement of settlement amounts it paid.[137] The Massachusetts court stated: "We observe first that the policies at issue do not contain a provision for reimbursement to [the insurer] of any settlement paid by it." Both courts further refused to imply that such an agreement was reached and required that for the insurer to obtain any such reimbursement, the policyholder must explicitly agree to such an arrangement: "American Modern's repeated reservation of its asserted right to reimbursement is entirely inconsequential."[138]

D. EQUITY AND EFFICIENCY CONCERNS WEIGH AGAINST REIMBURSEMENT

Policyholders have argued, with varying degrees of success, that an insurer benefits unfairly if it can hedge on its defense obligations by reserving its rights to recoup while potentially controlling the defense and

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134. *United Nat'l Ins. Co.*, 309 F.3d at 925.

135. 2 P.3d 510 (Wyo. 2000).

136. *Id.* at 515. A number of courts have upheld reimbursement clauses in insurance contracts. *See* Texas Ass'n of Counties County Gov't Risk Mgmt. Pool v. Matagorda County, 52 S.W.3d 128, 131-32 n.4 (Tex. 2000), collecting cases, including Rural Mut. Ins. Co. v. Peterson, 395 N.W.2d 776, 778-82 (Wis. 1986); Employers Mut. Cas. Co. v. Nicholas, 238 P.2d 1120 (Col. 1951); Serv. Mut. Liab. Ins. Co. v. Aronofsky, 31 N.E.2d 837 (Mass. 1941).

137. *Med. Malpractice Joint Underwriting Ass'n*, 680 N.E.2d at 1128; American Modern Home Ins. Co. v. Reeds at Bayview Mobile Home Park, LLC, No. 05-1149, 2006 WL 994573, at *3 (4th Cir. Apr. 4, 2006) (unpublished) (after finding no coverage and no duty to defend, court reversed lower court's order of reimbursement of settlement payment finding that there was no policy language that allowed such a result and policyholder did not agree to such a result).

138. *Med. Malpractice Joint Underwriting Ass'n*, 680 N.E.2d at 1128; *American Modern Home Ins. Co.*, 2006 WL 994573, at *3.

thereby avoiding bad faith claims and possible estoppel for failing to timely defend in the first place.[139] This escape hatch arguably allows insurers to have their cake and eat it too. One court wrestling with this issue explained:

> The question as to whether there is a duty to defend an insured is a difficult one, but because that is the business of an insurance carrier, it is the insurance carrier's duty to make that decision. If an insurance carrier believes that no coverage exists, then it should deny its insured a defense at the beginning instead of defending and later attempting to recoup from its insured the costs of defending the underlying action. Where the insurance carrier is uncertain over insurance coverage for the underlying claim, the proper course is for the insurance carrier to tender a defense and seek a declaratory judgment as to coverage under the policy. However, to allow the insurer to force the insured into choosing between seeking a defense under the policy, and run the potential risk of having to pay for this defense if it is subsequently determined that no duty to defend existed, or giving up all meritorious claims that a duty to defend exists, places the insured in the position of making a Hobson's choice. Furthermore, endorsing such conduct is tantamount to allowing the insurer to extract a unilateral amendment to the insurance contract. If this became common practice, the insurance industry might extract coercive arrangements from their insureds, destroying the concept of liability and litigation insurance.[140]

In *Shoshone First Bank v. Pacific Employers Insurance Co.*,[141] the Wyoming Supreme Court did not allow the insurer to obtain reimbursement for the non-covered claims in a mixed action partially due to concerns for efficiency. The court stated: "It is obvious that no right of allocation should exist if the costs incurred for the defense of a non-covered claim were necessarily incurred or would have to be incurred

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139. United Nat'l Ins. Co. v. SST Fitness Corp., 309 F.3d 914, 921 (6th Cir. 2002); *see also id.* at 924 (Clay, J., dissenting).

140. Shoshone First Bank v. Pac. Employers Ins. Co., 2 P.3d 510, 516 (Wyo. 2000)

141. 2 P.3d 510 (Wyo. 2000).

because of the defense of a covered claim."[142] The court specifically rejected the *Buss* holding in this regard because of efficiency concerns such as having to hire separate counsel to represent the insured in covered versus uncovered claims and potential disagreements among the defense counsel team.[143]

IV. THE *BUSS* STOP: *GENERAL AGENTS v. MIDWEST SPORTING GOODS*

The Illinois Supreme Court blended the rationales of the courts that rejected *Buss* when it weighed in on the recoupment issue in *General Agents Insurance Co. v. Midwest Sporting Goods Co.*[144] The *General Agents* case stemmed from a nuisance action by the City of Chicago and Cook County against Midwest Sporting Goods Company contending that Midwest and others created a public nuisance by selling guns to inappropriate buyers. Midwest's liability insurer, General Agents Insurance Co. ("Gainsco"), denied coverage for the action. Later, after an amended complaint was filed, Gainsco sent Midwest's independent counsel a letter that continued to dispute coverage but concluded:

> Subject to the foregoing, and without waiving any of its rights and defenses, *including the right to recoup any defense costs paid in the event that it is determined that the Company does not owe the Insured a defense in this matter,* the Company agrees to provide the Insured a defense in the captioned suit. In light of the competing interests between the Company and the Insured in respect of the coverage for this matter, the Company agrees to the Insured's selection and use of your firm as its counsel in this matter. However, the Company notes its right to associate with the Insured and its counsel in the defense of the underlying litigation.[145]

Midwest thereafter accepted Gainsco's payment of defense costs without challenging this purported reservation.

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142. *Id.* at 515.
143. *Id.*
144. 828 N.E.2d 1092 (Ill. 2005).
145. *Id.* at 1094.

Gainsco then brought a declaratory judgment action to test its obligations. In a decision later affirmed on appeal, a trial court ruled that Gainsco had no duty to defend Midwest in the nuisance action. Gainsco then moved for a judgment for recovery of the defense costs it had paid. The trial court granted the motion, ordering repayment of all monies Gainsco had paid for Midwest's defense. That judgment was also affirmed.[146] The Illinois Supreme Court, however, granted review of the recoupment decision and reversed it.[147]

The Illinois Supreme Court recounted that *Buss* and cases following it had established a majority rule "that an insurer may recover defense costs from its insured where the insurer agrees to provide the insured a defense pursuant to an express reservation of rights, including the right to recoup defense costs, the insured accepts the defense, and a court subsequently finds that the insurer did not owe the insured a defense."[148] The supreme court concluded that Gainsco would be entitled to recoupment of defense costs if the court followed that rule because "Gainsco timely and expressly reserved its right to reimbursement of defense costs, Midwest accepted payment of those defense costs without objection, and a declaratory judgment action determined that Gainsco did not owe Midwest a defense in the underlying lawsuit."[149]

The court declined to follow the majority rule, however, embracing instead the minority position that refuses "to allow an insurer to receive reimbursement of its defense costs even though the underlying claim was not covered by the insurance policy and the insurer had specifically reserved its right to reimbursement."[150] The court was persuaded by the minority view that permitting recoupment by reservation, absent an insurance policy provision authorizing it, was "tantamount to allowing the insurer to extract a unilateral amendment to the insurance contract."[151] An

146. Gen. Agents Ins. v. Midwest Sporting Goods, 765 N.E.2d 1152 (Ill. App. Ct. 2002).

147. The decision ruling that Gainsco owed no duty to defend was not before the supreme court. Gen. Agents Ins. v. Midwest Sporting Goods, 828 N.E.2d 1092, 1095 (Ill. 2005).

148. *Id.* at 1100.

149. *Id.* at 1101.

150. *Id.*

151. *Id.* at 1102 (quoting Shoshone First Bank v. Pacific Employers Ins. Co., 2 P.3d 510, 516 (Wyo. 2000) and Am. States Ins. Co. v. Ridco, Inc., Civ. No. 95CV158D, 1996 WL 33401184, at *2 (D. Wyo. Feb. 8, 1996)).

insurer cannot, the court reasoned, reserve a right not in the policy.[152] The court expressed agreement with the Eighth Circuit's *FAG Bearings* decision that an insurer must honor its duty to defend as long as any questions remain about whether underlying claims are covered.[153] It also agreed with the view of the Third Circuit that the insured is not unjustly enriched absent recoupment because an insurer agreeing to defend under a reservation of rights is acting as much for its own protection against the effects of "an inept or lackadaisical defense" as for the insured's benefit.[154]

Ultimately, echoing the rationale of Justice Kennard's dissent in the *Buss* case, the Illinois Supreme Court concluded that the matter should be decided by the terms of the insurance policy at issue. It concluded:

> In sum, we acknowledge that a majority of jurisdictions have held that an insurer is entitled to reimbursement of defense costs when (1) the insurer did not have a duty to defend, (2) the insurer timely and expressly reserved its right to recoup defense costs, and (3) the insured either remains silent in the face of the reservation of rights or accepts the insurer's payment of defense costs. We choose, however, to follow the minority rule and refuse to permit an insurer to recover defense costs pursuant to a reservation of rights absent an express provision to that effect in the insurance contract between the parties.[155]

The *General Agents'* policy language based approach has been adopted in at least three later decisions. In *Employers Casualty Co. v. Industrial Rubber Products, Inc.*,[156] a federal district court applying Minnesota law decided that "an insurer is not entitled to the reimbursement of defense costs expended prior to the determination of coverage, unless specifically provided for in the insurance policy."[157] A Pennsylvania trial court next

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152. Gen. Agents Ins. v. Midwest Sporting Goods, 828 N.E.2d at 1103 (citing First Ins. Co. v. State, 665 P.2d 648, 654 (Haw. 1983)).

153. *Id.* at 1103-04 (citing Liberty Mut. Ins. Co. v. FAG Bearings Corp., 153 F.3d 919, 924 (8th Cir. 1998)).

154. *Id.* at 1102-03 (quoting Terra Nova Ins. Co. v. 900 Bar, Inc., 887 F.2d 1213, 1219-20 (3d Cir. 1989)).

155. *Id.* at 1104.

156. No. Civ. 04-3839, 2006 WL 453207 (D. Minn. Feb. 23, 2006).

157. *Id.* at *6. The court was persuaded by the Eighth Circuit's decision *Liberty Mutual v. FAG Bearings Corp.*, 153 F.3d 919, 923 (8th Cir. 1998), which the *General Agents* court followed, but cited *General Agents* with approval as well. *Id.* at *5-6.

espoused the *General Agents* approach. In *LA Weight Loss Centers, Inc. v. Lexington Insurance Co.*,[158] the court faced an insurer's claim for recoupment of defense costs after the court decided there was no coverage for an employment discrimination class action suit. The court weighed the majority and minority positions on recoupment and concluded:

> After taking into consideration the parties' respective memoranda, as well as the authorities cited therein, the court finds the analysis relied upon by the minority of the courts that have addressed the issue to be more persuasive and adopts said reasoning herein. A reservation of rights letter does not create a contract allowing an insurer to recoup defense costs from its insured, but rather, is a means to assert defenses and exclusions which are already set forth in the policy. Certainly, if an insurer wishes to retain its right to seek reimbursement of defense costs in the event it later is determined that the underlying claim is not covered by the policy, the insurer is free to include such a term in its insurance contract. Absent such a provision in the policy, an insurer should not be permitted to unilaterally amend the policy by including the right to reimbursement in its reservation of rights letter.[159]

Most recently, in *Pekin Insurance Company v. Tysa, Inc.*,[160] a federal district court predicted that the Iowa Supreme Court would adopt the reasoning in *General Agents* and the Minnesota and Pennsylvania courts that ruled in accordance with its policy language based approach. The *Pekin* court concluded that although the majority of cases permit recovery:

> an examination of the long-standing Iowa jurisprudence regarding the breadth of the duty to defend and the reasonable expectations of the insured convinces this Court that the Iowa Supreme Court would be more persuaded by the Illinois, Minnesota, and Pennsylvania decisions finding that using a reservation of rights to permit recovery of

158. No. 1560, 2006 WL 689109 (Pa. Ct. C.P. Philadelphia County Ct. Mar. 1, 2006).

159. *Id.* at *6.

160. No. 3:05-cv-00030-JEG, 2006 U.S. Dist. LEXIS 93525 (S.D. Iowa Dec. 27, 2006).

> defense costs amounts to a unilateral modification of the policy terms and that, because the duty to defend is broader than the duty to indemnify, the insured is not unjustly enriched when the insurer provides a defense for claims that are at least possibly within the coverage terms, although such claims may later be found to be outside the policy.[161]

Of course the recent trend is not uniform. One case decided after *General Agents* went the other way, though without discussing the *General Agents* decision.[162] Another, the previously discussed *Perdue Farms* case decided by the Fourth Circuit under Maryland law, cited and agreed with the result of *General Agents* but without expressly adopting the policy based approach.[163]

The Illinois Supreme Court's approach, which focuses on policy wording to resolve the issue of recoupment, has much to recommend it. One of the most enduring rules of insurance law requires a court to apply the clear terms of the policy as written.[164] As discussed below, however, the policy language based approach refutes *Buss* even more strongly than the *General Agents* opinion and others like it indicate. Permitting recoupment violates the plain terms of standard liability policies.

A. PERMITTING RECOUPMENT VIOLATES STANDARD GENERAL LIABILITY POLICY WORDING

As noted above, courts refusing recoupment under the policy language based approach, such as the Illinois Supreme Court in *General Agents*,

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161. *Id.* at *53-54.

162. St. Paul Fire & Marine Ins. Co. v. Compaq Computer Corp., 377 F. Supp. 2d 719 (D. Minn. 2005) (under Texas law, insurer could recoup payments made under reservation of rights under a quantum meruit theory), *aff'd*, 457 F.3d 766 (8th Cir. 2006).

163. Perdue Farms, Inc. v. Travelers Cas. & Sur. Co. 448 F.3d 252, 258 (4th Cir. 2006) (holding that trial court properly refused an insurer's request for recoupment of defense costs where only some counts of a suit fell within policy coverage because, *inter alia*, "[a] partial right to reimbursement of defense costs would ... undermine the bargain that Maryland courts describe insurers reaching with their insureds").

164. Secura Ins. v. Stainless Sales, Inc., 431 F.3d 987, 990 (6th Cir. 2005) ("[I]nsurance policy terms that are clear and precise must be enforced as written."); Nat'l State Bank v. Am. Home Assurance Co., 492 F. Supp. 393, 396 (S.D.N.Y. 1980) ("[T]he policy must be enforced as written, and the Court is not free to modify its terms by judicial construction."); Nat'l Farmers Union Prop. & Cas. Co. v. George, 963 P.2d 1259, 1261 (Mont. 1998) ("If the language of a policy is clear and explicit, the policy must be enforced as written.").

have stressed the lack of a policy provision providing for recoupment as a basis for their decision. Courts permitting reimbursement, such as the California Supreme Court in *Buss*, have proceeded from the premise that standard liability policies are silent as to reimbursement and these courts have been willing to imply such a right by operation of law.[165] Both sides have overlooked key policy language that runs expressly against a right of reimbursement, rendering the policy language based approach stronger than the courts have presented it.

Not only do standard liability policies generally not include recoupment provisions, they usually expressly disclaim the idea in their supplementary payments clauses. Those clauses promise that the insurer will bear the full cost for cases it defends. This promise precludes allocation of defense costs among claims and forecloses reimbursement.

Standard commercial general liability policies contain supplementary payments provisions stating: "We will pay, with respect to any claim or

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165. Buss v. Superior Court, 939 P.2d 766, 776-77 n.13 (Cal. 1997) (suggesting that the existence of an implied right of reimbursement renders express terms on the point unnecessary).

'suit' we defend: 1. All expenses we incur."[166] The policies at issue in the *General Agents* case, for example, had this language.[167]

These supplementary payments clauses unambiguously promise that the insurer will pay "*all* expenses" that it incurs in connection with suits it defends.[168] The clause is flatly inconsistent with the allocation of defense costs in mixed actions as was done in the *Buss* case. The *Buss* court was willing to allocate defense costs among claims in a suit because the court saw no contractual promise to pay for the defense of all claims in a mixed

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166. Clarence E. Hagglund et al., CGL POLICY HANDBOOK App. A at App-4 (Supp. 2001); *e.g.*, Employers Reins. Corp. v. Mid-Continent Cas. Co., 358 F.3d 757, 772 (10th Cir. 2004) ("The pertinent language of the supplementary payments provisions...states: 'We will pay, with respect to any claim we investigate or settle or "suit" against an insured we defend: a. all expenses we incur'"); Cincinnati Ins. Co. v. Meramec Valley Bank, 259 F. Supp. 2d 922, 925 (E.D. Mo. 2003) ("The Commercial General Liability Coverage Part contains a provision for Supplementary Payments agreeing to pay, with respect to any claim or suit Cincinnati defends, all reasonable expenses and costs."); W. Cas. & Sur. Co. v. Preis, 695 S.W.2d 579, 583 (Ct. App. Tex. 1985) ("The said policy contained the following Supplementary Payments provision...The Western will pay, in addition to the applicable limit of liability: (a) all expenses incurred by the Western, all costs taxed against the INSURED in any suit defended by The Western..."); *see* also 20-131 APPLEMAN ON INSURANCE § 131.5 ("The supplementary payments of the 1986 ISO [standard general] liability forms...are as follows: 'We will pay, with respect to any claim or "suit" we defend: 1. All expenses we incur.'"); DONALD S. MALECKI & ARTHUR L. FLITNER, COMMERCIAL GENERAL LIABILITY 10 (4th ed. 1992) ("Closely related to the insurer's duty to defend are the supplementary payments that the insurer promises to make in addition to paying damages. These payments, which apply to both Coverage A and Coverage B, are as follows. 'We will pay, with respect to any claim or "suit" we defend: 1. All expenses we incur"); Carter Mudge, *Special Feature: Saving for a Rainy Day*, ORANGE COUNTY LAW., May 2005, at 34 ("Most CGL policies also contain Supplementary Payments Provisions...providing all expenses incurred in the defense of the insured, and all costs taxed against the insured, are paid by the carrier and are in addition to the applicable policy limits").

167. Record in Gen. Agents Ins. Co. v. Midwest Sporting Goods Co., No. 98814 (Ill. Supreme Court) at C000109, C000147, C000182, C000214.

168. Attorney fees the insurer incurs are "expenses" under this clause. *See* Employers Reins. Corp. v. Mid-Continent Cas. Co., 358 F.3d 757, 768, 771 (10th Cir. 2004) ("We agree...that 'claim expenses,' which [under the parties' reinsurance agreement] include 'all payments under the supplementary payments provisions of 'MCCC's policy,' thus cover MCCC's declaratory judgment attorney fees and expenses...MCCC's payments of its insured's attorney fees incurred in the underlying tort actions should be treated as 'claim expenses'" as well); Commercial Underwriters Ins. Co. v. Royal Surplus Lines Ins. Co., 345 F. Supp. 2d 652, 671-72 (S.D. Tex. 2004) ("attorney fees [were] an expense incurred by Royal in the defense of the [insured] Nursing Home Defendants" falling within the terms of CGL policy's "Supplementary Payments" clause promising to "pay with respect to any claim we investigate or settle, or any 'suit' against an insured we defend: 1. All expenses we incur...").

action.[169] The supplementary payments clause would have been strong support for the view expressed by Justice Kennard in her dissent in *Buss* that an "insurer must, at its own expense and without any claim for reimbursement, defend the whole of...a 'mixed action.'"[170]

By promising that the insurer will bear all defense costs for claims and suits it defends, the supplementary payments clause also precludes an insurer's claim for reimbursement in non-mixed actions. Under the plain terms of the clause, if the insurer defends (whether it acted because its duty was clear or it thought that the question of coverage was close enough so that it would be dangerous to refuse to defend), it must bear those costs.[171] Allowing the insurer to shift defense costs back to the insured through reimbursement would contravene the clause's express promise that the insurer will pay them. Accordingly, contrary to what a reader may conclude from reviewing cases on both sides of the question, standard liability policies are not silent about allocation or recoupment. They expressly disclaim it.

The existence of express contractual terms on the matter entirely undercuts the *Buss* court's reasoning in recognizing a right as implied in law. As previously explained, the court in *Buss* was persuaded to recognize a right of recoupment in addressing an extreme set of facts. The court decided that a right of recoupment could be implied from the extent of the duty to defend established by the policy's basic terms. It did not, however, address the impact of whatever supplementary payments provision appeared in either the policy before it, or other standard liability policies. The court could not have properly implied a right of allocation and reimbursement in conflict with the policy's express promise that the insurer would bear all defense costs. Quasi contractual remedies such as the one espoused in *Buss* are not designed to overcome such express

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169. Buss v. Superior Court, 939 P.2d 766, 775 (Cal. 1997) ("We cannot justify the insurer's duty to defend the entire 'mixed' action contractually, as an obligation arising out of the policy...").

170. *Id.* at 786 (Kennard, J., dissenting).

171. *See* Arthur Paul Berg, *The Supplementary Payments Provision and the Insurer's Obligation to Pay Attorney Fee Awards*, 1988 CGL Reporter (10)400-6 to (10)400-7 ("[C]ourts likely would hold that [an insurer's funding of] a defense through [its] insured's independent counsel satisfies the defense requirement of the supplementary payments provision." Also, "it is likely that a court familiar with the normal cannons of construction would" conclude that the supplementary payments clause applies if "an insurer defends its insured when it had no duty to do so. This may happen because the insurer was mistaken as to its obligations or, more likely, because the insurer was unsure and elected to defend as the safest course").

contractual terms.[172] Such remedies cannot be used to contradict such express terms.[173] The promise to bear all expenses in the cases the insurer defends weighs heavily against the right of recoupment the *Buss* court created.

The *Buss* court's own reasoning precludes reimbursement when it is analyzed in light of the promise in the supplementary payments clause. The *Buss* court concluded that an insurer cannot seek reimbursement for the cost of defending potentially covered claims because the insurer "bargained to bear the costs in question."[174] The court believed that the policy promised to defend potentially covered claims, and holding the insurer to its promise could not be judged unfair.[175] As to those defense costs for potentially covered claims, the court concluded:

> Surely, [the insurer] does not have a right of reimbursement implied in fact in the policy, having bargained to bear the costs in question. Neither does it have such a right implied in law. Under the law of restitution, a right of this sort runs against the person who benefits from "unjust enrichment" and in favor of the person who suffers loss thereby. Any "enrichment" of the insured by the insurer through the insurer's bearing of

172. *See* Fusion, Inc. v. Neb. Aluminum Castings, Inc., 934 F. Supp. 1270, 1275 (D. Kan. 1996) ("Courts applying Kansas law have concluded that quantum meruit and restitution are not available theories of recovery when a valid, written contract addressing the issue exists"); Interbank Invs., LLC v. Eagle River Water & Sanitation Dist., 77 P.3d 814, 816 (Colo. Ct. App. 2003) ("In general, a party cannot recover for unjust enrichment by asserting a quasi-contract when an express contract covers the same subject matter because the express contract precludes any implied-in-law contract."); Krupnick & Assoc., Inc. v. Hellmich, 378 S.W.2d 562, 569-70 (Mo. 1964) (an "express contract would also preclude the existence of the contract implied by law or quasi contract, necessary to form the basis for recovery in quantum meruit"); Prof'l Recruiters, Inc. v. Oliver, 456 N.W.2d 103, 106 (Neb. 1990) ("an express contract precludes the existence of a contract implied by law or a quasi-contract").

173. *See* Seiden Assocs., Inc. v. ANC Holdings, Inc., 754 F. Supp. 37, 39 (S.D.N.Y. 1991) ("To the extent there is a valid and enforceable contract between plaintiff and defendants, plaintiff will not be able to seek recovery in quasi contract in addition to or in conflict with the express terms of that contract"); Bellino Schwartz Padob Adver. v. Solaris Mktg. Group, 635 N.Y.S.2d 587, 588 (N.Y. App. Div. 1995) ("The existence of an express contract between Solaris and plaintiff governing the subject matter of the plaintiff's claim also bars any quasi-contractual claims against defendant Titan, as a third-party nonsignatory to the valid and enforceable contract between those parties").

174. Buss v. Superior Court, 939 P.2d 766, 776 (Cal. 1997).

175. *Id.*

> bargained-for defense costs is consistent with the insurer's obligation under the policy and therefore cannot be deemed "unjust." It follows a fortiori that the insurer may not proceed by means of a "reservation" of its "right" of reimbursement. It simply has no such "right" to "reserve." That is true even if the insured agrees to the "reservation." The creation of a right of reimbursement would amount to a pro tanto supersession of the policy which would require a separate contract supported by separate consideration.[176]

The same reasoning should avoid reimbursement in any case the insurer defends in light of the insurer's commitment in the supplementary payments clause. Given that the insurer has expressly promised to pay all defense costs in any suit it defends, shifting those costs cannot be accomplished by a promise implied in fact or law.

B. INSURERS CAN REVISE THEIR POLICIES ACCORDINGLY

The policy language based recoupment cases require insurers to add recoupment provisions to their policies if they want such a right. Justice Kennard urged the same proposition in her dissent in *Buss*.[177] Insurers have routinely included reimbursement wording in other types of liability policies. For example, a policy form designed to cover lawyers' professional liability states:

> As a condition of any payment of Defense Costs before the final disposition of a Claim, the Company may require a written undertaking on terms and conditions satisfactory to it guaranteeing the repayment of any Defense Costs paid on behalf of any Insured if it is finally determined that this Policy would not cover Loss incurred by such Insured in connection with such Claim."[178]

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176. *Id.* (citations omitted).

177. *Id.* at 785-86 (Kennard, J., dissenting).

178. Chubb Pro Lawyers Professional Liability Policy, Form No. 14-02-9303 (Ed. 2004) at Section XII p. 10-11 http://www.Chubb.com (emphasis omitted).

The same wording can be found in other types of specialized liability policies, such as directors and officers liability insurance policies.[179]

If insurers desire a right of recoupment under general liability policies, they can negotiate endorsements with their insureds, amending the standard CGL supplementary payments clause or amending the standard CGL form, while seeking any regulatory approval that might be necessary. The policy language based approach does not, therefore, inalterably preclude recoupment; it merely requires that such a right be spelled out in a policy if the insurer wishes to include it. Accordingly, failure to include such provisions should be understood as a decision not to seek such a right. There is no injustice in refusing recovery for an insurer that does not avail itself of this right.

CONCLUSION

Courts deciding between the majority and minority positions on recoupment would do well to keep the policy language based approach in mind. Honoring contractual commitments is essential to the law of contracts, and as shown above, standard liability policies typically contain terms stating the insurer will bear "all expenses" it incurs in defending the insured. It is not unfair to hold the insurer to the policy terms it drafts. Insurers can negotiate changes in their standard policy terms if they want to insist on a right to recoupment. It will be interesting to see whether the many courts that have yet to face the question will pile on the *Buss* or halt it, and whether the fast growing "minority" – courts that refuse to recognize

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179. *See, e.g.*, Nat'l Union Fire Ins. Co. v. U.S. Liquids, Inc., 271 F. Supp. 2d 926, 936 (S.D. Tex. 2003) (directors and officers liability policy "require[d] that the insured repay advanced defense costs 'in the event and to the extent that the Insureds or the Company shall not be entitled under the terms and conditions of the policy to payment of such Loss'"), *aff'd*, 88 Fed. Appx. 725 (5th Cir. 2004); Executive Risk Indem., Inc. v. Integral Equity L.P., No. 3:03-CV-0269-G, 2004 WL 438936, at *12 (N.D. Tex. Mar. 10, 2004) ("[T]he Policy allows Executive Risk – 'as a condition of any payment of Defense Expenses' -- to 'require a written undertaking on terms and conditions satisfactory to [Executive Risk] guaranteeing the repayment of any Defense Expenses paid to or on behalf of any Insured if it is finally determined that Loss incurred by such Insured would not be covered.'"); Applied Tech. Prods. v. Select Ins. Co., No. 03-5823, 2004 WL 945149, at *1 (E.D. Pa. Apr. 28, 2004) (policy providing coverage for employment practices claims provided for advancement of defense costs but stated: "Any advancement of Defense Costs under this Policy shall be subject to the Insurer's receipt of a written undertaking by the Insured(s), to repay the Insurer any advanced Defense Costs which are not covered under this Policy...").

a right of recoupment under general liability policies – will become the majority.

SURVEY OF COURTS TAKING A POSITION ON REIMBURSEMENT OF DEFENSE COSTS[180]

State Law	Reimbursement Allowed?	Relevant Cases
Alabama	Likely no because reimbursement of settlement payment was not allowed in an Alabama Supreme Court decision	*Mt. Airy Ins. Co. v. Doe Law Firm*, 668 So. 2d 534 (Ala. 1995) (insurer had no right to reimbursement of settlement payment despite reserving rights on same; insured refused to sign agreement saying payment did not waive right to reimbursement; court ruled insurer's payment was voluntary so as to preclude reimbursement though insured had threatened to sue for bad faith if payment was not made).
Alaska	Likely yes (district court predicting Alaska law)	*Unionamerica Ins. Co. v. Gen. Star Indem. Co.*, No. A01-0317-CV (HRH), 2005 WL 757386, at *8 (D. Ala. Mar. 7, 2005) (predicting Alaska Supreme Court would allow reimbursement "if there was no coverage and hence no duty to defend" after insurer expressly reserved right).
Arkansas	Likely yes (same for settlement costs) (district court predicting Arkansas law)	*Nobel Ins. Co. v. Austin Powder Co.*, 256 F. Supp. 2d 937, 940 (W.D. Ark. 2003) (no reimbursement of defense or settlement costs allowed because insurer did not give adequate or timely notice it reserved right specifically to seek reimbursement for defense costs). *Med. Liab. Mut. Ins. Co. v. Alan Curtis Enters., Inc.*, No. 4:05-CV-01317, 2006 U.S. Dist. LEXIS 89180, at *39-*44 (E.D. Ark. Dec. 8, 2006) (not deciding if Arkansas allows reimbursement due to lack of "timely and adequate notice" of insurer's intent to seek it).

180. This chart identifies the position on reimbursement of defense costs taken by courts applying the law of specified states. The chart also notes parenthetically any position taken on settlement reimbursement, and in the case of one state, a position on reimbursement of a judgment. Our research, which extended to the end of 2006, did not locate a case taking a position on the reimbursement of defense or settlement costs in Arizona, Idaho, Indiana, Kansas, Maine, Nebraska, New Hampshire, North Carolina, North Dakota, South Carolina, South Dakota, Tennessee, Utah, Vermont, Washington, or West Virginia. While we attempted to search as broadly as possible, cases that did not cite *Buss*, one of the major decisions following or refusing to follow *Buss* or another case cited herein may not have been located. The reader should independently research any jurisdiction deemed important.

State Law	Reimbursement Allowed?	Relevant Cases
California	Yes (same for settlement costs)	*Scottsdale Ins. Co. v. MV Transp.*, 115 P.3d 460 (Cal. 2005) (CGL insurer that properly reserved rights was entitled to reimbursement for defense costs advanced to insured against third party misappropriation of trade secrets lawsuit after judicial determination that no duty to defend ever arose.). *Buss v. Superior Court of L.A. County*, 939 P.2d 766, 774, 776 (Cal. 1997) (in mixed action, when insurer defends entire action, it may seek reimbursement for defense costs as to the claims not even potentially covered after judicial finding of same. Right to reimbursement is implied in law as quasi-contractual. Insured was unjustly "enriched" through the insurer's bearing of unbargained-for defense costs). *Blue Ridge Ins. Co. v. Jacobsen*, 22 P.3d 313, 320 (Cal. 2001) (insurer can unilaterally reserve right to reimbursement of settlement payment, notwithstanding insured's objections). *Walbrook Ins. Co. v. Goshgarian & Goshgarian*, 726 F. Supp. 777 (C.D. Cal. 1989) (defense cost reimbursement allowed despite insured's objection to insurer's reservation of rights because insured's acceptance of the defense impliedly agreed to reservation). *Hogan v. Midland Nat'l Ins. Co.*, 476 P.2d 825, 831 (Cal. 1970) (when insurer failed to fully defend entire mixed action and thereby breached its obligations, it has a higher "undeniable evidence" burden of proof if it attempts to obtain a reimbursement of non-covered defense costs).
Colorado	Likely yes, but maybe not in a mixed action	*First Fed. Sav. & Loan Ass'n of Fargo N.D. v. Transamerica Title Ins. Co.*, 793 F. Supp. 265, 269 (D. Colo. 1992) (citing California *Walbrook* case in dicta and stating insurer can reserve right to later recover attorney fees paid in defense and insured's silence in face of such reservation is tantamount to acceptance), *aff'd*, 19 F.3d 528 (10th Cir. 1994).

State Law	Reimbursement Allowed?	Relevant Cases
Colorado (continued)		*Farmington Cas. Co. v. United Educators Ins. Risk Retention Group, Inc.*, 117 F. Supp. 2d 1022, 1029 (D. Colo. 1999) (stating in dicta "Colorado law is not clear on whether it would allow an insurer to recover defense costs from the insured in a 'mixed' action . . . I am not persuaded that the appellate courts of Colorado would adopt the rule allowing allocation of expenses in a 'mixed' case between the insurer and the insured, at least without some type of policy language that supports same. Here, as with the standard CGL policy, Farmington is required to defend the 'suit', not a 'claim or covered claim'"). *HECLA Mining Co. v. N.H. Ins. Co.*, 811 P.2d 1083, 1089 (Colo. 1991) (stating in dicta that insurer believing it has no duty to defend, can undertake defense subject to reservation of right to seek reimbursement for defense costs, but not addressing mixed actions).
Connecticut	Leaning yes	*Sec. Ins. Co. of Hartford v. Lumbermens Mut. Cas. Co.*, 826 A.2d 107, 125 (Conn. 2003) (when policyholder was self insured for certain periods, insurer may seek reimbursement from policyholder for its share of past defense costs). *Ranger Ins. Co. v. Kovach*, No. 3:96CV02421 (EBB), 1999 WL 1421657, at *3 (D. Conn. Dec. 3, 1999) (predicting in dicta Connecticut Supreme Court would follow *Buss*).
Delaware	Leaning yes in a mixed action	*Nationwide Mut. Ins. Co. v. Flagg*, 789 A.2d 586, 597 (Del. Super. Ct. 2001) (insurer had duty to defend "all claims, but it may seek reimbursement ... on those claims which may be proven later to fall outside the policy coverage.").
Florida	Yes (but likely no as to settlement costs) (district court applying Florida law)	*Colony Ins. Co. v. G&E Tires & Serv., Inc.*, 777 So. 2d 1034 (Fla. Ct. App. 2000) (after finding no coverage, court awarded insurer reimbursement of its defense costs, reasoning that in accepting defense, policyholder accepted terms in reservation of rights letter).

State Law	Reimbursement Allowed?	Relevant Cases
Florida (continued)		*Jim Black & Assocs., Inc. v. Transcon. Ins. Co.*, 932 So. 2d 561 (Fla. Ct. App. 2006) (affirming determination that insurer was entitled to recover costs of defense of suit not covered by policy). *Wendy's of N.E. Fl., Inc. v. Vandergriff*, 865 So. 2d 520, 522 (Fla. Ct. App. 2003) (denying reimbursement for lack of reservation of rights but saying "insurer is entitled to reimbursement ... if the defense was initially provided under an expressed reservation of rights providing for attorney's fees and costs if the insurer prevailed, and if the insured accepts such defense"). *Steadfast Ins. Co. v. Sheridan Children's Healthcare Serv., Inc.*, 34 F. Supp. 2d 1364, 1367 (S.D. Fla. 1998) (denying insurer request for reimbursement of settlement payment because court found payment was voluntarily made and because insurer did not obtain insured's express consent). *Royal Surplus Lines Ins. Co. v. Coachman Indus., Inc.*, No. 3:01 CV 301 J-HTS, 2002 WL 32894915, at *25 (M.D. Fla. Sept. 17, 2002) (insurer may potentially obtain reimbursement of settlement costs without reserving right to obtain same, if insured withheld information relating to coverage defense before settlement).
Georgia	Unsettled	*Transp. Ins. Co. v. Freedom Elecs., Inc.*, 264 F. Supp. 2d 1214, 1220-21 (N.D. Ga. 2003) (denying insurer request for reimbursement of defense costs; insurer and insured entered into a "Bilateral Reservation of Rights and Defense Agreement" in which the insurer did not reserve right to be reimbursed for defense costs).
Hawaii	Unsettled	*First Ins. Co. of Haw., Inc. v. State*, 665 P.2d 648, 654 (Haw. 1983) (insurer must pay defense costs even absent indemnity coverage; "Affording ... a defense under a reservation of rights agreement merely retains any defenses the insurer has under its policy; it does not relieve the insurer of the costs incurred in defending ... where the insurer was obligated, in the first instance, to provide such a defense").

State Law	Reimbursement Allowed?	Relevant Cases
Hawaii (continued)		*Scottsdale Ins. Co. v. Sullivan Prop., Inc.*, No. Civ. 04-00550HGBMK, 2006 WL 505170, at *2 n.3, 12 (D. Haw. Feb. 28, 2006) (insurer entitled to defense cost reimbursement after it timely reserved such right because insurer had no duty to defend insured). *Executive Risk Indem., Inc. v. Pac. Educ. Servs., Inc.*, 451 F. Supp. 2d 1147, 1162-64 (D. Haw. 2006) (denying request for reimbursement without prejudice for insufficient briefing; court observed that despite district court *Scottsdale* decision, it had to leave "for another day" a ruling "on whether, under Hawaii law, defense costs are or are not reimbursable pursuant to a reservation of rights based on a determination that an insurer had no duty to defend;" briefing before it presented "an insufficient basis on which to predict how the Hawaii Supreme Court would rule on the reimbursement issue").
Illinois	No	*Gen. Agents Ins. Co. v. Midwest Sporting Goods Co.*, 828 N.E.2d 1092, 1097 (Ill. 2005) (insurer may not recover defense costs pursuant to reservation of rights absent express provision to that effect in parties' insurance contract).
Iowa	No (district court predicting Iowa law)	*Pekin Ins. Co. v. Tysa, Inc.*, No. 3:05–cv–00030 – JEG, 2006 U.S. Dist. LEXIS 93525 (S.D. Iowa Dec. 27, 2006) (reimbursement would result in a unilateral modification of the policy, and insured is not unjustly enriched).
Kentucky	Unknown	*Employers Reins. Corp. v. Mut. Ins. Co. Ltd.*, Civ. No. 3:05CV556-S, 2006 U.S. Dist. LEXIS 73472 (W.D. Ky. Sept. 22, 2006) (declining to dismiss defense cost reimbursement claim but recognizing absence of Kentucky cases on point and saying if court finds "no coverage under the policies ... we will address the issue")
Louisiana	Likely no in a mixed action (5th Circuit interpreting LA law).	*Yount v. Maisano*, 627 So. 2d 148, 153 (La. 1993) (insurer with defense duty had to pay defense costs though exclusion ultimately avoided indemnity).

State Law	Reimbursement Allowed?	Relevant Cases
Louisiana (continued)	(Likely yes to settlement costs as predicted by Texas Supreme Court, in an opinion under reconsideration, and by 5th Circuit)	*Riley Stoker Corp. v. Fid. & Guar. Ins. Underwriters, Inc.*, 26 F.3d 581, 589 (5th Cir. 1994) (refusing to apportion defense costs between covered and uncovered claims; "when an insurer has a duty to defend any claim asserted, the insurer must defend the entire action ... against its insured. Thus, an insurer who wrongfully refuses to defend is liable for reasonable attorney's fees and expenses incurred by the insured in defending both the covered and uncovered claims ... against it"). *Excess Underwriters at Lloyd's, London v. Frank's Casing Crew & Rental Tools, Inc.*, No. 02-07306, 2005 WL 1252321, at *10 (Tex. May 27, 2005), *reh'g granted*, 2006 Tex. LEXIS 1 (Tex. Jan. 26, 2006) (holding Louisiana court would allow settlement reimbursement based on Louisiana Civil Code and state supreme court decision providing remedy when person was "enriched without cause at the expense of another person"). *Peavey Co. v. M/V ANPA*, 971 F.2d 1168, 1177 (5th Cir. 1992) (holding insurer could be reimbursed for settlement payment when it reserved right to recover settlement payment if there is no coverage and insured agreed).
Maryland	Likely no in mixed actions (likely no as to settlement costs) (4th Cir. interpreting Maryland law)	*Perdue Farms, Inc. v. Travelers Cas. & Sur. Co. of Am.*, 448 F.3d 252, 258-59 (4th Cir. 2006) (court refused to allow reimbursement for non-covered claims defense costs because duty to defend is broad and for reasons of equity). *Am. Modern Home Ins. Co. v. Reeds at Bayview Mobile Home Park, LLC*, No. 05-1149, 2006 WL 994573, at *3 (4th Cir. Apr. 14, 2006) (after finding no coverage or defense duty, court reversed order of reimbursement of settlement payment because no policy language allowed that result and policyholder did not agree to it).
Massachusetts	Likely no in mixed actions (1st Cir. interpreting Mass. law) (no as to settlement costs)	*Millipore Corp. v. Travelers Indem. Co.*, 115 F.3d 21, 35 (1st Cir. 1997) (because insurers had duty to defend, no reimbursement was appropriate, though coverage was unlikely).

State Law	Reimbursement Allowed?	Relevant Cases
Massachusetts (continued)		*Dash v. Chi. Ins. Co.*, No. Civ. A. 00-11911-DPW, 2004 WL 1932760, at *8-10 (D. Mass. Aug. 23, 2004) (in mixed action that resulted in adverse verdict against insured, insurer who breached defense duty was ordered to pay for entire defense bill, including for non-covered claims (rejecting and distinguishing *Buss* as unsupported by Massachusetts law)). *Med. Malpractice Joint Underwriting Ass'n of Mass. v. Goldberg*, 680 N.E.2d 1121, 1128-29 (Mass. 1997) (denying insurer's request for reimbursement of settlement payment because policy did not contain provision for settlement reimbursement and policyholder did not explicitly agree to any such arrangement).
Michigan	Unsettled	*NCMIC Ins. Co. v. Dailey*, No. 267801, 2006 WL 2035597, at *4-6 (Mich. Ct. App. July 20, 2006) (holding insurer entitled to reimbursement of defense costs paid after holding policy was properly rescinded for material misrepresentations in application to prevent unjust enrichment notwithstanding that insurer failed to specifically reserve right to recoup same, but instead gave insured general notice it would seek restitution).
Minnesota	Unsettled	*Employers Mut. Cas. Co.v. Indus. Rubber Prods., Inc.*, No. Civ. 04-3839, 2006 WL 453207, at *5-6 (D. Minn. Feb. 23, 2006) (refusing defense cost reimbursement after no coverage finding despite insurer reservation of rights and policyholder silence in response). *Knapp v. Commonwealth Land Title Ins. Co.*, 932 F. Supp. 1169, 1172 (D. Minn. 1996) (insurer had right to recoup fees and costs for defending non-covered claims where no duty to defend existed, it reserved right to seek reimbursement, and insured's lack of response and acceptance of defense implied agreement).
Mississippi	Likely no (district court applying Mississippi law)	*Mobile Telecomm. Techs. Corp. v. Aetna Cas. & Sur. Co.*, 962 F. Supp. 952, 956 (S.D. Miss. 1997) (denying insurer reimbursement despite reserving rights because it paid voluntarily).

State Law	Reimbursement Allowed?	Relevant Cases
Missouri	Likely no (8th Cir. applying Missouri law)	*Liberty Mut. Ins. Co. v. FAG Bearings Corp.*, 153 F.3d 919, 923-24 (8th Cir. 1998) (ruling insurance policy did not cover claims in underlying lawsuit, but policyholder need not reimburse insurer for defense costs incurred prior to the declaratory judgment). *Util. Serv. & Maint., Inc. v. Noranda Aluminum, Inc.*, No. ED 82504, 2004 WL 1877916, at *4 (Mo. Ct. App. Aug. 24, 2004), *transferred to* 163 S.W.3d 910, 911 (Mo. 2005) (appellate court's holding of no coverage for indemnity and granting insurer reimbursement of defense costs was deprived of precedential value by transfer to the supreme court, which then held there was coverage for the underlying suit).
Montana	Yes	*Travelers Cas. & Sur. Co. v. RIBI Immunochem Research, Inc.*, 108 P.3d 469 (Mont. 2005) (granting defense cost reimbursement because insured was apprised of reservation of rights and accepted the defense by accepting payments).
Nevada	Likely yes (federal courts predicting Nevada law)	*Capitol Indem. Corp. v. Blazer*, 51 F. Supp. 2d 1080, 1090-91 (D. Nev. 1999) (refusing defense cost reimbursement for claims not potentially covered due to lack of party understanding for same; "The right to reimbursement does not arise unless there is an understanding between the parties that the insured would be required to reimburse the insurer for monies expended in providing a defense"). *Forum Ins. Co. v. County of Nye*, No. 91-16724, 1994 WL 241384, at *3 (9th Cir. June 3, 1994) (allowing reimbursement where insured objected to reservation of right to recoup; insured's acceptance of defense was sufficient to show an "understanding" of reimbursement; insureds may not "refus[e] to accept the agreement yet retain the fruits of it").
New Jersey	Unsettled, leaning yes	*SL Indus., Inc. v. Am. Motorists Ins. Co.*, 607 A.2d 1266, 1280 (N.J. 1992) (when insurer breaches its duty to defend, it is liable to pay for only defense costs related to covered claims).

State Law	Reimbursement Allowed?	Relevant Cases
New Jersey (continued)		*Hebela v. Healthcare Ins. Co.*, 851 A.2d 75, 86 (N.J. Super. Ct. App. Div. 2004) (stating in dicta that when insurer honored its duty to defend and sought reimbursement, "the right of reimbursement exists because the insured would be unjustly enriched in benefiting by, without paying for, the defense of a non-covered claim" and holding insurer that breaches duty to defend is liable for defense costs for only covered claims). *Morrone v. Harleysville Mut. Ins. Co.*, 662 A.2d 562, 567 (N.J. Super. Ct. App. Div. 1995) (holding insurer has duty to defend, but stating "the underlying litigation alleges both covered and noncovered claims, potentially necessitating apportionment both as to indemnification and defense costs;" in dicta, expressing concern over possible conflict between insurer and insured if there are both covered and noncovered claims, and suggesting insurer and insured must either: (a) expressly agree to reservation of rights, or (b) insured must control defense and "insurer may be obligated to finance the costs of defense, subject to a right of reimbursement").
New Mexico	Leaning yes (district court and 5th Circuit predicting New Mexico law)	*Resure, Inc. v. Chem. Distribs., Inc.*, 927 F. Supp. 190 (M.D. La. 1996) (applied New Mexico law to grant reimbursement of defense costs after finding all underlying claims excluded from coverage where policyholder did not object to reservation of right to reimbursement and did not brief issue), *aff'd*, 114 F.3d 1184 (5th Cir. 1997) (table case).
New York	Likely yes (district court predicting New York law)	*Gotham Ins. Co. v. GLNX, Inc.*, No. 92 Civ. 6415, 1993 WL 312243, at *4-5 (S.D.N.Y. Aug. 6, 1993) (awarding insurer reimbursement where it issued letter reserving right to seek reimbursement and insured produced no evidence it refused consent to that reservation).
Ohio	Likely yes (6th Cir. predicting Ohio law)	*United Nat'l Ins. Co. v. SST Fitness Corp.*, 309 F.3d 914 (6th Cir. 2002) (insurer should recover defense costs if entire underlying suit is found outside of coverage and it sent timely reservation letter mentioning reimbursement).

State Law	Reimbursement Allowed?	Relevant Cases
Ohio (continued)	(likely no as to a judgment) (federal district court predicting Ohio law)	*Am. Motorist Ins. Co. v. Custom Rubber Extrusions, Inc.*, No. 1:05cv2331, 2006 U.S. Dist. LEXIS 59436 (N.D. Ohio Aug. 23, 2006) (concluding "it is unlikely that the Ohio courts would extend the framework of *United National* ... even further to encompass an insurer's right to seek reimbursement for the payment of a judgment, based solely on a unilateral reservation of rights").
Oklahoma	Unknown (but likely yes as to settlement costs) (district court predicting Oklahoma law) (legal commentator)	*Melton Truck Lines, Inc. v. Indem. Ins. Co. of N. Am.*, No. 04-CV-263-JHP-SAJ, 2006 WL 1876528 (N.D. Okla. June 26, 2006) (holding insurer properly reserved right to reimbursement of settlement amounts paid). A law review article predicts Oklahoma will follow California insurance law and adopt *Buss*. *See* Melinda L. Kirk, Comment, *The Insurer's Right to Seek Reimbursement: Will the* Buss *Stop in Oklahoma?*, 35 TULSA L.J. 599, 618 (2000) (citing *Conner v. Transamerica Ins. Co.*, 496 P.2d 770 (Okla. 1972) and *Tri-State Ins. Co. v. Hobbs*, 347 P.2d 226 (Okla. 1959), which enforced a clause in an insurance policy that provided for reimbursement from the insured to insurer if state insurance regulations extended coverage to incidents that were not originally covered under the policy).
Oregon	Unknown (but likely yes for settlement costs) (district court and 9th Circuit predicting Oregon law)	*Interstate Fire & Cas. Co. v. Archdiocese of Portland in Or.*, 899 F. Supp. 498 (D. Or. 1995), *aff'd*, 139 F.3d 1234 (9th Cir. 1998) (Interstate issued an excess indemnity policy with no duty to defend; together with insured and primary carrier it paid to settle underlying action under reservation of rights; Interstate then sued insured and primary insurer; court held Interstate's policy was not triggered and granted reimbursement of settlement payment).
Pennsylvania	No (same for settlement costs)	*Terra Nova Ins. Co. v. 900 Bar, Inc.*, 887 F.2d 1213, 1219-20 (3d Cir. 1989) (recoupment is inconsistent with legal principles inducing insurer's offer to defend under reservation of rights; insurer seeks to protect its own interests as much as insured's in deciding to defend).

State Law	Reimbursement Allowed?	Relevant Cases
Pennsylvania (continued)		*LA Weight Loss Ctrs., Inc. v. Lexington Ins. Co.*, Nos. 072109/072287, 2006 WL 689109 (Pa. Ct. C.P. Philadelphia County Ct. Mar. 1, 2006) (reimbursement of defense costs refused because policy did not allow it, reservation of rights letter does not create a new contract, and insured is not unjustly enriched). *Coregis Ins. Co. v. Law Offices of Carole F. Kafrissen*, 140 F. Supp. 2d 461 (E.D. Pa. 2001) (denying reimbursement of settlement payment because it was paid voluntarily). *But see Centennial Ins. Co. v. Meritor Sav. Bank, Inc.*, Civ. A. No. 91-6346, 1992 WL 164906, at *8 (E.D. Pa. July 6, 1992) (after finding no coverage, court retained jurisdiction to determine total reimbursement owed).
Texas	Likely yes (Minnesota district court predicting Texas law) (Unsettled as to settlement costs)	*St. Paul Fire & Marine Ins. Co. v. Compaq Computer Corp.*, 377 F. Supp. 2d 719 (D. Minn. 2005) (predicting Texas would allow defense cost reimbursement under doctrine of quantum meruit), *aff'd*, 457 F.3d 766 (8th Cir. 2006). *Excess Underwriters at Lloyd's, London v. Frank's Casing Crew & Rental Tools, Inc.*, No. 02-0730, 2005 WL 1252321 (Tex. May 27, 2005) (opinion subject to revision or withdrawal), *reh'g granted*, 2006 Tex. LEXIS 1 (Tex. Jan. 26, 2006) (insurer has a right to reimbursement of settlement funds when (1) there is no coverage and insurer timely asserted reservation of rights, told insured it intends to seek reimbursement, and paid to settle claims not covered, (2) insured demanded insurer accept settlement offer within policy limits, or (3) an insured expressly agrees settlement offer should be accepted). *Texas Ass'n of Counties County Gov't Risk Mgmt. Pool v. Matagorda County*, 52 S.W.3d 128 (Tex. 2000) ("*Matagorda II*") (when coverage is disputed and insurer is presented with reasonable settlement demand within policy limits, it may fund settlement and seek reimbursement only if it obtains insured's clear and unequivocal consent to settlement and right to seek reimbursement).

State Law	Reimbursement Allowed?	Relevant Cases
Texas (continued)		*Matagorda County v. Tex. Ass'n of Counties County Gov't Risk Mgmt. Pool*, 975 S.W.2d 782, 784-85 (Tex. Ct. App. 1998) ("*Matagorda I*") (refusing reimbursement of defense costs and settlement costs; insurer failed to reserve right of defense cost reimbursement; its letter did show intent to seek settlement reimbursement, but there was no indication insured agreed to be bound by settlement or that insurer could later seek reimbursement).
Virginia	Likely no (district court predicting Virginia law)	*Med. Protective Co. v. McMillan*, No. Civ. A. 501CV00073, 2002 WL 31990490 (W.D. Va. Dec. 16, 2002) (insurers not entitled to reimbursement for defending claim at least potentially covered under its policy given that insurer did not reserve right to reimbursement and no policy language supported it).
Wisconsin	Unsettled	*Lockwood Int'l, B.V. v. Volm Bag Co. Inc.*, 273 F.3d 741, 743 (7th Cir. 2001) (citing *Buss* and stating "if defense costs are *readily* apportionable between the covered and the uncovered claims, the insurance company need pay only for the former").
Wyoming	No	*Shoshone First Bank v. Pac. Employers Ins. Co.*, 2 P.3d 510 (Wyo. 2000) (rejecting *Buss* in mixed action case and holding no defense costs are recoverable for uncovered claims because "[t]he insurer is not permitted to unilaterally modify and change policy coverage"). *Am. States Ins. Co. v. Ridco, Inc., Riddles Jewelry, Inc. & Ken B. Berger*, Civ. No. 95CV158D (D. Wyo. 1999) ("Endorsing such conduct is tantamount to allowing the insurer to extract a unilateral amendment to the insurance contract. If this became common practice the insurance industry might extract coercive arrangements from their insureds, destroying the concept of liability and litigation insurance," *quoted in*, *Shoshone*, 2 P.3d at 516.

HELPING INDIVIDUAL INVESTORS DO WHAT THEY KNOW IS RIGHT: THE SAVE MORE FOR RETIREMENT ACT OF 2005

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INTRODUCTION

As the American worker's life grows increasingly harried, the average workday seems to lengthen every year, and the concept of having multiple careers over the course of one's lifetime becomes the rule rather than the exception, one shudders at the prospect of a "working retirement." Yet this phenomenon seems increasingly likely as savings rates decline, life expectancies rise, and deficits soar. As the oldest baby boomers near retirement age, much uncertainty exists regarding their collective outlook. The safety net consisting of a traditional employer pension plan and Social Security is slowly but definitively unraveling beneath the metaphorical feet of an aging country. Americans are increasingly forced to ensure their own retirement security through employer-sponsored defined contribution plans; statistics show that many workers are not up to the task.

This Note seeks to outline the nature of the crisis that accompanies the dramatic shift from employer sponsored defined benefit to defined contribution plans, and to advocate a particular avenue for reform. As will be seen, many Americans, perhaps even those with obvious means to do so, do not contribute adequately to their employer's defined contribution plans. This Note will draw heavily on behavioral economics research, which uses empirical data to call into question many of the cherished assumptions of the neoclassical economists regarding savings and consumption behavior. This Note adds to the currently existing literature on the subject through its discussion of newly proposed and much needed legislation – the Save More for Retirement Act of 2005 proposed in April, 2005 – that aims to increase employee contributions to their employers' defined contribution plans. Part I of this Note outlines a brief history of defined benefit and defined contribution plans, explores the mechanics of the latter, and emphasizes the significance of this dramatic change. Part II discusses low savings and participation rates among defined contribution plan participants, and highlights the importance of saving for retirement early in one's life, something too few Americans seem to be doing. Part III addresses the

economic theory that has long made sweeping assumptions about consumer behavior, and additionally explores the behavioral research that seems to undermine many of these assumptions. Part III also addresses the rationale for government intervention from a theoretical perspective. Part IV explores the legislation that has been proposed that would potentially remedy the problematic situations discussed in earlier parts of the Note, discusses current ERISA provisions that would need to change if the legislation is adopted, and outlines why such change is desirable.

I. HISTORY AND MECHANICS OF DEFINED CONTRIBUTION PLANS

A. HISTORY

The first private pension, or defined benefit plan, in the United States was introduced in 1875 by American Express Company, a railroad freight forwarder.[1] Defined benefit plans guarantee a specified amount of money at retirement, which is typically determined by a formula consisting of years of service and average final salary.[2] Following the railroads, a number of the nation's larger employers implemented pensions during the first part of the twentieth century in an effort to promote a stable, career-oriented workforce.[3] Perhaps counter-intuitively, the Depression had a positive impact on defined benefit plans, as tax rates soared and employers found the tax benefits of the plans to be financially advantageous.[4] Defined benefit plans increased in popularity after World War II and reached their peak in the late 1970's, when approximately 62% of all active workers were covered exclusively by these plans.[5] Beginning in the late 1970's participation declined slowly and steadily, until 1997 when just 13% of workers had such plans as their sole retirement benefit.[6] Participation rates in defined benefit plans have remained fairly steady since then.[7] However,

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1. Stephen P. McCourt, *Defined Benefit and Defined Contribution Plans: A History, Market Overview and Comparative Analysis,* BENEFITS & COMPENSATION DIG., Feb. 2006, at 1, http://www.ifebp.org/PDF/webexclusive/06feb.pdf.

2. Amy B. Monahan, Addressing the Problem of Impatients, Impulsives and Other Imperfect Actors in 401(K) Plans, 23 VA. TAX REV. 471, 475 (2004).

3. McCourt, *supra* note 1, at 1.

4. *Id.*

5. Mary Williams Walsh, *More Companies Ending Promises for Retirement*, N.Y. TIMES, Jan. 9, 2006, at A1.

6. *Id.* at A14.

7. *Id.*

some of the last remaining American companies offering defined benefit programs have begun to "freeze" these benefits in an effort to stave off unanticipated costs, such as interest rate changes and longer life expectancies, which tend to make the plans more costly.[8] Mirroring the decline in defined benefit plans, the percentage of workers participating in defined contribution plans and having no defined benefit pension has increased from 16% of active workers in 1979 to 62% in 2004.[9] Recent data shows that 55 million Americans are covered by defined contribution plans, representing more than $2.2 trillion in assets.[10]

Why the fairly recent dramatic shift to defined contribution plans? Although a complete explanation of this change is beyond the scope of this Note, perhaps the most frequently cited explanation is an increasingly mobile workforce.[11] Traditional pension plans are not as portable as defined contribution plans, and workers who frequently change jobs will receive a small pension from each employer, each of which accounts for only the salary and years of service for that particular employer.[12] The popular "rollover" option that is available with 401(k) plans avoids this

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8. *See id.* When pension plans are frozen, the company stops the growth of retirement benefits, which typically accumulate with each additional year of service. Employees are able to retain those benefits that they earned before the freeze, however. Pension freezes may be on the rise, however, because as recently as 2003 the majority of pensions that were frozen had fewer than 100 employees. Recent moves by IBM, which had the third-largest pension fund behind General Motors and General Electric, and other large companies suggests that such trends are moving from traditionally troubled industries such as steel and textiles, into more established industries and involving larger companies.

9. Walsh, *supra* note 5, at A14.

10. Vanguard, How America Saves 2005, A Report on Vanguard 2004 Defined Contribution Plan Data (2004), *available at* https://institutional2.vanguard.com/iip/pdf/CRR_HAS_2005.pdf [hereinafter Vanguard Report].

11. Monahan, *supra* note 2, at 476. *See also* Walsh, *supra* note 5, at A1 (arguing that even strong and economically stable companies such as Verizon, Lockheed Martin, and Motorola have frozen pensions in the face of "longer worker lifespans, looming regulatory and accounting changes, and... heightened global competition"). *But see* Susan J. Stabile, *The Behavior of Defined Contribution Plan Participants*, 77 N.Y.U. L. REV. 71, 75-77 (2002) (rejecting the worker mobility explanation for the shift to defined contribution plans and arguing that defined contribution plans are less costly to employers and are less burdensome with respect to regulatory requirements. The plans also attract more conscientious workers who desire an opportunity to save for their own retirement without employer interference).

12. Monahan, *supra* note 2, at 476-77.

problem.[13] Also, defined benefit plans tend to be more expensive than defined contribution plans for employers.[14]

B. MECHANICS OF DEFINED CONTRIBUTION PLANS

Given the prominence of 401(k) plans in the contemporary American retirement landscape, a brief overview of the mechanics of this type of plan is instructive. Though widespread, it is important to note that the 401(k) is only one type of defined contribution plan. The 401(k) is a "profit sharing or stock bonus plan that contains a cash-or-deferred arrangement," [15] the most common of which is a salary reduction agreement. In such an arrangement, eligible employees may choose to reduce their pay and have employers contribute the balance of their income to the 401(k), allowing the employee to currently exclude from taxable income the portion of salary that the employer contributes to the plan. The employer may or may not choose to "match" the employee's contributions up to a certain level. A common employer "match" is 50% of the employee's contribution up to 6% of the employee's salary.

Employer and employee contributions to traditional 401(k) plans are tax-deferred, meaning that taxes are not levied on the contributions or earnings until funds are withdrawn.[16] Because of the tax-favored nature of the investment, certain restrictions are placed on contribution and withdrawal. For example, in 2006 employees may not contribute more than $15,000.[17] Additionally, defined contribution plans are also subject to ERISA's nondiscrimination provisions that aim to ensure that highly compensated employees do not disproportionately benefit from the tax-

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13. *Id.* at 477.

14. *See id.* at 477-78 (outlining the following causes of increased costs of defined benefit plans: (1) defined benefit plans are entirely employer funded (as opposed to funded either entirely by the employee or by some combination of employer and employee); (2) administrative costs associated with acquiring the expertise required to calculate fund requirements; (3) Pension Benefit Guarantee Corporation premiums required for defined benefit plans; (4) the cost to the employer of the assumption of investment risk for plan assets).

15. Alicia H. Munnell et al., *What Determines 401(K) Participation and Contributions?* 4 (Ctr. for Ret. Research at Boston College, Working Paper No. 2000-12, 2000), *available at* http://www.bc.edu/centers/crr/papers/wp_2000-12.pdf.

16. *Id.* at 5.

17. *Id.* Employees over a certain age may make "catch-up" contributions beyond the level specified above.

advantages.[18] Federal law also imposes a 10% penalty on funds that are withdrawn before the worker reaches age 59½.[19] Participants may have access to funds through borrowing for specified purposes, however.[20] A frequently cited advantage of the shift to defined contribution plans is that employees are able to invest their own money as they see fit – and perhaps ultimately enjoy a more prosperous retirement from a financial standpoint as a result.[21] This was especially true during "a once-in-a-lifetime bull market that encouraged [individual workers] to think they could get rich quick in stocks."[22] As will be seen later, however, there is also the possibility that neophyte investors may become unduly confident in their investment skills in this environment, and invest in a portfolio that is overly-aggressive. Additionally, other investors may be unduly conservative in their investments. The next section will explore some of the implications of the shift to defined contribution plans from the perspective of the individual investor.

C. SIGNIFICANCE OF THE SHIFT FROM DEFINED BENEFIT TO DEFINED CONTRIBUTION PLANS

The gradual shift from defined benefit to defined contribution plans has extraordinary consequences for the average American worker, and perhaps even society as a whole.[23] Perhaps the single most salient difference between defined benefit and defined contribution plans is that the former guarantees a specified retirement benefit to an individual, while the latter does not. Another difference that has great practical significance is the notion that employees are not required to actively make choices in defined benefit plans, while most defined contribution plans require employees to affirmatively make elections from a myriad of complex and often

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18. Munnell, *supra* note 15, at 5.

19. *Id.* at 5. Funds may be withdrawn without penalty for disability or death.

20. *Id.* at 4-5.

21. Kelly Smith & Lani Luciano, *America's Best Company Benefits*, MONEY, Oct. 1999, at 116.

22. Terry Savage, *Problems Affect 401(k)s, But They Can Be Solved*, CHI. SUN-TIMES, Jan. 17, 2002, at 51.

23. *See* McCourt, *supra* note 1, at 4 (suggesting that the absence of the pool of wealth made available by the existence of large defined benefit program may have a deleterious effect on the nation's economy. Without the $10 trillion in savings that defined benefit plans provide to the U.S. economy, "U.S. interest rates would be substantially higher, the cost of capital for all companies in the United States substantially higher, overall investment substantially lower and economic growth substantially diminished").

intimidating investment options.[24] In fact, employees are faced with a multifaceted decision with respect to retirement savings in defined-contribution plans: not only must they surmount the initial obstacle of deciding whether or not to participate, but they must also decide how much to contribute and how to invest their assets.[25]

The largest potential problem accompanying the shift from defined benefit to defined contribution programs is that millions of individuals who had relied on experienced professionals to manage their retirement assets for them immediately became their own fund managers, very often with little relevant experience.[26] One consequence of such a phenomenon is that market risk is shifted from employers to employees.[27] The Department of Labor expressed its concerns as follows: "there has been an increasing concern on the part of the Department, employers, and others that many participants may not have a sufficient understanding of investment principles and strategies to make their own informed investment decisions."[28] Even employees who faithfully contribute to their defined contribution plans on a regular basis can have significant difficulties in

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24. Stabile, *supra* note 11, at 76.

25. Munnell, *supra* note 15, at 3.

26. *The MetLife Study of Employee Benefits Trends* (Nov. 2003), *available at*, http://www.metlife.com/WPSAssets/188375565910757576 23V1FD7547_Broch.pdf (finding that just 30% of respondents were confident in their own ability to make sound investment decisions for themselves and their family).

27. For an interesting discussion of this shift in risk allocation with respect to retirement planning, see Edward A. Zelinsky, *The Defined Contribution Paradigm*, 114 YALE L.J. 451, 458-62 (2004). The author divides the risk into three types: investment risk, funding risk, and longevity risk. Investment risk – the risk that retirement assets will receive an insufficient rate of return – shifts from the employer to employee under defined benefit programs the employer is charged with providing a promised benefit, even in the event of investment returns that fall short of this level. Under defined contribution arrangements, the risk or reward of exceedingly poor or good returns, respectively, shifts to the employee because the employee's entitlement is the account balance. Zelensky defines "funding risk" as the possibility that insufficient funds to secure an adequate retirement will be placed into the retirement account at all. By definition under defined benefit programs, the responsibility is that of the employer to ensure that promised funds are adequately invested. Under many defined contribution plans, by contrast, because it is up to the employee to elect whether to have his/her current compensation reduced in exchange for later compensation in accordance with a defined contribution plan, the responsibility to ensure adequate funds in retirement is that of the employee rather than the employer. Finally, longevity risk – the chance that the employee will outlive retirement benefits – shifts to employees because under defined benefit programs, individuals received a stream of income until their death. In defined contribution plans, of course, funds last only as long as individual investors do not exhaust them.

28. 29 C.F.R. § 2509.96-1(2006).

retirement in the event of an economic downturn.[29] Despite the rhetoric disseminated by proponents of defined contribution plans that these arrangements allow individuals to prosper financially by taking charge of their own retirement security, studies show that investment returns in defined contribution plans may be inferior to those of defined benefit plans.[30] As will be discussed throughout this Note, a potentially more debilitating problem is illustrated by recent behavioral economics literature, which suggests that investor inertia and other unfortunate human foibles may lead to excessively low contribution rates and may ultimately undermine Americans' retirement security.

II. PARTICIPATION AND SAVINGS RATES: A CAUSE FOR CONCERN?

A. THE IMPORTANCE OF "STARTING EARLY": THE REMARKABLE EFFECTS OF COMPOUND INTEREST

The shift from defined benefit to defined contribution plans may be construed as a double-edged sword: while individuals will no longer be guaranteed a stable stream of income in retirement, the shift enables individuals to take charge of their own retirement savings and to perhaps enjoy a more prosperous retirement through wise investment.[31] Indeed, retirement benefits can increase quite dramatically, even exclusive of times of extraordinarily high rates of investment returns, provided that interest has a sufficient amount of time to compound. As the materials in the pages ahead will demonstrate, current savings rates present a cause for concern. The implications for younger savers are significant as well: although low savings rates among this group does not alone signal a problem with

29. *See* Walsh, *supra* note 5, at A6. Syl Schieber, director of research for Watson Wyatt Worldwide, calculated the retirement benefits available to a hypothetical investor who began working at 25, and put 6% of his salary into a 401(k) account for the next 40 years. Upon retirement at 65, this individual would be able to buy an annuity that paid 134% of his pre-retirement income if he retired in 2000 (during an economic boom), but could buy an annuity that replaced just 57% of his pre-retirement income if he retired in 2003 (during an economic downturn). *Id.*

30. *See* McCourt, *supra* note 1, at 4 (reporting that the average defined benefit plan outperformed the average defined contribution plan by 0.8% per year between 1985 and 2001, an aggregate difference of 25% in total return over a 30-year span).

31. *But see id.* (reporting that most studies show that "the average investor in 401(k) plans produces investment results worse than the average return generated by defined benefit plans").

retirement liquidity, non-savers may be forgoing an opportunity to secure a financially stable retirement that they will not be able to regain. Some commentators might argue that many Americans would benefit from a greater amount of time for retirement assets to accumulate, as studies show that the average American is not a very savvy investor.[32]

Certainly the benefits of compound interest in saving for retirement and of "starting early" in one's life have been thoroughly documented. Nevertheless, a brief overview of two hypothetical investors, A and B, vividly illustrates the tremendous benefit of beginning to save for retirement early in one's life. The savings behavior of two separate investors with vastly different habits is illustrated below, over a 40 year period.[33] Investor A begins investing when he is 25 years old, in Year 0, and invests $5,000 per year every year until Year 20 – when he is 45 – and then does not invest any new money again, but does allow interest to accrue on his account until Year 40, when he is 65. Investor B begins saving in Year 20, at age 45, and invests $10,000 a year – twice the annual and total contribution of investor A – for 20 years (the same amount of time as investor A) until he reaches age 65 in Year 40. The results depicted below may surprise the reader.

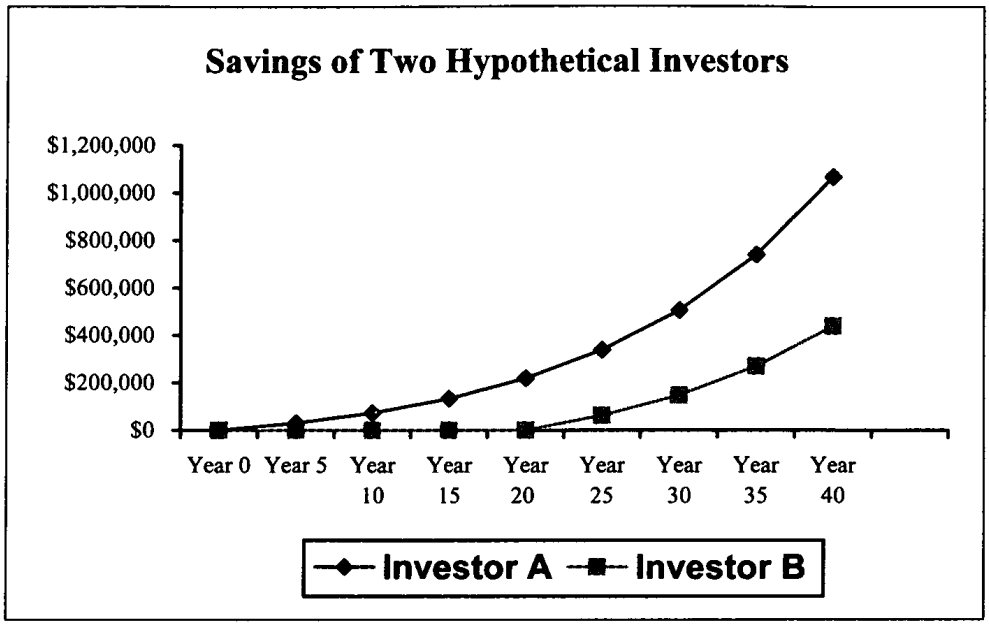
Table 1

Savings of Two Hypothetical Investors

	Investor A	Investor B
Year 0	$0	$0
Year 5	30,766	0
Year 10	73,918	0
Year 15	134,440	0
Year 20	219,326	0
Year 25	338,382	61,533
Year 30	505,365	147,836
Year 35	739,567	268,881
Year 40	1,068,048	438,652

32. *See id.* (reporting on a study that found that between 1984 and 2002, "the average equity mutual fund investor earned only 2.6% per year, on average, compared to a 12.2% annual return for the S&P 500 index. The average fixed income mutual fund investor earned only 4.2% annually, compared to a long-term government bond return of 11.7%").

33. Figures generated from the author's calculations. A 7% annual rate of return was assumed; interest was compounded annually.



The results are, of course, dramatic. Perhaps the first thing to note is that in Year 40, both investors have much more money than they actually contributed themselves. It is thus important not to invest too conservatively when one can be reasonably certain of adequate returns elsewhere. At the end of 40 years, Investor A has more than 10 times what he invested: $1,068,048 versus an actual investment total $100,000, all of which, it should be noted, reduced his taxable income in the year in which it was earned.[34] The similar is true of Investor B, although his gains are not as dramatic because the interest did not have the same opportunity to accrue.

A comparison between the final investments of the two individuals is instructive as well. Investor A finished with more than twice as much money as did Investor B at the end of 40 years ($1,068,048 versus $438,652), but invested only half as much ($100,000 versus $200,000). The main reason for this phenomenon is that in Year 20, when he was

34. It might be said that it costs person A less than $5,000 to invest that much annually in his tax-advantaged defined contribution plan. Assuming person A is in the 40% marginal tax bracket, the options are to invest a full $5,000 in the defined contribution plan or to take home an extra $3,000 because the $5,000, if not invested, would be taxed at ordinary income tax rates. Thus, in this case, the investor forgoes a current income stream of $3,000 for the opportunity to invest the non-taxed sum of $5,000.

finished investing, A already had a balance of nearly one-quarter-million dollars (at this point just 2.5 times what he actually invested), while B had not yet begun to invest. Between Years 20 and 40, A invests nothing but merely allows the interest to compound. The final item of note is that gains accelerate as time advances. For example between Years 0 and 5 person A invested $25,000 and had a balance of just $5,766 more than the amount he actually invested at the end of year 5. Between years 35 and 40, when he invested no new money, A had a positive cash flow of $328,481 (that is, he gained $328,481 in interest income alone).[35] This is, incidentally, almost double the gain that investor B enjoyed during this period (a total of $169,771), $50,000 of which was newly invested funds. Although this data could be analyzed countless different ways, the underlying point is that even investors who begin saving substantially in their 40s and 50s will find themselves with far less in retirement savings than those who save at lower rates but allow more time for these funds to accrue.

B. WHO PARTICIPATES IN 401(K) PLANS AND HOW MUCH DO THEY SAVE?

Given that the burden of saving for retirement is increasingly placed on the individual, one would hope that even liquidity-strained individuals save in at least small amounts early in life so they can capitalize on the advantages of compound interest as illustrated in the section above. Unfortunately, participation rates in defined contribution plans are low and declining, and many individuals are not saving at sufficient rates to secure a financially stable retirement. This section is meant to depart from the overly simplistic savings rates – often presented in the aggregate – that may cause the unwary to infer that savings behavior is fairly constant among different demographic groups. To the contrary, the data presented in this section[36] shows that despite the dramatic benefit of adequate retirement savings early in one's life, certain subgroups of individuals are chronic under-savers, and are particularly likely to experience a financially precarious retirement.

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35. This phenomenon is a consequence of the fact that interest accrues on the existing balance – clearly this figure is much higher in later years than in earlier ones.

36. VANGUARD REPORT, *supra* note 10, at 5. Data is taken from a 2005 Vanguard publication surveying the defined contribution behavior of participants enrolled in these plans in 2004. The median Vanguard participant is a 44 year-old male who earns $54,000 per year and has an account balance of approximately $24,000 in retirement savings in his employer's defined contribution plan. *Id.*

Overall, approximately two-thirds of employees participated in their employer's defined contribution plan according to the Vanguard data.[37] The unfortunate corollary is that approximately one-third did not participate in their employer's defined contribution plan. Plan participation rates varied across different demographic factors. Income, for example, was one of the primary determinants of plan participation rates. Individuals with income over $100,000 were more than twice as likely as individuals making less than $30,000 to contribute to their defined contribution plan in 2004 (89% versus 39%).[38] Age is also an important factor in explaining participation rates. Workers less than 25 years of age were by far the least likely to participate in their employer's defined contribution plan in 2004 (29%), followed by workers over age 65 (53%).[39] Participation rates by age are depicted in Table 2 below.

Table 2

Participation Rates by Age

	2000	2002	2004
Under 25	31%	30%	29%
25-34	61	60	58
35-44	72	72	69
45-54	75	75	72
55-64	76	74	72
65+	61	58	53

Source: Vanguard, 2005

Job tenure, a variable highly correlated with age, influenced plan participation as well. While approximately one-third of employees with less than one year of employment participated, more than twice as many employees with more than ten years of experience did (36% versus 78%).[40] Particularly disturbing are participation rates among those with between two and three years tenure. While more than two-thirds of these individuals participated in their employer's defined contribution plan in 2000, slightly more than half did so by 2004 (68% versus 53%).[41] Some

37. *Id.* at 4.
38. *Id.* at 12.
39. *Id.*
40. *Id.*
41. *Id.*

studies also demonstrate that women face particularly dire retirement prospects if they do not arrange their financial affairs appropriately.[42]

When one examines average account balance by age, the picture becomes even more dismal. Perhaps the most troubling single statistic from Table 3 below is that individuals between the ages of 45 and 54 have an average account balance of only $38,193.[43] Even more striking is the realization that this median, by definition, suggests that half of all individuals surveyed actually have account balances that are *less than* or equal to this figure. Although many individuals who seemingly have pessimistic prospects for a well-funded retirement based on the above data in fact have additional sources of income, for many others that is not the case: "a defined contribution plan is the sole source of an employer-sponsored pension plan for many employees and the primary source for many others... for many employees, their 401(k) plan is their only meaningful source of employer-provided retirement income."[44]

Table 3

Account Balance by Age

	Median
Under 25	$1,536
25-34	8,683
35-44	22,194
45-54	38,193
55-64	51,937
65+	53,346

Source: Vanguard, 2005

Overall, the concern for the retirement prospects of the average American seems well-placed given even a cursory analysis of the above

42. *See generally* Cindy Hounsell & Pat Humphlett, The Female Factor: Why Women Face Greater Retirement Risk and What Can Be Done to Help Beyond Employer-Based Retirement Programs (2005), *available at* http://www.wiser.women.org/asr_femalefact_v3.pdf (suggesting that due to longer life expectancy than men, lower wages, and possibly more conservative investment strategies than men, that women face a greater risk than men of experiencing a decline in standard of living in retirement).

43. *See* WILLIAM GALE ET AL., THE AUTOMATIC 401(K): A SIMPLE WAY TO STRENGTHEN RETIREMENT SAVINGS 2 (2005), *available at* http://www.brookings.edu/views/papers/20050228_401k.pdf (finding that in 2001, half of all households headed by individuals between the ages of 55 and 59 had less than $10,000 in an employer sponsored program such as a 401(k) or other type of tax-preferred plan).

44. Stabile, *supra* note 11, at 74-75.

data. As noted in the section above, in 2004 fully one-third of respondents reported not participating in their employer's defined contribution program at all; non-participation rates were far higher among younger employees. Perhaps even more troubling is the trend toward lower rates of participation and lower savings rates that seems to be developing. As illustrated in Table 2, rates of participation declined by two to three percentage points between 2000 and 2004 in all age cohorts except the over 65 age group, where participation rates declined by eight percentage points during this time period.[45] This is, of course, particularly disturbing given the current climate in which the deficit is soaring and in which the President himself has stated that Social Security is in serious jeopardy. One possible redeeming factor within this data is that employers seem to be aware of the fact that their employees' retirement savings may be inadequate.[46] As will be addressed in the sections that follow, intervention on the part of employers and the government may be some of the only antidotes to the bleak retirement prospects facing millions of retirees in the years ahead.

III. THEORETICAL PARADIGMS

A. ECONOMIC THEORY AND THE SHIFT TO DEFINED CONTRIBUTION PLANS

It is useful to view the shift from defined benefit to defined contribution plans through the lens of traditional economic theory. Neoclassical economic theory suggests that individuals are rational actors who view all the choices before them and choose the option that will maximize their wealth.[47] The theory assumes that decision makers possess

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45. It should be noted, however, that further calculation would be necessary to determine statistical significance.

46. *See* 401khelpcenter.com, Survey Reveals New Employer Trends in Retirement, (2006), http://www.401khelpcenter.com/press_2006/pr_hewitt_011006.html (last visited Sept. 22, 2006) (reporting on the results of a 2006 employer survey of more than 200 large companies and finding that employer confidence in employees' ability to take account for their own retirement this year declined from 12% in 2005 to 6% in 2006, and that 23% of employers are very likely to add some form of automatic enrollment options to 401(k) plans this year; 13% are very likely to add contribution escalation features this year; and 20% plan to add automatic plan rebalancing this year).

47. *See* Colin Camerer et al., *Regulation for Conservatives: Behavioral Economics and the Case for "Asymmetric Paternalism,"* 151 U. PA. L. REV. 1211, 1214-15 (2003). Camerer argues that though some disagreement exists among economists with respect to what precisely "full rationality" is, most economists generally agree with the following three

"unlimited sophistication,"[48] and are not, for example, intimidated by an overwhelming number of unfamiliar alternatives to an extent that would affect their decision. From this perspective, a scheme in which individuals have the widest array of choices from which to choose would likely be superior to one with little or no choice, as the theory assumes that individuals always make the optimal decision, given the alternatives available.[49] This conclusion assumes that an individual is more likely to find an optimal choice among a larger rather than smaller set of alternatives.

Contrary to the above theory, however, studies have shown that individuals are not, in fact, rational actors 100% of the time and have been known to make poor decisions, particularly with respect to retirement planning.[50] The field of behavioral economics impugns many of the assumptions of neoclassical economists presented above and seeks to define new, more realistic assumptions that are more reflective of human behavior.[51] Specifically, Choi et al. contend that employees often make the decision that "requires the least current effort... often... the 'path of least

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propositions: "First, people have well-defined preferences (or goals) and make decisions to maximize those preferences. Second, those preferences accurately reflect (to the best of the person's knowledge) the true costs and benefits of the available options. Third, in situations that involve uncertainty, people have well-formed beliefs about how uncertainty will resolve itself, and when new information becomes available, they update their beliefs using Bayes's law - the presumed ability to update probabilistic assessments in light of new information." *Id.*

48. Monahan, *supra* note 2, at 480.

49. *Id.* at 473. *See also* Deborah M. Weiss, *Paternalistic Pension Policy: Psychological Evidence and Economic Theory*, 58 U. CHI. L. REV. 1275, 1276-78 (1991) (questioning the neoclassical economic model of consumer choice and suggesting that individuals err systematically and that such inconsistency of consumer choice "offers a foundation for a methodical analysis of paternalistic savings policies... that will aid in the creation of more satisfactory retirement security programs").

50. *See* Monahan, *supra* note 2, at 481-83. The author uses Professor Weiss's conceptions of two types of "imperfect actors" who, when faced with saving for retirement in a defined contribution plan such as a 401(k) fail to save sufficiently, but for different reasons. "Impatients" are those who make poor decisions with respect to savings rates because they choose to save later rather than sooner. These actors procrastinate, "which produces a strong tendency toward inertia" and incorrectly "assume that whatever they will be doing later is not as important as what they are doing now." *Id.* "Impulsives," on the other hand, are keenly aware of the importance of saving sufficiently for retirement but suffer from "self-control problems" and "situationally inconsistent preferences," meaning that their preferences "vary according to the situation." *Id.*

51. Camerer, *supra* note 47, at 1215.

resistance.'"[52] The reality, the authors note, is that for many employees the easiest course of action is simply not to contribute to a retirement portfolio at all.[53] Thus, contrary to the models of neoclassical economists that would predict that individuals consistently maximize their utility and choose the best alternative, Choi et al. have shown that when they are presented with a broad range of investment options, individuals frequently fail to act and ultimately opt for the status quo by default. While the possibility exists that investors are in fact choosing the best alternative by doing nothing, this hypothesis is contradicted by available data.[54]

The consequences of the tendency for individuals to act irrationally are enormous. As noted above, such inertia often leads investors ultimately to choose the default contribution, a phenomenon which leads to significant employer influence on employee savings rates.[55] If employers elect non-participation as the default contribution, employees forgo the opportunity to save for retirement in a tax-favored way, an alternative that has been shown to be tremendously beneficial from a financial standpoint, and that, regrettably, cannot be fully regained. In many cases, employees forgo the

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52. James J. Choi et al., *Defined Contribution Pensions: Plan Rules, Participant Decisions, and the Path of Least Resistance* 4 (Nat'l Bureau of Econ. Research, Working Paper No. 8655, 2001).

53. *Id. See also* Cass R. Sunstein & Richard H. Thaler, *Libertarian Paternalism Is Not an Oxymoron*, 70 U. CHI. L. REV. 1159, 1175-76 (2003). This phenomenon is lucidly described by the authors in a natural experiment in which they found the default rule to be "sticky." The authors compared the insurance regimes of New Jersey and Pennsylvania, the former of which adopted a default program with a relatively low insurance premium and no right to sue, while the latter adopted a default program with a higher premium and a full right to sue. Individuals had the option of opting out of their state's default regime, but in both cases the defaults tended to stick. Only approximately 20% of New Jersey drivers opted for the full right to sue, and 75% of Pennsylvania drivers opted for this right (their default). Since there is no reason to suggest that drivers of the two states should have systematically different preferences, the authors attributed the differential effects to the existence of different default provisions. *But see* Gregory Mitchell, *Libertarian Paternalism Is an Oxymoron*, 99 NW. U. L. REV. 1245, 1276 (2005) (rejecting Sunstein and Thaler's basic premise and arguing that the authors "neglect alternative approaches to dealing with irrational choice behavior that are more consistent with libertarian principles and that make choice-framing paternalism evitable, subjugate the liberty of irrational individuals to the central planner's paternalistic welfare judgments, and fail to deal with the redistributive consequences of libertarian paternalism").

54. Choi, *supra* note 52, at 7-8.

55. *Id.* at 4. *See also* Stabile, *supra* note 11, at 87-88 (suggesting that such control by employers runs counter to the philosophy underlying the current statutory regime in which employers are not held liable for investor losses. The theory underlying this principle is that the investment choices are those of the investor; this notion is undermined by data suggesting the context-dependent nature of investor decisions).

opportunity to receive "free money" from their employer if a "match" of employee investments is offered, as is typically the case. Skeptics may suggest that this result is desirable, given that employees actively made the choice to opt for non-participation. While this argument has some merit, research shows that many individuals actually do wish to save more than they currently do for retirement, but somehow have not taken the initiative to enroll in their employer's defined contribution plan to the extent they would prefer.[56]

The available data suggests that the decisions of even those who manage to open a retirement account are flawed in many respects. First, investor decisions are largely context-dependent, meaning that actors' ultimate choices are heavily influenced by the alternatives presented to them.[57] Additionally, Benartzi and Thaler have shown that individuals' asset allocations correspond roughly to the number of options available, suggesting that investment decisions may be too heavily influenced by the asset allocations presented.[58] Moreover, Stabile has found that investor decisions may be inferior to those of asset managers, due in large part to

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56. Choi et al. surveyed a random sample of employees at a large U.S. food company and compared responses regarding employees' ideal versus actual savings rates. Respondents consistently reported that they believed that they currently saved too little, but that they planned to increase 401(k) contributions in the future. The authors also found that of these individuals who plan to increase their savings rate soon, just 14% of this group actually increase their savings rate within four months. Additionally, of those who admitted to being at a point in their lives where they reported they "should be saving seriously already," 35% were "behind" in saving. Choi, *supra* note 52, at 6-8. *See also* David T. Laibson et. al., *Self-Control and Saving for Retirement*, *in* BROOKINGS PAPERS ON ECONOMIC ACTIVITY 91, 94 (William C. Brainard & George L. Perry eds., 1998) (reporting results of a survey finding that 76% of respondents believed that they should be saving more).

57. *See* Stabile, *supra* note 11, at 87. The evidence Stabile offers is from an EBRI study in which investors were offered one of three investment allocation options: a guaranteed investment contract (GIC) and employer stock, plans which contained only one of the above options, and plans which contained neither investment options. *See id.* The study found that "participants in plans offering neither option have the highest allocations to equity funds, that plans offering an employer stock fund but no GIC fund have substantially lower allocations to all other investment options, and that participants in plans with a GIC fund but no employer stock fund have lower allocations to bond, money market, and equity funds. The EBRI also found that where a plan requires that a company match be invested in employer securities, participants tend to direct a higher percentage of their self-directed funds into that option as well." *Id.*

58. For example, if a fund offers ten options, people tend to allocate 1/10 of savings to each available option. Shlomo Benartzi & Richard H. Thaler, *Naive Diversification Strategies in Defined Contribution Savings Plans*, 91 AM. ECON. REV. 79, 79 (2001).

the fact that many investors are financially illiterate.[59] Such investors predictably make poor decisions, including investing too conservatively, and attempting to "time the market," a strategy that most investment experts discourage.[60] Neophyte investors are also prone to excessive inactivity with respect to the management of their investment portfolio.[61] Stabile also found that individual investors tend to invest too heavily in company stock, noting that typically 30% to 40% of plan assets are invested in stock among companies that offer securities as part of the employer's 401(k) plan.[62] Given the poor decisions many investors have been shown to make with respect to saving for retirement, the next section will explore whether government intervention is justifiable from a theoretical perspective.

B. THE CASE FOR INTERVENTION: CAN "PATERNALISM" BE THEORETICALLY JUSTIFIED?

The foregoing sections have sought to outline a fundamental inconsistency that could prove deleterious to a great many Americans, as well as society as a whole: while the benefits of saving sufficiently for retirement have perhaps never been more dramatic, a surprisingly small fraction of the population seems to be exploiting the benefits available through tax-advantaged investment in defined contribution plans. This section sets forth some of the potential consequences that may result from this behavior, and ultimately attempts to justify government intervention in this important area.

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59. Stabile, *supra* note 11, at 88. *See also* Colleen E. Medill, *The Individual Responsibility Model of Retirement Plans Today: Conforming ERISA Policy to Reality*, 49 EMORY L.J. 1, 14 (2000) (noting that investors' lack of knowledge about financial management of retirement assets may jeopardize their ability to accumulate sufficient assets in retirement); Laura Lallos, *The 60 Minute 401(k)*, MONEY, Nov. 2000, at 85 (noting that almost half of survey respondents could not name even one investment option in their 401(k) plan).

60. Stabile, *supra* note 11, at 89-90.

61. *Id.* at 90.

62. *Id.* at 90-91. *See also* James J. Choi et al., *Employee Investment Decisions About Company Stock* 2 (Nat'l Bureau of Econ. Research, Working Paper 10228, 2004) (suggesting the following possible employer motivations for offering employees stock in 401(k) plans despite the obvious dangers of doing so: providing stock is relatively inexpensive, morale or incentive effects that result of employees having an ownership interest in the company, and that friendly employees may prove beneficial in a management or takeover dispute).

One of the more prominent theories that advocates government intervention is that of "libertarian paternalism," which has been articulated by Cass Sunstein and Richard Thaler. Contrary to the contentions of various critics, the authors argue that far from being an oxymoron, the theory allows for "private and public institutions to influence behavior while also respecting freedom of choice."[63] The underlying idea is that people's choices are often unclear and/or uninformed and are often influenced by, among other things, the way in which various choices are presented.[64] Libertarian paternalists "attempt to steer people's choices in welfare-promoting directions without eliminating freedom of choice."[65] The authors see the need for change because data from behavioral economics and cognitive psychology has shown that individuals may "make inferior decisions in terms of their own welfare – decisions that they would change if they had complete information, unlimited cognitive abilities, and no lack of self-control."[66]

Susan Stabile argues that some degree of paternalism is justified with respect to defined contribution plans for two reasons: (1) individuals often do not make good decisions because of certain biases affecting decisions; and (2) poor investor behavior may be harmful to third parties.[67] Stabile argues that the above evidence about the flaws in investor decisions suggests that they are "incapable of understanding their own best interests, or they are incapable of acting in their self-interest" and that government intervention becomes more justifiable as a result.[68] Whether or not

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63. Sunstein & Thaler, *supra* note 53, at 1159. *See also* Cass R. Sunstein, *Switching the Default Rule*, 77 N.Y.U. L. REV. 106, 133-34 (2002) (drawing on behavioral law and economics and arguing that switching default rules might have the effect of producing change in many different areas of labor and employment law).

64. Sunstein & Thaler, *supra* note 53, at 1159.

65. *Id.*

66. *Id.* at 1162. *See also* Shlomo Benartzi & Richard H. Thaler, *How Much Is Investor Autonomy Worth?*, 57 J. FIN. 1593, 1594-98 (2002). Employees shared their retirement portfolios with researchers performing a behavioral experiment. Researchers presented the investors with a statistical distribution of expected retirement income of three portfolios: their own, the average of fellow employees, and the median of fellow employees. Subjects rated the median portfolio more highly than their own and just 20% of investors rated their own portfolio more highly than the median. Sunstein and Thaler interpret this data to mean that "people do not gain much ... from choosing investment portfolios for themselves." Sunstein & Thaler, *supra* note 53, at 1169-70.

67. Susan J. Stabile, Freedom to Choose Unwisely: Congress' Misguided Decision to Leave 401(k) Plan Participants to Their Own Devices, 11 CORNELL J. L. & PUB. POL'Y 361, 391 (2002).

68. *Id.*

individuals are "incapable" of understanding or acting in their own best interest, it is clear that they are not, in practice, acting in accordance with their own best interest, as demonstrated by the materials in the sections above. Voluminous evidence suggests that employees want to invest at greater rates in their employers' defined contribution plans but that a debilitating status-quo bias prevents them from doing so.[69] This situation, in tandem with the dire consequences that may ensue if the coming waves of retirees are not sufficiently funded for retirement, justifies aggressive government intervention.[70]

The second justification for legal intervention that Stabile advances relates to the social harm that could result if the current system remains unchanged. Stabile argues persuasively that employee decisions not to participate in 401(k) plans, to participate at low levels, or to participate and subsequently opt for a cash distribution, have negative externalities that will impact the rest of society.[71] Rather than retiring with insufficient assets, some employees may decide not to retire at all, or to retire later in

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69. *See* Sunstein & Thaler, *supra* note 53, at 1175-76. *But see* Mitchell, *supra* note 53, at 1276.

70. Opponents of relatively aggressive models of intervention such as the Save More for Retirement Act of 2005 often suggest that other less intrusive methods of increasing savings rates in defined contribution plans exist. Proponents of this school of thought might argue that alternatives are desirable because they rely more on the demonstrated intent and explicit actions of the investor herself. Increased education is a popular alternative that has been shown to be inadequate. Choi et al. interpreted a study undertaken by Brigitte C. Madrian and Dennis F. Shea in which the authors examined the effect of a general education seminar that was conducted at one particular company. Madrian and Shea tracked seminar attendance and matched data on seminar attendance with subsequent statements about changes that seminar participants desired to make with respect to savings behavior, in addition to the actual changes that participants made regarding their retirement savings. During one particular six month period, of the fraction of attendees who currently did not participate in their employer's defined contribution plan but responded that they intended to start as a result of the seminar, only 14% actually joined their plan at the end of the six month period. Choi et al. note that some of these individuals would have likely joined their employer's 401(k) plan even in the absence of the seminar, as 7% of non-attending employees did. Of seminar attendees who had already been participating in their employer's 401(k) plan, "41 percent reported plans to make changes in the selection of their investment choices within the 401(k) plan, and 36 percent reported plans to change the fraction of their money allocated to the various 401(k) investment choices." The fraction of individuals who actually made those changes was substantially lower. This data strongly suggests that education alone is insufficient to deal with the serious issues presented by employee non-participation in employer defined contribution plans. Choi, *supra* note 52, at 30-31.

71. Stabile, *supra* note 67, at 391.

life than they otherwise would if they had adequate retirement savings.[72] A potential consequence is having a sizable portion of the workforce with decreased levels of motivation for work.[73] More workers of retirement age occupying employment positions would also decrease the number of employment opportunities available to both new employees and to employees that would otherwise be promoted to those positions.[74] Stabile notes that attempting to justify additional regulations on corporations is particularly easy, because "corporations... are creations of society" that enjoy favorable tax treatment, and "[i]f notions of corporate social responsibility imply that public corporations 'have an obligation to contribute to the betterment of society in a manner distinct from the maximization of corporate profit,' those same notions demand that corporations adopt a more responsible attitude toward promoting the retirement security of their own employees."[75]

The abysmal savings rates that seem virtually ubiquitous in an aging country in conjunction with the persuasive evidence presented by various behavioral economists that individuals wish to save more but simply fail to do so for irrational reasons justifies government intervention. The argument that significant social harm could ensue if current savings practices remain unchecked is additional fodder for reform advocates. The section below will discuss various reforms that could be implemented that would almost inevitably increase savings rates markedly.

IV. ALTERNATIVES

The foregoing sections have sought to justify government intervention in employer-sponsored defined contribution plans due to the imminent crisis in the American retirement security arena. The remaining portions of this Note outline the most promising alternatives, with emphasis on a particular piece of legislation that was introduced to the Senate in April, 2005: The Save More for Retirement Act of 2005.

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72. *Id.* at 395.
73. *Id.*
74. *Id.*
75. *Id.* at 396.

A. THALER AND BENARTZI'S SAVE MORE TOMORROW PLAN

The data presented above demonstrate that individuals often desire to save for retirement at greater rates, but do not do so for a variety of reasons. The behavioral experts Thaler and Benartzi have devised an ingenious way to get employees to overcome many of the obstacles that prevent them from saving adequately for retirement. Acknowledging the empirical fact that many individuals desire to save more but often lack willpower and sophisticated investment knowledge, the plan capitalizes on the notion that people are generally more willing to forgo a future benefit than a current benefit.[76] As such, the plan invites employees to commit to increased 401(k) contributions in advance of when the payroll deductions would actually be taken. As described by Thaler and Benartzi, the (SMarT) plan works as follows:

> First, employees are approached about increasing their contribution rates approximately three months before their scheduled pay increase. Second, once they join, their contribution to the plan is increased beginning with the first paycheck after a raise. Third, their contribution continues to increase on each scheduled raise until the contribution rate reaches a preset maximum. Fourth, the employee can opt out of the plan at any time.[77]

The authors found that those who joined the plan, on average, more than tripled their savings rates, from 3.5% to 11.6%, in 28 months.[78]

According to Thaler and Benartzi, the SMarT plan is successful in part because it was designed with an eye toward circumventing the traditional obstacles to saving for retirement.[79] One of the primary obstacles in saving

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76. Professor Thaler eloquently described this phenomenon as follows in a personal interview: "For example, given the option of going on a diet three months from now, many people will agree. But tonight at dinner, that dessert looks pretty good." Richard Thaler, *Save More Tomorrow: A Simple Plan to Increase Retirement Saving,* CAPITAL IDEAS, Sept. 2004, http://gsbwww.uchicago.edu/news/capideas/sept04/savemoretomorrow.html.

77. Id..

78. *Id.*.

79. *Id.* Traditional obstacles include, as discussed herein: (1) ascertaining how much to save; (2) addressing problems related to investor self-control; (3) addressing problems related to investor inertia; and (4) addressing investors' feelings of loss aversion. *Id.*

adequately for retirement is attempting to ascertain how much to save.[80] The life-cycle theory of consumption assumes that individuals decide what level of consumption they desire over a lifetime and borrow and save in accordance with that calculation.[81] Since incomes are relatively lower when workers are younger, more borrowing usually occurs then, with retirement savings occurring later in one's career. The SMarT plan helps individual investors approximate the appropriate level of savings.[82] Second, the plan addresses problems of self-control that can often impede one's ability to save for retirement.[83] Because individuals only contribute at higher rates when they receive pay increases, investors never see a decrease in their take-home pay, and often see increases when they receive pay raises, although less dramatic increases than would be the case if they did not opt for the SMarT program. Third, the authors capitalize on investor inertia - that is, the tendency for investors to fail to make changes in savings rates or investment allocations, even once they are actively investing in their employer's plan.[84] Since employees agree to gradual increases in their contribution rate in advance of when the deductions are actually taken, they do not actively increase contributions as time progresses. Finally, the authors' plan addresses an individual's feeling of loss aversion: the tendency to be more concerned with losses than with comparable gains.[85]

Thaler and Benartzi reject critics' arguments that automatic enrollment and the SMarT plan are a sort of "sneaky paternalism." The authors emphasize the inevitability of having some form of a default rule, and point out that these plans are not mandatory because individuals are able to opt out of the program if they desire. Introducing a default rule that many policymakers believe individuals themselves would make if they had complete information and did not lack self-control is meant to be helpful to individual investors and to society as a whole.

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80. Indeed, the authors note that ascertaining the appropriate amount to save can be a technical undertaking that even trained economists find challenging. *Id.*

81. *Id.*

82. Thaler, *supra* note 76.

83. *Id.*

84. Julie Agnew et al., *Portfolio Choice and Trading in a Large 401(k) Plan*, 93 AM. ECON. REV. 193, 200-201 (2003) (discussing the infrequent rate of portfolio adjustments for investors in defined contribution plans).

85. *See* Thaler, *supra* note 76.

B. THE SAVE MORE FOR RETIREMENT ACT OF 2005

Were it not for Senator Jeff Bingaman, the innovative scheme presented above could perhaps be dismissed as a whimsical notion proposed by two ivory-tower theorists who are devoid of any sense of the political palatability of such a dramatic proposal. All this changed in April, 2005 when Senator Bingaman, a Democrat from New Mexico, introduced the Save More for Retirement Act of 2005 (S. 875). This legislation would amend the Internal Revenue Code and ERISA in an effort to increase savings in defined contribution plans such as 401(k) plans using the same mechanisms as Thaler and Benartzi's plan.[86] Likely sensing the imminent crisis enshrouding America's retirement security landscape, in his comments on the Senate floor, Senator Bingaman emphasized the urgent need for Congress to "look at ways to expand retirement savings" and noted the historically low national savings rate.[87]

As in Thaler and Benartzi's plan, the first part of the new legislation seeks to change the default investment contribution to automatic enrollment. Additionally, in an effort to increase savings rates, the plan would "encourage plans to add a feature that increases employees' contributions annually until it reaches at least 10 percent of the employees' compensation."[88] The Save More for Retirement Act of 2005 includes a safe harbor provision to encourage employers to make changes to the plan. The plan would be treated as nondiscriminatory for ERISA non-discrimination testing purposes if the following safe harbor provisions are met: "the employer must provide either a non-elective match of 3 percent of the employee's compensation or an elective match of 50 percent of the first 7 percent of the employee's compensation."[89] Additionally, the employer must allow vesting in two years if the employee is enrolled in the plan before their first paycheck, or in one year if the employee is enrolled within the first quarter of starting work. The legislation instructs the Department of Labor to provide regulations that will provide guidance to employers in selecting default provisions beyond money market accounts and guaranteed investment contracts, although the specifics of those

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86. B. Janell Greiner, *Save More for Retirement Act of 2005*, BENEFITS BLOG, Apr. 25, 2005, http://www.benefitscounsel.com/archives/001463.html.

87. *Id.*

88. *Id.*

89. *Id.* The criteria will also be deemed to have been met if the employer provides comparable benefits in another qualified account for the same employees.

regulations have not been articulated.[90] Importantly, the legislation seeks to amend ERISA § 404(c) rather than eliminate it, and retains employer exemptions from liability if participants exercise control over their accounts. The safe harbor provision of the legislation is set out below:

Table 4
Non-Discrimination Testing Safe Harbor
Employer Contributions
Non-elective match of 3% of employee's compensation OR Elective match of 50% of the first 7% of employee compensation
Vesting
2 years if deferrals taken from first paycheck OR 1 year if employer enrolls employees within the first quarter of hire
Employee Contributions
If employee does not opt out of participation AND does not opt out of the default feature, the plan must: Start employee's contribution at 3% of compensation AND Increase contribution 1% annually or whenever employee receives a raise AND Contribution rate must increase up until at least 10% of compensation
Employee Protection
Employee can withdraw without penalty as of the latest of: $500 of contributions 2 paychecks OR 1 month
Pre-emption from State wage withholding laws
ERISA preemption to extent that state wage withholding laws would prevent employers with automatic enrollment plans from sending employees' contributions to their retirement plan
Source: American Benefits Council, 2005[91]

The proposed legislation is desirable for a number of reasons. At the most fundamental level, it attempts to reconcile the following two competing notions: while individuals have a right to control their own retirement planning choices and invest their assets as they so desire,

90. *Id.* Specifically, the legislation calls for guidance on the appropriateness of designating default investments.

91. American Benefits Council, *Save More For Retirement Act of 2005,* http://www.americanbenefitscouncil.org/documents/s-875_bingaman_summ.pdf.

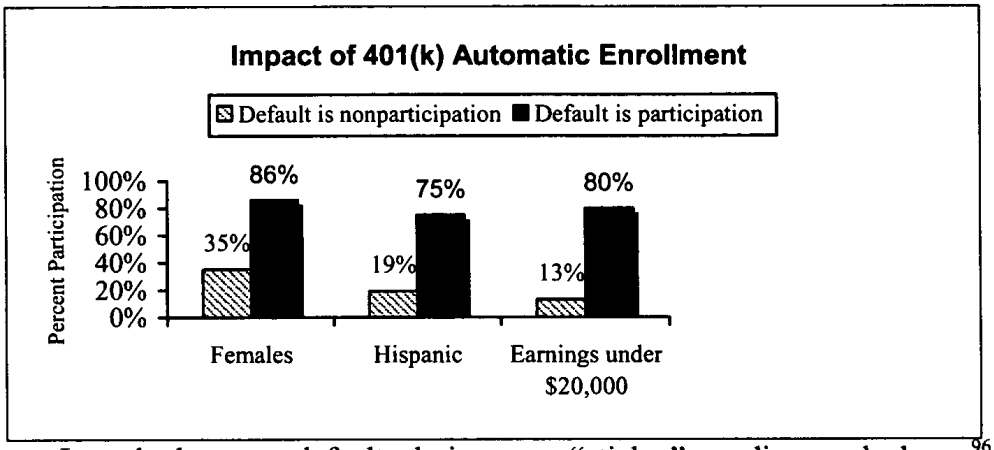
extensive research has shown that individuals "make inferior decisions in terms of their own welfare – decisions that they would change if they had complete information, unlimited cognitive abilities, and no lack of self-control."[92] By thoroughly informing individuals of the consequences of automatic enrollment, the plan ensures that individuals are free to make any choice regarding participation in their employer's defined contribution plan they desire, but simultaneously addresses the strong status quo bias that prevents many investors from investing in their employer's defined contribution plan. Further, the way in which the plan seeks to encourage investment is preferable to other alternatives that have been suggested by commentators. Specifically, the existence of the safe harbor provision provides an incentive for employers to implement the program, and attempts to ensure that employees at all income levels will have an opportunity to invest. Finally, as will be discussed below, the plan amends rather than eliminates ERISA section 404(c), and enables employers to continue to enjoy exemption from liability for investor losses. The former alternative is preferable to the latter because removing employer exemptions from liability provides a disincentive for employers to offer defined contribution plans – a step that would truly be disastrous to Americans' retirement security.

C. CHANGE THE DEFAULT: AUTOMATIC ENROLLMENT

Perhaps the foundation of Senator Bingaman's proposed legislation is automatic enrollment. Under this scenario, the default enrollment option regarding the employer's defined contribution plan is participation; employees must actively "opt out" of the default arrangement if they do not wish to contribute to the plan. Under most such arrangements, employees are specifically informed of the nature of automatic enrollment and are always able to "opt out" quite easily. The benefits of automatic enrollment are dramatic, particularly among certain subgroups of individuals who have historically participated in defined contribution plans at the lowest levels. Choi et al. has demonstrated that automatic enrollment significantly influences 401(k) participation.[93] In a study of three large firms, the authors use several years of administrative data to study the impact of automatic enrollment on participation rates in defined contribution plans, savings behavior, and asset accumulation. The researchers found that

92. Sunstein & Thaler, *supra* note 53, at 1162.
93. Choi, *supra* note 52, at 28.

although employees have the option of "opting out" of participation, few ultimately do. The authors found that automatic enrollment virtually eliminates those employees who do not contribute to their employer's defined contribution plans, and increases participation rates to approximately 90%.[94] The results are particularly striking for those subgroups with historically low participation rates, such as women and minorities.[95]



Largely because default choices are "sticky," as discussed above,[96] participation is dramatically affected by the employer's choice of default, particularly among the subgroups depicted in the chart above. Participation in 401(k) plans increased more than two-fold among women (from 35% to 86%) when automatic enrollment was introduced. Results were even more pronounced for Hispanics and those earning less than $20,000 per year.[97]

Despite the dramatic impact of automatic enrollment on participation rates in 401(k) plans, Choi et al. conclude that automatic enrollment "probably had a modest positive impact on *employee balances*, controlling for tenure."[98] The main reason for this outcome is that low default savings rates had offsetting effects on wealth accumulation in the Choi study. That is, even though more people enrolled in defined contribution plans when

94. *Id. See also* Brigitte C. Madrian & Dennis F. Shea, *The Power of Suggestion: Inertia in 401(k) Participation and Saving Behavior*, Q.J. ECON. 1149, 1158-59 (2001) (finding participation rates for new workers increased from 49% to 86% after a switch to automatic enrollment).

95. Madrian & Shea, *supra* note 94.

96. Sustein & Thaler, *supra* note 53, at 1160.

97. Madrian & Shea, *supra* note 94.

98. Choi, *supra* note 52, at 28.

the default was participation, their balances did not increase dramatically because their contribution rates (e.g. percent of income) remained relatively low. The authors found that "initially, about 80% of participants accept both the default savings rate (2% or 3%...) and the default investment fund (a stable value or money market fund)... after three years, half of the plan participants subject to automatic enrollment continue to contribute at the default rate and invest their contributions exclusively in the default fund."[99] Thus these conservative investment outcomes led to relatively low levels of wealth accumulation.[100] In fact, research has shown that investors would have opted for higher savings rates if given the opportunity to do so.[101] Available data also suggests that most employees would not object to their employer adopting automatic enrollment.[102] The Save More Tomorrow plan, in contrast to plans incorporating only automatic enrollment such as those discussed above, uses automatic enrollment as a foundation, but improves on that arrangement by periodically increasing the amount of money set aside for retirement and offering age-appropriate investment allocations.

D. EFFECTS OF CHANGING ERISA SECTION 404(c)

ERISA was enacted in 1974 to regulate defined benefit programs.[103] The legislation mandates "disclosure and reporting requirements for retirement plan sponsors and sets standards of conduct for plan fiduciaries. ERISA also sets standards for vesting and accrued benefits, minimum funding requirements, and termination of retirement plans."[104] The underlying goal of ERISA is to "protect and strengthen the rights of employees, to enforce strict fiduciary standards, and to encourage the development of private retirement plans."[105]

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99. *Id.* at 2.

100. *Id.* at 28. Default savings rates of two to three percent of income and default investments in money market accounts undermine long-term wealth accumulation.

101. Madrian and Shea, *supra* note 94.

102. American Benefits Counsel, *Automatic Enrollment and Automatic Acceleration Features Encourage Worker Participation in Defined Contribution Plans*, http://www.americanbenefitscounsel.org/documents/abc_ae_ai_042105.pdf (reporting that two-thirds of non-participants in their employer's 401(k) plan would be either very likely or somewhat likely to remain in their employer's plan if they were automatically enrolled).

103. Keith R. Pyle, Note, *Compliance Under ERISA Section 404(c) with Increasing Investment Alternatives and Account Accessibility*, 32 IND. L. REV. 1467, 1468 (1999).

104. *Id.* at 1468-69.

105. *In re* Unisys Sav. Plan Litig., 74 F.3d 420, 434 (3d Cir. 1996).

Nevertheless, certain ERISA provisions remain some of the most significant impediments to implementing the reforms outlined above. Section 404(c) of ERISA states the consequences that result from a participant's exercise of control of his defined contribution account. That section provides that if a pension plan provides individual accounts and allows the investor to "exercise control" over the assets in the account, "such participant or beneficiary shall not be deemed to be a fiduciary by reason of such exercise, and . . . no person who is otherwise a fiduciary shall be liable under this part for any loss, or by reason of any breach, which results from such participant's, or beneficiary's exercise of control."[106] Thus if the investor is deemed to have "exercised control" as set forth in the regulations, the employer is able to avoid liability for any losses that may occur in employer sponsored defined contribution plans. Of course, employers wish to ensure that employees "exercise control" so that employers are exempt from liability in accordance with § 404(c).[107] Because employees cannot be deemed to have "exercised control" when passively accepting the default provision of automatic enrollment, employers are understandably reluctant to adopt plans with such features.[108] The Save More for Retirement Act addresses this issue by amending § 404(c) so that an investor is deemed to have "exercised control" - even if she is invested in the default alternative - if the default investment plan is allocated in accordance with regulations to be promulgated by the Department of Labor.

Some commentators have questioned the theoretical foundation of the concept of "control" in a world in which individuals have been shown to make irrational investment decisions.[109] Susan Stabile, for example, questions the extent to which even individuals who make an affirmative choice to participate in their employer's 401(k) plan can actually be said to have "exercised control" over their account as defined by ERISA.[110] Stabile argues that section 404(c) should be eliminated since it "lacks a

106. 29 U.S.C. § 1104(c)(1) (2000).

107. *See* Stabile, *supra* note 67, at 375-76 ("[I]n automatic enrollment plans, there is no section 404(c) relief unless a participant makes an affirmative election to change from the default contribution and investment options selected by the employer").

108. *See* 29 C.F.R. § 2550 (2005) ("decisions have affirmatively been made by participants and beneficiaries who have exercised independent control... Unless an affirmative instruction is given, there can be no relief under ERISA section 404(c)"). Of course, employers are able to control their exposure by using money market and stable value funds as well as guaranteed investment contracts as the default investments.

109. *See, e.g.*, Stabile, *supra* note 67, at 376.

110. *Id.* at 376.

firm theoretical basis because control by participants is illusory."[111] The crux of the argument is that individuals who are deemed to have "exercised control" in their 401(k) plans have often not, in fact, exercised meaningful control because of the "influence exerted by employers and other fiduciaries."[112] Because employers may influence employees to invest in company stock and service providers may "steer participants into funds paying the largest fees," the argument goes, the extent to which investors actually exercise control is diminished.[113] While there can be little question that individuals' decisions regarding retirement savings can sometimes be faulted, ERISA § 404(c) serves a useful purpose, and as a liability shield, offers employers an incentive to offer these voluntary investment programs for employees. As will be discussed in the section below, the potential costs of eliminating the provision would likely outweigh the benefits.

1. Potential Consequences of the Imposition of Liability under § 404(c)

An increased risk of employer liability could potentially have disastrous effects on Americans' retirement security. An advocate for the elimination of § 404(c) herself, Stabile notes the possible employer responses to potentially creating liability on the part of employers for employee losses.[114] First, employers might decide to end participant-direction of defined contribution plans and opt to make the decisions for employees themselves. Stabile argues that management by professional asset managers is actually a positive outcome, because many individual investors have indicated a desire for professionals to manage their investments.[115] A second possible response is for employers to provide more extensive education to employees, and to monitor investor decisions.[116] Finally, employers may decide to eliminate 401(k) plans entirely in response to increased potential for liability.[117] Although Stabile emphasizes that pension plan sponsorship is voluntary, she notes the unlikelihood of this dramatic alternative, as "[c]orporations competing for

111. *Id.* at 397.
112. *Id.* at 383, 386.
113. *Id.* at 385.
114. *Id.* at 398-400.
115. Stabile, *supra* note 67, at 398-99.
116. *Id.* at 399.
117. *Id.* at 400.

talented and skilled employees have no choice but to offer pension plans in order to compete with competitors offering such plans."[118]

Senator Bingaman's proposed legislation is preferable to eliminating § 404(c) for a variety of reasons. Given the behavioral evidence presented above, it is clear that the objectives heretofore accomplished by non-discrimination provisions will be accomplished with the non-discrimination testing safe-harbor: data suggest that it is quite likely that the proposed legislation will succeed in increasing participation rates dramatically.[119] Additionally, the changes to § 404(c) deal with the problems related to actual control that Stabile raises, without the potentially harsh consequences that could accompany elimination of § 404(c) protection. While it is clear that employers would still exercise some influence on investors' choices, the ultimate choice would still be that of the investor, as he would be made aware of the automatic nature of the defined contribution plan and be required to consent to this arrangement. Moreover, in contrast to the situation that now exists, control would be explicit, and presumably employees would be more aware than they currently are of potential employer influence, on both an implicit and explicit basis. As a result, it is likely that employees would act more affirmatively to alter choices they find unfavorable, rather than continue to be subtly, and perhaps deceitfully, influenced by employer actions.

Furthermore, even proponents of elimination of § 404(c) acknowledge the possibility that employers would discontinue their defined contribution plans for employees. In light of the data set forth at the outset, this could clearly have a deleterious effect on Americans' retirement security. In ultimately reaching the conclusion that discontinuation would likely not occur, Stabile suggests that for competitive reasons firms would not be able to take this step, as it would effectively preclude them from attracting the most talented job applicants.[120] Such reasoning ignores the fact that large firms could potentially act in concert with one another to discontinue the practice of offering defined contribution plans, and that other less well-known organizations might well follow suit. Given the pronounced lack of investment-savvy on the part of many Americans, it is indeed possible that some organizations that do not offer a defined contribution plan might attempt to lure the unwary with above-market salaries, essentially offering

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118. *Id.*

119. Richard H. Thaler & Shlomo Benartzi, Save More Tomorrow: Using Behavioral Economics to Increase Employee Saving, 112 J. POL. ECON. S164 (2004).

120. Stabile, *supra* note 67, at 400.

new employees the option to consume somewhat more in the form of inflated salaries now, while choosing to forgo a much larger benefit in the form of a mature defined contribution benefit later. The unfortunate truth is that many investors may not know of the benefit of even small contributions to retirement savings early in one's life.

E. THE PENSION PROTECTION ACT OF 2006

On August 17th, 2006, President Bush signed the Pension Protection Act of 2006 into law. Although the legislation was perhaps more newsworthy for its impact on defined benefit plans, the law had significant implications for the world of defined contribution plans as well.

The 2006 Act paves the way for employees to automatically enroll employees in defined contribution plans, and amends ERISA "to provide a safe harbor for plan fiduciaries investing participant assets in certain types of default investment alternatives in the absence of participant investment direction."[121] Specifically the legislation extends § 404(c) protection to plans using automatic enrollment features, subject to various regulations prescribed by the Department of Labor.[122]

The automatic enrollment provisions of the Pension Protection Act constitute an effective starting point for addressing the upcoming crisis regarding Americans' retirement security. As the Choi study demonstrates, however, automatic enrollment alone is not a complete solution. To more fully address savings inadequacy, employers must make every effort to periodically accelerate employees' contributions to the extent consistent with ERISA.

CONCLUSION

The precarious future of Social Security in conjunction with the increased role of the defined contribution plans in the average American's retirement portfolio suggests that reform is needed. Many Americans have not been devoting adequate care to retirement planning, and have not been taking full advantage of the potential benefits available to them through a tax-advantaged defined contribution plan. But new research has identified

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121. U.S. DEPT. OF LABOR, PROPOSED REGULATION RELATING TO DEFAULT INVESTMENT ALTERNATIVES UNDER PARTICIPANT DIRECTED INDIVIDUAL ACCOUNT PLANS, *available at* (last visited Jan. 19, 2007).

122. For a detailed examination of the effect of the Act on § 404(c) of ERISA and of the details of the Department of Labor regulations, see *id.*

one of the main causes of this disturbing trend, and the Save More for Retirement Act of 2005 offers a sound solution. By changing the law to reflect the actual savings and consumption patterns of individual investors as demonstrated by behavioral research, individual retirees will enjoy a more prosperous retirement, and society will not be forced to bear the costs of a nation of chronic under-savers. Furthermore, it is essential that employers not face disincentives to offering defined contribution plans to their employees, as the consequences of such an occurrence in terms of Americans' retirement security would be disastrous. As such, ERISA § 404(c) should be amended rather than eliminated, as proposed in Senator Bingaman's legislation. The strength of the Save More for Retirement Act of 2005 is that it facilitates what research has shown are the decisions employees would make if they were not limited by the cognitive constraints that often influence the behavior of many investors.

THE *CHAWLA* DECISION: A DEATH KNELL FOR THE USE OF THE LIFE INSURANCE TRUST IN ESTATE PLANNING?

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INTRODUCTION

Chicken Little ran around telling anyone who would listen that the sky was falling. According to some commentators today, the sky may well be falling again - at least as far as estate planners and the insurance industry are concerned. Troubling to all is a recent judgment that, if broadly read and widely applied, could render billions of dollars in life insurance policies void and eliminate the use of a widely used, basic estate planning tool: the trust funded by life insurance proceeds.[1]

In February 2005, the Eastern District of Virginia issued a decision in *Chawla v. Transamerica Occidental Insurance Co.*,[2] wherein the district court denied the claim of the trustee for the proceeds of a life insurance policy owned by the trust and taken out on the decedent, a co-trustee. Although the court initially based its decision on the existence of a material misrepresentation of fact on the application, the case quickly gained notice for its alternate holding that the trust lacked an insurable interest in the life of the insured, and therefore was void.

Until the meaning of the holding is clarified on appeal, estate planners and the insurance market are in limbo as to the wisdom of using life insurance in trusts as a tool of estate planning. While there is significant disagreement over the possible effect of the decision, billions of dollars of life insurance policies could ultimately be affected if the decision is upheld and followed by other courts with statutes similar to the one governing the policy in issue.[3]

After a review of the facts of the case and the district court decision, this Note will examine the general insurable interest requirement and the Maryland insurable interest statute at the heart of the case in order to analyze how the appellate court may decide the matter. This Note will then discuss the implications of various outcomes and possible responses.

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1. Kurt R. Gearhart, *The Life Insurance Industry and Estate Planning Community Wait – The* Chawla *Appeal*, BOWNE INS. & FIN. SERVICES REP., Spring 2005, at 6, www.sidley.com/db30/cgi-bin/pubs/2005%20Bowne%20Spring%20Issues.pdf.

2. No. 03-1215, 2005 U.S. Dist. LEXIS 3473 (E.D. Va. Feb. 3, 2005), *aff'd in part and vacated in part*, 440 F.3d 639 (4th Cir. 2006).

3. Gearhart, *supra* note 1, at 7.

I. THE DISTRICT COURT'S DECISION

In May 2000, the decedent, Harald E. Geisinger, applied for a $1 million life insurance policy on his own life from the defendant, the Transamerica Occidental Life Insurance Company, initially naming the plaintiff, Vera Chawla, as the owner and beneficiary of the policy.[4] Transamerica, however, refused to issue the policy as applied for because Chawla, a friend and the husband of Geisinger's physician, lacked an insurable interest in Geisinger's life.[5] To facilitate the purchase, and although not explicitly authorized to do so by the terms of the trust agreement,[6] Geisinger changed the proposed owner and beneficiary of the policy to the "Harald Geisinger Special Trust" (hereinafter the "Trust"), of which both he and the plaintiff were co-trustees.[7]

Part Two of the insurance application contained various questions about the decedent's medical history. In response, Geisinger denied being hospitalized within the specified timeframe and receiving treatment for alcohol addiction.[8] Based on that information, Transamerica issued the policy. In accordance with the contract's delivery provisions, the policy became effective on July 7, 2000, upon payment of the first premium and signature by and delivery to Chawla, as trustee, in her Maryland home.[9] In October 2000, a revised policy for $2.45 million dollars was issued, again based on a similar set of responses to the medical questions initially asked.[10]

After Geisinger died in September 2001, Chawla filed a claim for benefits under the policy in her capacity as trustee.[11] Contending that Geisinger had failed "to disclose certain medical information that was

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4. *Chawla*, 2005 U.S. Dist. LEXIS 3473, at *1.

5. *Id.* at *2-3.

6. *Id.* at *2. Although the Court noted this alleged lack of power, this fact does not seem to have affected the Court's decision or rationale. On appeal, Chawla argues that it was a power granted to the Trust. *See* Brief of Appellant at *55, Chawla v. Transamerica Occidental Life Ins. Co., 440 F.3d 639 (4th Cir. 2006) (No. 05-1160), 2005 WL 1827727.

7. *Chawla*, 2005 U.S. Dist. LEXIS 3473, at *2. As the court later noted in its opinion, Mr. Geisinger was the Trust's sole beneficiary during his lifetime; he had the right to receive all income from the Trust and to occupy his residence, the title to which was held by the Trust. *Id.* at *18.

8. Chawla v. Transamerica Occidental Ins. Co., No. 03-1215, 2005 U.S. Dist. LEXIS 3473, at *2 (E.D. Va. Feb. 3, 2005), *aff'd in part and vacated in part*, 440 F.3d 639 (4th Cir. 2006).

9. *Id.* at *3.

10. *Id.* at *3-4.

11. *Id.* at *6.

material to Defendant's decision to issue the policy," Transamerica denied the claim.[12] It subsequently rescinded the policy and returned the premiums.[13] Notwithstanding the representations made in the applications, Geisinger had previously been hospitalized in 1999 and early 2000 for brain surgery and attendant complications, as well as for alleged treatment for chronic alcohol abuse.[14]

In September 2003, Chawla filed suit for breach of contract in order to recover the proceeds of the policy.[15] Transamerica answered and filed a counterclaim alleging fraud.[16] On these facts, the court decided Chawla's Motion for Summary Judgment in favor of Transamerica, thereby rendering its counterclaim for fraud moot.[17] In finding for Transamerica, the court offered two alternate rationales: material misrepresentations in the application and the lack of an insurable interest.[18]

The Court's reasoning on the material misrepresentation rationale was very straightforward, as Maryland law[19] provides that a "material misrepresentation in the form of an incorrect statement in an application invalidates a policy issued on the basis of such application."[20] In reaching its conclusion the Court applied a two-step approach, first asking whether a misrepresentation had occurred, and if so, was it material to the decision to issue the policy.[21]

Determining that the medical history questions were reasonably calculated to elicit the information omitted by Geisinger, the Court found

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12. *Id.*

13. *Id.*

14. Chawla v. Transamerica Occidental Ins. Co., No. 03-1215, 2005 U.S. Dist. LEXIS 3473, at *6 (E.D. Va. Feb. 3, 2005), *aff'd in part and vacated in part*, 440 F.3d 639 (4th Cir. 2006).

15. *Id.* at *6.

16. *Id.*

17. *Id.* at *20.

18. *Id.* at *15.

19. Although the case was filed in Virginia, Judge Hilton applied Maryland insurance law because, "'[u]nder Virginia law a contract is made when the last act to complete it is performed, and in the context of an insurance policy, the last act is delivery to the insured.'" *Id.* at *7 (quoting Seabulk Offshore Ltd. v. Am. Home Assurance Co., 377 F.3d 408, 418-19 (4th Cir. 2004)). Since payment of the first premium and delivery of the policy took place in Maryland, the contract was controlled by Maryland substantive law. *Id.* at *8.

20. Chawla v. Transamerica Occidental Ins. Co., No. 03-1215, 2005 U.S. Dist. LEXIS 3473, at *8 (E.D. Va. Feb. 3, 2005), *aff'd in part and vacated in part*, 440 F.3d 639 (4th Cir. 2006) (quoting Hofmann v. John Hancock Mutual Life. Ins. Co., 400 F. Supp. 827, 829 (D. Md. 1975).

21. *Id.* at *8-9.

that a misrepresentation had occurred.[22] Under the Maryland Insurance Code, such a misrepresentation may void the insurance policy and preclude payment of benefits if the misrepresentation is "fraudulent or material to the acceptance of the risk or to the hazard that the insurer assumes" or if the provision of complete and proper information would have caused the insurer to refuse to issue the policy, either in whole, or at the same amount or premium rates.[23] Based on the evidence submitted, the court held that either prong would prevent Chawla's recovery of the policy proceeds. It was clear that Geisinger's prior medical history would increase his risk of mortality (thereby increasing Transamerica's risk) and would have prevented the issuance of the policy for failure to meet underwriting guidelines.[24]

As discussed in depth *infra*, the district court also held that "even absent a material misrepresentation, Plaintiff's [Chawla's] claim necessarily fails as a matter of law because the Trust maintained no insurable interest in the life of the decedent thus rendering the policy void."[25] Commentators have noted that, given such a strong rationale applying clearly established law, it was surprising that the Court proceeded to uphold the rescission of the policy and denial of payment of the proceeds on the ground that the Trust lacked an insurable interest in Geisinger's life.[26]

II. THE INSURABLE INTEREST REQUIREMENT

A. ORIGINS AND PURPOSE

The general requirement that a beneficiary of an insurance policy have an insurable interest in that insured "has its origins in the common practice

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22. *Id.* at *9.

23. MD. CODE ANN., INS. § 12-207(b) (LexisNexis 2003).

24. *Chawla*, 2005 U.S. Dist. LEXIS 3473, at *11.

25. *Id.* at *15.

26. *See, e.g.*, Robert E. Madden et al., *Trust Has No Insurable Interest in Insured*, 32 EST. PLAN. 43, 46 (2005); Gearhart, *supra* note 1, at 7. A complete reading of the appellate briefs indicates that the offering of an alternate holding may not be that surprising, as there appears to be conflicting evidence as to whether Transamerica knew, or should have known, about the medical facts that the Court found to be material misrepresentations. Brief of Appellant, *supra* note 6, at *30; Brief of Appellee at *37, Chawla v. Transamerica Occidental Life Ins. Co., 440 F.3d 639 (4th Cir. 2006) (No. 05-1160), 2005 WL 2044759; Appellant's Reply Brief at *12-13, Chawla v. Transamerica Occidental Life Ins. Co., 440 F.3d 639 (4th Cir. 2006) (No. 05-1160), 2005 WL 2240232.

of eighteenth century English marine insurers of not requiring the insured to demonstrate either ownership in or some other legal relationship to the ship or cargo being underwritten."[27] The lack of interest in the insured permitted wagering as to whether the ships would complete their voyages, and indeed, even provided an incentive to disrupt the voyages, thereby promoting fraud.[28]

The requirement was imported into life insurance policies shortly thereafter, as the practice of placing wagers on the lives of those being tried for capital crimes became widespread.[29] While the financial windfall to be gained upon the insured's death may have acted to induce beneficiaries to bring the insured's life to a premature end, it was not this concern, but rather the actual act of gambling and wagering, that Parliament sought to end when it enacted an insurable interest statute for life insurance policies in 1774.[30]

The insurable interest requirement in life insurance in America, like much of American jurisprudence, is a carryover from the English.[31] Although first adopted by the state courts,[32] many state legislatures later enacted insurable interest statutes[33] like those in England. Regardless of its origin, the often broad language that is used has left significant room for judicial interpretation.[34]

While the proscription of gambling may have been the original intent behind requiring an insurable interest, today that is generally no longer the case. Although insurance is viewed as an economically valuable tool to protect against fortuitous losses, and therefore shouldn't be used to facilitate the simple transfer of wealth achieved by gambling, the

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27. ROBERT H. JERRY, II, UNDERSTANDING INSURANCE LAW 291 (3d ed. 2002).

28. *Id.*

29. *Id.* at 292. Another recognized gaming practice was to procure insurance on famous old people, with the premiums being a function of the person's known health at the time. *Id.*

30. *Id.*

31. *See* Conn. Mut. Life Ins. Co. v. Schaefer, 94 U.S. 457, 460 (1876) ("In this country, statutes to the same effect have been passed in some of the States; but where they have not been, in most cases either the English statutes have been considered as operative, or the older common law has been followed.").

32. *See, e.g.*, Home Life Ins. Co. of N.Y. v. Masterson, 21 S.W.2d 414, 416 (Ark. 1929); Colgrove v. Lowe, 175 N.E. 569, 571 (Ill. 1931); Washington v. Atlanta Life Ins. Co., 136 S.W.2d 493, 494 (Tenn. 1940).

33. *See, e.g.*, GA. CODE ANN. § 33-24-3 (2005); LA. REV. STAT. ANN. § 22:613 (2004); OKLA. STAT. ANN. tit. 36, § 3604 (1999 & Supp. 2006).

34. Edwin A. Patterson, *Insurable Interest in Life*, 18 COLUM. L. REV. 381, 381-82 (1918).

requirement has remained primarily as a means of mitigating the moral hazard that those lacking an interest might be tempted to destroy that which is insured.[35]

B. WHAT CONSTITUTES AN INSURABLE INTEREST?

Generally speaking, only the owner of a life insurance policy is required to have an insurable interest in the life insured.[36] Accordingly, the analysis of what constitutes a legally sufficient insurable interest often depends on whether the policy is owned by the insured and insures his own life, or whether the policy was procured by a third-party on the life of another.

It is generally accepted that a person has an unlimited insurable interest in their own life.[37] "Thus, legally, there is no limit to the amount of life [in]surance . . . that one can effect on one's own life."[38] In reality though, the amount is limited based on the insured's ability to pay the premium,[39] and on the amount the insurance company "is willing to issue because it is impossible to assess the value of life in economic terms."[40] Furthermore, such self-insurance does not generally increase the moral hazard associated with insuring a human life. Since the policy owner may designate whomever he so chooses as a beneficiary,[41] it is assumed that the owner

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35. JERRY, *supra* note 27, at 294.

36. *See, e.g.*, Crotty v. Union Mut. Life Ins. Co., 144 U.S. 621, 623 (1892) ("It is the settled law of this court that a claimant under a life insurance policy must have an insurable interest in the life of the insured. Wagering contracts in insurance have been repeatedly denounced."). *See also* JERRY, *supra* note 27, at 296. *But see* Stillwagoner v. Travelers Ins. Co., 979 S.W.2d 354, 358 (Tex. App. 1998) (reaffirming that under Texas law, the beneficiary of an insurance policy owned by the insured must also have an insurable interest in order to collect the proceeds).

37. *See, e.g.*, Bohannon v. Manhattan Life Ins. Co., 555 F.2d 1205, 1209 (5th Cir. 1977) ("An individual has an unlimited insurable interest in his own life and may name whomever he pleases as beneficiary regardless of whether the beneficiary has an insurable interest."); Mut. Sav. Life Ins. Co. v. Noah, 282 So. 2d 271, 273 (Ala. 1973) (stating that an individual has an unlimited insurable interest in his own life); Pittsburgh Underwriters v. Mut. Life Ins. Co. of N.Y., 27 A.2d 278, 280 (Pa. Super. Ct. 1942) ("'It is elementary that everyone has an unlimited insurable interest in his own life.'") (citation omitted).

38. D.S. HANSELL, INTRODUCTION TO INSURANCE 166 (2d ed. 1999).

39. *Id.*

40. ROBERT E. KEETON & ALAN J. WIDISS, INSURANCE LAW 180 (1988).

41. Absent a statutory requirement otherwise, the policy owner generally is free to name whomever as the beneficiary. Because of the insured's presumed self-interest, the beneficiary need not have an insurable interest in order to recover. *See, e.g.*, Bohannon v. Manhattan Life Ins. Co., 555 F.2d 1205, 1209 (5th Cir. 1977) ("An individual . . . may name

will not name as his beneficiary someone likely to murder him in order to reap the proceeds.[42]

Because one is presumed to have an insurable interest in one's own life, a common means of avoiding the insurable interest rule in trust arrangements is to have the insured purchase a policy on oneself and later transfer it to a trust. The requirement is therefore met, because, at the time of the policy's acquisition—generally the only time that the requirement is tested—the owner was the insured himself. Of course such a benefit is not without its price, as this transfer becomes subject to the within-three-years-of-death rule of the Internal Revenue Code[43] and thus has the potential to

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whomever he pleases as beneficiary regardless of whether the beneficiary has an insurable interest."); Nat'l Life & Accident Ins. Co. of Nashville, Tenn. v. Alexander, 147 So. 173, 174 (Ala. 1933) ("[A] person has an unlimited insurable interest in his own life, and that such person may take out a policy of insurance on his own life payable to whom he desires; that what is termed an 'insurable interest' is not necessary to the validity of such an issue procured by the assured.").

However, where a third-party who is named as the beneficiary encourages the policy owner to procure coverage on himself and subsequently pays the premiums, a court may void the policy if the beneficiary does not also have an insurable interest in the life of the insured. In such cases, the court is likely to view the policy as a simple wager, and thus, against public policy. *See, e.g.*, New England Mut. Life Ins. Co. v. Null, 605 F.2d 421 (8th Cir. 1979); Commercial Travelers' Ins. Co. v. Carlson, 137 P.2d 656 (Utah 1943).

42. JERRY, *supra* note 27, at 311.

43. As a condition to fully removing the incidents of ownership and thereby allowing the proceeds to be excluded from consideration as part of the decedent's estate, the three-year rule requires that the insured remain alive for three years following the transfer to the trust,. *See* Jonathan G. Blattmachr & Michael L. Graham, *No Fear,* Chawla *and the ILIT: Past, Present and Future*, INTERACTIVE LEGAL SYSTEMS E-NEWSLETTER, May 2005, http://www.mylegalnews.com/ilsdocs/Archives/05_2005_A1_.htm. The rule is found in I.R.C. § 2035 (2000), which, in relevant part, provides that:

> (a) Inclusion of certain property in gross estate. If--
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> (1) the decedent made a transfer (by trust or otherwise) of an interest in any property, or relinquished a power with respect to any property, during the 3-year period ending on the date of the decedent's death, and
>
> (2) the value of such property (or an interest therein) would have been included in the decedent's gross estate under section 2036, 2037, 2038, or 2042 if such transferred interest or relinquished power had been retained by the decedent on the date of his death, the value of the gross estate shall include the value of any property (or interest therein) which would have been so included.

Under section 2042, insurance proceeds receivable by the deceased's estate and those receivable by all other beneficiaries on policies in which the deceased retained any incidents of ownership, are subject to inclusion in the value of the gross estate. *See* I.R.C. § 2042 (2000).

eliminate the estate and tax savings usually associated with life insurance trusts.[44]

Although the application of the requirement to insurance on oneself is relatively well-settled and not often disputed, there still exists a significant amount of diversity as to exactly what relationships and interests will constitute a valid insurable interest for third-parties who procure insurance on the life of another.[45] This is unfortunate, as it is in exactly such situations that there exists an increased risk that the very problems the requirement seeks to cure will actually occur.[46]

Broadly speaking, recognized insurable interests may be divided into two categories: one based on a close, familial relationship and the other based on an economic interest.[47] While it is challenging to identify precisely what will constitute an insurable interest sufficient to remove the contract from the realm of wager policies, Justice Field eloquently articulated the conditions giving rise to the interest in his oft-quoted passage from *Warnock v. Davis*:[48]

> It may be stated generally, however, to be such an interest, arising from the relations of the party obtaining the insurance, either as creditor of or surety for the assured, or from the ties of blood or marriage to him, as will justify a reasonable expectation of advantage or benefit from the continuance of his life. It is not necessary that the expectation of advantage or benefit should be always capable of pecuniary estimation; for a parent has an insurable interest in the life of his child, and a child in the life of his parent, a husband in the life of his wife, and a wife in the life of her husband. The natural affection in cases of this kind is considered as more powerful -- as operating more efficaciously -- to protect the life of the insured than any other consideration. But in all cases there must be a

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44. *See generally* Jennifer Jordon McCall & Tamara M. Fagin, *Estate Planning with Life Insurance, 35th Annual Estate Planning Institute* (PLI Est. Plan. & Admin., Tax Law & Estate Planning Course Handbook Series No. 2902, 2004), *available at* 330 PLI/Est 215 (Westlaw) (discussing the benefits of and the rules governing the inclusion of life insurance proceeds in one's estate).

45. Peter N. Swisher, *The Insurable Interest Requirement for Life Insurance: A Critical Reassessment*, 53 DRAKE L. REV. 477, 479-80 (2005).

46. JERRY, *supra* note 27, at 312.

47. *Id.* at 311.

48. 104 U.S. 775 (1881).

> reasonable ground, founded upon the relations of the parties to each other, either pecuniary or of blood or affinity, to expect some benefit or advantage from the continuance of the life of the assured. Otherwise the contract is a mere wager, by which the party taking the policy is directly interested in the early death of the assured.[49]

Premised on the belief that the love and affinity amongst family members will sufficiently counterbalance any incentive to bring about the insured's untimely death, a blood or close personal relationship between the insured and the owner may give rise to an insurable interest.[50] While the existence of the interest based *solely upon love and affinity* is the rule only in a minority of jurisdictions,[51] courts often find an attendant economic interest in such relationships as well,[52] because, as a practical matter, close family members often provide each other with a significant amount of economic support. Indeed, the expected loss of income and resultant harm to one's family is often what prompts an insured to take out a personal life insurance policy in the first place.[53]

The closer the family relationship between the policy owner and the insured, the more likely a court will be to find an insurable interest. Accordingly, courts have found insurable interests to exist among members of nuclear families: between spouses,[54] siblings,[55] and parents and their

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49. *Id.* at 779.

50. Swisher, *supra* note 45, at 498-99.

51. *Id.*

52. *See, e.g.*, Warnock v. Davis, 104 U.S. 775, 779 (1882) (recognizing that the "expectation of advantage or benefit from the continuance of [life of the insured]" goes beyond mere familial ties); Chicago Guar. Fund Life Soc. v. Dyon, 79 Ill. App. 100, 104 (Ill. App. Ct. 1898) (father-son relationship does not give rise to an insurable interest absent the son's pecuniary interest in the continued life of his father); Prudential Ins. Co. of Am. v. Hunn, 52 N.E. 772, 773 (Ind. App. 1899) (the existence of an insurable interest must be based on more than just close familial ties and must demonstrate an expected economic gain); Ryan v. Metro Life Ins. Co., 93 S.W. 347, 348 (Mo. Ct. App. 1906) (relationship between cousins was insufficient to give rise to an insurable interest absent an economic interest).

53. *See* Cent. Bank of Washington v. Hume, 128 U.S. 195, 204 (1888)("A person has an insurable interest in his own life for the benefit of his estate. The contract affords no compensation to him, but to his representatives.").

54. *See, e.g.*, Jenkins v. Lovelady, 273 So. 2d 189, 195 (Ala. 1973); Shaw v. Bd. of Admin., 241 P.2d 635, 637 (Cal. Dist. Ct. App. 1952).

55. *See, e.g.*, Mut. Sav. Life Ins. Co. v. Noah, 282 So. 2d 271 (Ala. 1973); Penn v. Lighthouse Life Ins. Co., 392 So.2d 181 (La. Ct. App. 1980).

adult children.[56] While many other relationships have yet to be examined by the courts, some courts have declined to find an interest on the basis of more remote relationships such as aunt or uncle to niece or nephew,[57] and presumably would do the same for in-law relationships.[58] Where the family relationship is weak, an insurable interest may nonetheless still be found where there is an attendant economic interest in the relationship; logically, the weaker the family ties, the stronger the economic interest must be.[59]

Of perhaps greater importance, especially insofar as it affects estate planning, is what constitutes an economic interest sufficient to justify the acquisition of a life insurance policy by a third-party on the life of another. While a few states address this issue in detail by statute,[60] the majority of states do not, and thus it has been left up to the judiciary to do so on a case-by-case basis. Traditionally though, a person will meet this requirement if they have a "lawful and substantial economic interest in the continued life, health or bodily safety of the person insured, as distinguished from an interest which would arise only by, or would be enhanced in value by, the death, disablement or injury of the insured."[61] In *Drane v. Jefferson Standard Life Insurance Co.*,[62] the court described the required economic interest as one

> determined by monetary considerations, viewed from the standpoint of the beneficiary. Would he regard himself as better off from the standpoint of money, would he enjoy more substantial economic returns should the insured

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56. *See, e.g.*, Golden State Mut. Life Ins. Co. v. White, 374 S.W.2d 905 (Civ. App. Tex. 1964).

57. *See, e.g.*, Peoples First Nat'l Bank & Trust Co. v. Christ, 65 A.2d 393 (Pa. 1949).

58. JERRY, *supra* note 27, at 312-13 (noting the lack of law on in-law relationships, but suggesting that the existence of an insurable interest, absent a pecuniary benefit, is unlikely).

59. *Id.* at 313. For example, in *Willingham v. United Insurance Co. of America*, 628 So. 2d 328, 330-31 (Ala. 1993), the Supreme Court of Alabama held that foster parents did not have an insurable interest in their foster children under the Alabama Code, and because the state actually provided payment to the foster parents for the placements, the parents also lacked a pecuniary interest that would have overcome the weak family ties.

60. *See, e.g.*, ALA. CODE § 27-14-3 (2005) (specifying the insurable interests of corporations and charitable institutions, as well as the general insurable interest requirement for personal insurance); N.Y. INS. LAW § 3205 (McKinney 2005) (statutorily providing an insurable interest in a variety of relationships).

61. N.Y. INS. LAW § 3205(a)(1)(B) (McKinney 2005).

62. 161 S.W.2d 1057 (Tex. Comm'n App. 1942).

> continue to live; or would he have more, in the form of the proceeds of the policy, should [the insured] die?[63]

In jurisdictions lacking an insurable interest statute (or having a general, broad one), the courts have applied this logic to generally find an insurable interest between business partners,[64] a company and its key employees,[65] and a creditor and debtor.[66] Common to all these types of relationships is the existence of a legally recognized obligation between the parties. Thus, even in situations where one party has a substantial interest in the continued well-being of the other, and may very well be harmed by the other's death, a court may not find an insurable interest if the basis of that interest is not a legally enforceable obligation. In states with detailed insurable interest statutes, these interests are usually explicitly identified.[67] While generally codifying the insurable interests that were recognized at common law, they often go further and grant an insurable interest to specific entities such as charities [68] and trusts.[69]

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63. *Id.* at 1059. It is worth noting that this language is, almost word-for-word, the language the district court used to find that the Trust in *Chawla* lacked an insurable interest.

64. *See, e.g.*, Herman v. Provident Mut. Life Ins. Co. of Philadelphia, 886 F.2d 529 (2d Cir. 1989) (noting that an insurable interest of a law firm and its partners in the continued life of one of its principal partners that was valid at inception was not automatically extinguished upon the dissolution of the firm); Graves v. Norred, 510 So. 2d 816, 818 (Ala. 1987) (insurable interest of partners in each other's lives is not founded solely upon the existence of the partnership *per se*, but rather the continued benefit each would receive from the other's continued life); Ridley v. VanderBoegh, 511 P.2d 273, 280 (Idaho 1973) (partner has insurable interest in the life of another of his partners).

65. An employer-employee relationship will not automatically establish an insurable interest. In accordance with the general principle, the employer must expect to gain some continued benefit from the employee's continued health and welfare. Courts have interpreted this as creating an insurable interest only between a company and its key employees such as officers, high-level managers, and directors—all figures whose performance is necessary to the successful operation of the company and whose death would likely negatively impact the company. *See* J.T.W., Annotation, *Insurable Interest of Employer in Life of Employee*, 125 A.L.R. 408 (1940) (collecting cases addressing the contexts in which a valid insurable interest arises).

66. *See, e.g.*, Am. Cas. Co. v. Rose, 340 F.2d 469 (10th Cir. 1964); Rubenstein v. Mut. Life Ins. Co. of N.Y., 584 F. Supp. 272 (E.D. La. 1984); Theatre Guild Prods., Inc. v. Ins. Corp. of Ir., 25 A.D.2d 109 (N.Y. App. Div 1966), *aff'd*, 225 N.E.2d 216 (N.Y. 1967).

67. Which of course begs the question that, if a particular interest was not set forth in the statute, should that omission be interpreted as the legislature's purposeful refusal to recognize such an interest?

68. *See, e.g.*, ARIZ. REV. STAT. ANN. § 20-1104(c)(4) (2005); MISS. CODE ANN. § 83-5-251(3)(e) (2005); N.Y. INS. LAW § 3205(b)(3) (McKinney 2006).

69. *See, e.g.*, DEL. CODE ANN. tit. 18, § 2704(c)(5) (2004).

C. WHEN MUST THE INSURABLE INTEREST EXIST?

In contrast to the analogous requirement in property insurance, "[i]n life insurance, it is commonly said that the insurable interest must exist at the time the contract is made, and the lack of the interest at the time of the insured's death is irrelevant."[70] This timing requirement originates in the purpose of the insurable interest requirement itself, discussed *supra* in Part II.A. Since the requirement was initially promulgated as a deterrent to wagering and a disincentive to murdering the insured, it was important that the interest exist at the time the contract was made. For if the owner (who is generally the beneficiary in policies taken out on the life of someone other than the owner) has an insurable interest at contract formation, there is a lessened chance that the policy was procured as part of a wager or murder scheme.[71] Many commentators and legal experts, however, have assailed this viewpoint as unsupportable and based on "a number of dubious assumptions and largely unquestioned legal precedent."[72] Nonetheless, it is still the majority rule today.[73]

D. DENYING THE EXISTENCE OF AN INSURABLE INTEREST

The majority of courts considering the availability of a waiver or estoppel defense have held that the insurable interest requirement cannot be waived, nor may an insurer be estopped from asserting it.[74] As one of the issues raised in *Chawla*, the court relied upon the Maryland Court of Appeal's holding in *Beard v. American Agency Life Insurance Co.*,[75] in stating that it is "clear that the public interest, as protected by the insurable interest doctrine, is 'of paramount importance and overrides the equitable

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70. JERRY, *supra* note 27, at 317.

71. *Id.* at 317-18. *But see* Swisher, *supra* note 45, at 524 (highlighting the fact that such an outcome is a very real possibility, even in the context of policies taken out by the insured himself).

72. Swisher, *supra* note 45, at 524.

73. *Id.* at 524-26. Swisher's article provides a complete discussion of the fallacies of such a rule and the argument for requiring the existence of an insurable interest at both the time of contract formation and redemption.

74. *See, e.g.*, Beard v. Am. Agency Life Ins. Co., 550 A.2d 677 (Md. 1988); Hack v. Metz, 176 S.E. 314 (S.C. 1934); Bell v. Nat'l Life & Accident Ins. Co., 123 So.2d 598 (Ala. Ct. App. 1960). *See generally* Phoebe Carter, Annotation, *Estoppel of, or Waiver By, Issuer of Life Insurance Policy to Assert Defense of Lack of Insurable Interest*, 86 A.L.R.4TH 828 (1991).

75. 550 A.2d 677 (Md. 1988).

doctrines of waiver and estoppel.'"[76] The *Beard* court itself explained the rationale for this holding as follows:

> 'Waiver' is the voluntary, intentional relinquishment of a known right. Such a waiver may result either from affirmative acts of the insurer or its authorized representatives, or its nonaction with knowledge of the facts . . .
>
> 'Estoppel', on the other hand refers to an abatement raised by law of rights and privileges of the insurer where it would be inequitable to permit their assertion. It necessarily implies prejudicial reliance of the insured upon some act, conduct or nonaction of the insurer.
>
> Generally, waiver applies in cases where particular terms, conditions, limitations, or other provisions of the insurance contract are at issue. . . . In contrast, estoppel is an equitable doctrine which is applied when the insurer is accused of fraud or misrepresentation. . . . As these definitions indicate, when either waiver or estoppel is applied, the courts proceed on the theory that there is a presumptively valid contract between the parties which is objectionable due to some defect in the bargaining process or in the contract itself. With respect to the defense of insurable interest, however, waiver and estoppel do not apply because there is no presumptively valid contract upon which these two doctrines can operate as an insurance contract, without an insurable interest, is against public policy and void ab initio.[77]

Thus, to allow its application on a case-by-case basis, would completely undermine this important public policy concern.

One exception often recognized by the courts, however, is in cases where the insurer's agent wrote the policy despite knowing that the owner

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76. Chawla v. Transamerica Occidental Ins. Co., No. 03-1215, 2005 U.S. Dist. LEXIS 3473, at *20 (E.D. Va. Feb. 3, 2005), *aff'd in part and vacated in part*, 440 F.3d 639 (4th Cir. 2006) (quoting *Beard*, 550 A.2d at 688).

77. *Beard*, 550 A.2d at 688.

lacked an insurable interest.[78] Under such circumstances, issuance of the policy and the acceptance of premiums act as a waiver of the insurer's claim to the lack of an insurable interest.[79]

III. THE INSURABLE INTEREST STATUTE AT ISSUE IN *CHAWLA*

In *Chawla* the court found that the insurance contract was subject to Maryland's codified insurance law. Thus, it based its alternative holding on its interpretation of Section 12-201 of the Maryland Insurance Code.[80] In relevant part, the Code provides that

> (a) (1) An individual of competent legal capacity may procure or effect an insurance contract on the individual's own life or body for the benefit of any person.
>
> (2) Except as provided in subsection (c) of this section,[81] a person may not procure or cause to be procured an insurance contract on the life or body of another individual unless the benefits under the insurance contract are payable to:
>
> (i) the individual insured;
> (ii) the individual insured's personal representative; or
> (iii) a person with an insurable interest in the individual insured at the time the insurance contract was made.[82]

Although Geisinger initiated the acquisition of the policy, the district court found that it was ultimately procured and owned by the Trust. Under

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78. *See, e.g.*, McGehee v. Farmers Ins. Co., 734 F.2d 1422 (10th Cir. 1984); Nat'l Sec. Fire & Cas. Co. v. Hester, 298 So. 2d 236 (Ala. 1974). *But see* Vance v. Wiley T. Booth, 436 S.E.2d 256 (N.C. Ct. App. 1993).

79. Rep. Ins. Co. v. Silverton Elevators, 493 S.W.2d 748, 750 (Tex. 1973).

80. *See also* Beard v. Am. Agency Life Ins. Co., 550 A.2d 677 (Md. 1988).

81. Subsection (c) "applies only to a charitable, benevolent, educational, governmental, or religious institution that is described in § 170(b)(1)(A) or § 501(c)(3) of the Internal Revenue Code, or a trust for the benefit of that institution that is qualified as a pooled income fund under § 642(c)(5) or a charitable remainder trust under § 664 of the Internal Revenue Code." MD. CODE ANN., INS. § 12-201(c) (LexisNexis 2003). It does not address the type of trust at issue in *Chawla*.

82. MD. CODE ANN., INS. § 12-201 (LexisNexis 2003).

Maryland law a trust is deemed a "person" and not an "individual" for the purposes of construing the statute.[83] Accordingly, the district court held that the second part of the statute applied and its requirements needed to be met.[84] As the Trust was the named beneficiary, the first two categories clearly did not apply, and thus, the Trust was required to demonstrate that it had an insurable interest in Geisinger's life at the time it procured the policy.[85] After undertaking an insurable interest analysis, the Court found that the Trust had lacked an insurable interest in Geisinger's life at the time it acquired the policy.[86]

A separate provision of section 12-201 provides that only the interests specified therein will be recognized in Maryland for the purposes of personal life insurance. That provision explains:

> (b)(2)(i) For individuals related closely by blood or law, a substantial interest engendered by love and affection is an insurable interest. . .
>
> (3) For persons other than individuals closely related by blood or law, a lawful and substantial economic interest in the continuation of the life, health, or bodily safety of the individual is an insurable interest, but an interest that arises only by, or would be enhanced in value by, the death, disablement, or injury of the individual is not an insurable interest.[87]

Prior to purchasing the insurance policy, the Trust's primary asset was Geisinger's home. During his lifetime he was entitled to receive all income from the Trust and to occupy the residence. However, upon his death, the home and all remaining assets were to be distributed to Chawla, as the Trust beneficiary, so that they may be sold for an amount greater than the mortgage. Thus, the Court found that the Trust did not have an insurable

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83. *Id.* § 1-101(dd) ("'Person' means an individual, receiver, trustee, guardian, personal representative, fiduciary, representative of any kind, partnership, firm, association, corporation, or other entity.").

84. Chawla v. Transamerica Occidental Ins. Co., No. 03-1215, 2005 U.S. Dist. LEXIS 3473, at *16-17 (E.D. Va. Feb. 3, 2005), *aff'd in part and vacated in part*, 440 F.3d 639 (4th Cir. 2006).

85. *Id.* at *17.

86. *Id.* at *19-20.

87. MD. CODE ANN., INS. §§ 12-201(b)(2)(i), 12-201(b)(3) (West 2004).

interest in Geisinger's life, as it was likely "to gain more assets upon the decedents's [Geisinger's] death," and because it "suffered no detriment, pecuniary or otherwise, upon the death of the decedent."[88] Although the result would likely have been the same,[89] it is important to realize that the district court undertook its analysis viewing the Trust as a separate entity, rather than as a collection of the beneficiaries for whom it was set up.

IV. THE ARGUMENTS ON APPEAL

The case is currently on appeal to the Fourth Circuit and is scheduled for oral arguments in January 2006. While the appellant, Chawla, raises numerous issues, those with the most resonance in the legal community are those pertaining to the insurable interest holding,[90] as "[t]he estate planning community and life insurance industry have assumed since the advent of life insurance trusts that a trust formed by, and acting at the direction and with the consent of the insured, would also have an insurable interest in the life of the insured."[91] Given the importance the appeal decision may have, this section will consider the parties' arguments on the major points raised in their appellate briefs and discuss how each should be resolved by the circuit court.[92]

Chawla's primary contention on appeal is that the court was wrong to hold that "an irrevocable trust does not have an insurable interest in the life

88. *Chawla*, 2005 U.S. Dist. LEXIS 3473, at *18. The court also engaged in a brief analysis of whether the Trust arrangement amounted to a limited business setting in which the Code also recognizes an insurable interest. *See* MD. CODE ANN., INS. § 12-201(b)(5)(i) (West 2004). Relying on the Maryland Court of Appeals's definition of a "firm" in *Beard v. Am. Agency Life Insurance Co.*, 550 A.2d 677, 684 (Md. 1988), the court held that it did not. *Chawla*, 2005 U.S. Dist. LEXIS 3473, at *19.

89. The district court did not engage in an analysis of Chawla's personal interest in Geisinger's life, but it is clear from the general discussion that, as an individual, Chawla would not have an insurable interest because she was neither a close family member, nor joined with Geisinger in any business venture sufficient to create the required pecuniary interest.

90. *See generally* Gearhart, *supra* note 1; Robert E. Madden et al., *Trust Has No Insurable Interest in Insured*, 32 EST. PLAN. 44, 46 (2005).

91. Gearhart, *supra* note 1, at 6.

92. One issue that will not be addressed is the validity of the district court's finding that the Trust Agreement did not allow for the purchase of life insurance on the grantor. Although it made the finding, it did not appear to factor into the Court's reasoning. Furthermore, whether or not it was within the Trust's power to actually acquire the policy is immaterial to the central issue of the existence of an insurable interest.

of its grantor."[93] Chawla first argues that, contrary to the district court's holding, the insurable interest requirement should be governed by section 12-201(a)(1) of the Maryland insurance code, as Geisinger himself procured the insurance on his own life.[94] In essence, Chawla proposes that there is no distinction between Geisinger acting on his own behalf and in his capacity as trustee. In so doing, Chawla argues that Geisinger would be an individual for the purposes of the statute, and that it would therefore be unnecessary for the beneficiary of the policy to have an insurable interest, regardless of who the beneficiary was or how the Trust was construed.[95] Transamerica responds that such a reading is impermissible, as the statute recognizes a difference between an "individual" and a "person," the definition of the later including a trustee.[96]

Chawla's argument offers a strained reading of the statute. Under it, the analysis is conducted by asking what physical being applied for and obtained the insurance policy; the legal capacity in which that person acts is immaterial. Such an approach, however, misconstrues the statute. Although the Maryland insurance code does not define "individual," the fact that it does define a "person" so as to specifically include a trustee indicates two things: (1) that the analysis is based on legal capacity and not mere physical being; and (2) that a trustee is not an individual within the meaning of the statute. Logically, actions undertaken in a trustee capacity are not the actions of an individual, and thus are not governed by section 12-201(a)(1). So while it may be "undisputed that Geisinger in the words of § (a)(1) 'procure[d] or effect[ed] insurance on his own life,'"[97] he only did so in his capacity as a trustee for the Trust[98] which was the named owner and for whose benefit it was obtained. Legally it is the Trust who actually obtained the life insurance policy on Geisinger and designated itself as the beneficiary. That Geisinger was acting as the Trust's agent in doing so does not mean that the procurer and the insured are legally one and the same. Accordingly, the acquisition of the policy is not governed by section 12-201(a)(1) and therefore there must exist an insurable interest pursuant to section 12-201(a)(2).

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93. Brief of Appellant, *supra* note 6, at *50.

94. *Id.* at *51-52.

95. *Id.* at *52-53.

96. Brief of Appellee, *supra* note 26, at *53-54.

97. Brief of Appellant, *supra* note 6, at *51.

98. Chawla even concedes this point in her brief: "it is an undisputed fact that Geisinger signed Transamerica's VTA and the application as both the insured and as Trustee of the Trust." *Id.* at *52.

In the alternative, Chawla argues that the Trust does have an insurable interest in Geisinger's life. Specifically, the Trust has an insurable interest under section 12-201(b)(3) because it "had a lawful and substantial economic interest in Geisinger's continued life because it had a life estate interest in his life."[99] Thus, the fortune of the Trust is therefore directly tied to Geisinger's life, as the "Trust only held the Trust property so long as Mr. Geisinger remained alive and its interest ended automatically upon Mr. Geisinger's death."[100]

Transamerica counters that, because the benefits of the policy were payable to the Trust, which by its terms passed them directly on to Chawla, the Trust could not have validly obtained the policy pursuant to section 12-201(2)(a).[101] Furthermore, Chawla lacked an insurable interest under any of the statutorily proscribed classes that could give rise to an insurable interest pursuant to section 12-201(2)(a)(iii). She was not related closely by blood or law; did not maintain a substantial economic interest in Geisinger's life that did not arise from his death; nor was she involved in a business arrangement recognized by statute.[102]

Underlying both parties' arguments is the important question of who should properly be viewed as the beneficiary of the policy—the Trust itself, or Chawla, as the beneficiary of the Trust? Without explaining why, the district court assumed that the Trust should be viewed and analyzed as an entity of its own.[103] That assumption, however, does not withstand critical reflection. While never directly addressed in either party's brief,[104] the amici brief argues persuasively that the analysis should be conducted as to the beneficiaries of the trust, as they are the ones with equitable title to the Trust assets and are the people to whom the Trust owes its fiduciary

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99. *Id.* at *56. While the point is well taken, the characterization of the Trust as having a life estate in Geisinger's life is incorrect as a matter of law. As Transamerica notes in its brief, "it was actually the decedent who had retained such an interest...after he transferred the remainder interest to Chawla under the terms of the Trust." Brief of Appellee, *supra* note 26, at *57, n.28.

100. Brief of Appellant, *supra* note 6, at *57.

101. Brief of Appellee, *supra* note 26, at *54-55.

102. *Id.* at *56-58.

103. Chawla v. Transamerica Occidental Ins. Co., No. 03-1215, 2005 U.S. Dist. LEXIS 3473, at *16-17 (E.D. Va. Feb. 3, 2005), *aff'd in part and vacated in part*, 440 F.3d 639 (4th Cir. 2006).

104. The appellant's brief assumes that it is the Trust's interests that should properly be examined. The appellee's brief extensively discusses the "pass-through" nature of the trust arrangement and how it is Chawla who ultimately benefits from the Trust, but never specifically argues that is the Trust beneficiary's interest that should be examined.

responsibility.[105] To hold otherwise would be illogical and run counter to common principles of statutory construction,[106] especially when one considers that the little case law on the subject reveals that when courts "have analyzed how a particular statute, such as the Bankruptcy Code, has applied to a trust, courts have found trusts to be a collection of its beneficiaries and applied the statutes to the beneficiaries and not the trust itself."[107]

Furthermore, viewing the Trust as an entity of its own fails to recognize both the purpose of the Trust and the purpose of the insurable interest requirement in the first place. Proceeds of an insurance policy paid to a trust designated as the beneficiary inure to the benefit of the trust beneficiaries themselves.[108] There is no self-interest in the trust as an entity of its own; it is only concerned with acquiring and distributing assets to the extent that doing so is favorable to its beneficiaries. Given that the purpose of the insurable interest requirement is to prevent naked wagering and to decrease the moral hazard attendant to insuring a human life, the existence of a trust in and of itself almost presupposes an insurable interest, for in the majority of cases, the trust beneficiaries are family members or others with some important connection to the grantor. Thus it makes the most sense, both logically and legally, to apply statutory provisions to the beneficiaries of a trust and not the trust itself.

Nonetheless, on the facts of the case, the outcome is no different whether the Trust or Chawla is considered as the ultimate beneficiary. Clearly, section 12-201(b)(2)(i) does not give rise to a "love and affection" insurable interest. The provision only applies to an individual, thereby eliminating the Trust, and neither the Trust, nor Chawla is closely related to Geisinger by blood or law.[109] Nor do sections 12-201(b)(4) or 12-201(b)(5) apply, as the relationship between Geisinger and the Trust or Chawla is neither one of an employer and key employee, nor one of a business partnership or firm. As section 12-201(b)(3) would seem to provide the

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105. Brief for The League of Life and Health Insurers of Maryland et al. as Amicus Curiae Supporting Appellee, Chawla v. Transamerica Occidental Life Ins. Co., 440 F.3d 639 (4th Cir. 2006) (No. 05-1160), 2005 WL 2240233 [hereinafter Brief of Amici Curiae].

106. *See* Degren v. State, 722 A.2d 887, 895 (Md. 1999).

107. Mary Ann Mancini, *The* Chawla *Case, Insurance Trusts and the Insurable Interest Rule: "Houston, We Have a Problem,"* 31 AM. C. TR. & EST. COUNS. J. 125, 134 (2005).

108. Brief of Amici Curiae, *supra* note 105, at *16-17.

109. MD. CODE ANN., INS. § 12-201(b)(2)(i) (LexisNexis 2003) provides that "[f]or individuals related closely by blood or law, a substantial interest engendered by love and affection is an insurable interest."

only remaining possible way of establishing an insurable interest, either the Trust or Chawla must demonstrate a "lawful and substantial economic interest in the continuation of the life, health, or bodily safety" of the insured that does not arise, nor is enhanced by the death or injury of the insured.[110]

Concerning itself only with the analysis from the standpoint of the Trust as its own entity,[111] Chawla's application of case law supporting the proposition that "a beneficiary that holds property subject to a life estate in the insured establishes an insurable interest in the insured" is mistaken.[112] While it is true that the beneficiary only holds the property so long as the insured owner of the life estate is alive, in the cases cited by Chawla, the substantial economic interest arose from the fact that the beneficiary's estate would *involuntarily terminate* upon the insured's death, thereby creating a loss for the beneficiary - a loss that could be indemnified by receiving the proceeds of a life insurance policy on the owner of the life estate.[113] Such is not the case on the facts presented here. The Trust is unlike those beneficiaries because the trust arrangement itself does not create any loss against which the Trust need be indemnified; it is merely a vehicle for wealth transfer that is conditioned upon the death of the grantor, Geisinger. Accordingly, Chawla's argument on this point must necessarily fail. Furthermore, assuming *arguendo*, that the Trust is the proper focal point for the analysis, the district court's initial discussion of the benefits that would accrue to the Trust clearly demonstrates that it profits only upon the death of the insured. By its very terms, the Trust would suffer no loss

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110. *Id.* § 12-201(b)(3).

111. While Chawla never addresses from what vantage point the insurable interest should be analyzed, she approvingly mentions the amici's arguments in support of the trust beneficiary view in her reply brief. *See* Appellant's Reply Brief, *supra* note 26, at *27.

112. *See* Brief of Appellant, *supra* note 6, at *56.

113. Appellant cites to *Beard v. Am. Agency Life Ins. Co.*, 550 A.2d 677, 683 (Md. 1988), which discusses cases giving rise to an insurable interest based on the policy beneficiary's interest in the continued life of the insured as a means of protecting their existing investment or estate. For example, in *Sides v. Knickerbocker Life Ins. Co.*, 16 F. 650 (C.W.D. Tenn. 1883), the court held that a tenant farmer who leased property from an owner holding a life estate interest in it had an insurable interest in the life of the owner. Unlike in the current case, the tenant farmer lost his right to continue farming, and thus suffered substantial economic loss upon the death of the owner, as the owner's death terminated the owner's legal right to lease the land to another, i.e., the plaintiff farmer.

upon Geisinger's death; rather, it would gain an appreciable amount of assets in the form of the policy proceeds.[114]

Two separate interests must be considered when analyzing if the Trust's beneficiaries have an insurable interest: Geisinger's and Chawla's. The beneficiaries of the Trust are both Geisinger, and upon his death, Chawla. As a beneficiary in his own right, Geisinger clearly had an insurable interest in his own life.[115] This interest is insufficient to sustain a Trust beneficiary interest, however, because Geisinger was a Trust beneficiary only during his lifetime; "he could never benefit from the life insurance proceeds paid on his own life as he would then be dead."[116] Thus, whether the Trust has an insurable interest in the insured's life hinges on whether the Trust beneficiaries *who would benefit from the life insurance proceeds* have an insurable interest.[117]

Unfortunately, Chawla herself still fails to demonstrate that she possesses an insurable interest. In *Beard*, the court asked whether the beneficiary would be better off from a monetary standpoint if the insured died, than he would be if the insured continued to live.[118] Answering that question in the affirmative, the court declined to find an insurable interest predicated on a substantial economic interest.[119] Upon Geisinger's death, the Trust assets were distributed to the remainder Trust beneficiary, Chawla, who was to immediately sell them for an amount in excess of the mortgage on the residence it owned.[120] While the district court characterized this as a promised increase in assets for the Trust, even when properly viewed as a financial benefit for Chawla, the interest is not insurable under section 12-201(b)(3) because it is "an interest that arises only by . . . the death . . . of the individual [insured]."[121]

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114. Chawla v. Transamerica Occidental Ins. Co., No. 03-1215, 2005 U.S. Dist. LEXIS 3473, at *6 (E.D. Va. Feb. 3, 2005), *aff'd in part and vacated in part*, 440 F.3d 639 (4th Cir. 2006).

115. *See supra* note 37 and accompanying text.

116. Blattmachr & Graham, *supra* note 43.

117. *Id.* As discussed *infra*, some commentators and scholars believe that the effect of *Chawla* will be minimal, as it can easily be distinguished by and limited to its "unique" facts. That the insured is also the trust grantor, a co-trustee and a life beneficiary of the trust is clearly the most unique of them all.

118. Beard v. Am. Agency Life Ins. Co., 550 A.2d 677, 682 (Md. 1988).

119. *Id.* at 683.

120. Chawla v. Transamerica Occidental Ins. Co., No. 03-1215, 2005 U.S. Dist. LEXIS 3473, at *18 (E.D. Va. Feb. 3, 2005), *aff'd in part and vacated in part*, 440 F.3d 639 (4th Cir. 2006).

121. MD. CODE ANN., INS. § 12-201(b)(3) (LexisNexis 2003).

Lacking an insurable interest under any of the statutorily proscribed classes, the insurance contract is void and unenforceable as a matter of law,[122] and Transamerica was correct to rescind the policy and return the premiums paid. Accordingly, the district court's narrow holding that the Harald Geisinger Special Trust, through its trustee, Chawla, is precluded from recovering the proceeds of the life insurance policy on Geisinger should be affirmed.

V. THE IMPLICATIONS OF *CHAWLA*

What effect *Chawla* will ultimately have depends in large part on what the Fourth Circuit does on appeal. Given the likelihood of affirming or reversing on the material misrepresentation grounds, it is possible that the circuit court may not even decide the insurable interest requirement. But as the amici note in their brief, clarification of the district court's holding is necessary in order to quell disruption in the insurance marketplace and calm widespread concern as to the validity of life insurance policies issued to trusts.[123] The amici, three different insurance groups with substantial assets in Maryland,[124] suggest doing so by asking the court to rule that, in a life insurance trust, "when a trust is the designated beneficiary of a life insurance policy, insurable interest exists if the trust beneficiaries have an insurable interest in the life of the insured."[125]

According to the American Council of Life Insurers, about thirty states have insurable interest statutes similar to Maryland's.[126] Almost all states require that the purchaser of a policy on the life of another have an insurable interest in that person's life.[127] "Typically, trusts designed to hold life insurance policies benefit solely from the death of the insured and do not suffer any pecuniary or other detriment at the insured's death."[128]

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122. *See Beard*, 550 A.2d at 686.

123. Brief of Amici Curiae, *supra* note 105, at *5.

124. Amici parties and their current life insurance holdings in Maryland: Massachusetts Mutual Insurance Co. ($8.7 billion +); Barrer Life Insurance Co. ($7.8 billion +); and The League of Life and Health Insurers of Maryland (no reported volume of business). *Id.* at *1.

125. *Id.* at *5.

126. Jim Connolly, *Will Insurable Interest Case be Sea Change or Mere Ripple?* NAT'L UNDERWRITER LIFE & HEALTH-FIN. SERV., Apr. 11, 2005, at *7.

127. Jonathan M. Forster & Jennifer M. Smith, Chawla v. Transamerica *Occidental Life Insurance Company: The End of the ILIT?*, GREENBERG TRAURIG ALERT, Apr. 2005, at 2.

128. *Id.*

Thus, if the Fourth Circuit affirms the *Chawla* court's approach to analyzing insurance trusts, and it becomes generally adopted, most traditional insurance trusts would lack an insurable interest and potentially would be unable to recover on the policies in their portfolios.[129] According to one estate planning lawyer, such a result would call into question "the collectability of billions, or even trillions, of dollars of life insurance on the wealthiest Americans."[130] The more immediate problem though is the apparent reticence of some insurance agents and estate planners to recommend a life insurance trust in Maryland.[131] Fears over what doing so could mean if the Fourth Circuit sustains the holding has forced some practitioners to consider the professional wisdom (and liability) of writing an insurance trust in Maryland during this uncertain period.[132]

Although the concern has yet to have a direct impact on insurance sales, it has forced some insurers such as Banner Life to go out of its way to assure its policyholders that it would not try to invalidate a policy because a trust owned it.[133] Insurers, however, are suggesting a more narrow view of the case's holding. In fact, senior vice president and chief marketing officer for Transamerica, Bill Tate, even stated in an interview that

> [w]e believe that because this particular decision was based on facts so unique to this case, it does not call into question the insurable interest in policies owned by trusts. . . . Under this trust, this individual was the sole beneficiary of the life insurance benefits. In the context of this case, this individual had no insurable interest and the use of a trust in this way did not provide one. . . . Transamerica does not view this ruling as having any application to trusts generally, including those set up for estate planning purposes.[134]

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129. *Id.*

130. Albert B. Crenshaw, *A Matter of Trusts*, WASH. POST, Feb. 20, 2005, at F01 (quoting Frederick J. Tansil, an estate planning attorney in McLean, Va.).

131. Rick Miller, *Insurers Join Appeal of Ruling Questioning Life Insurance Trusts*, INVESTMENT NEWS, Aug. 29, 2005, at 3, *available at* 2005 WLNR 13859406.

132. *Id.*

133. *Id.* at 3. What this assurance is worth in practical terms is unknown. Even where an insurer may agree not to assert such a defense, because of the strong public policy behind requiring an insurable interest, it is possible that a court may, *sua sponte*, find one to be lacking and therefore declare the policy void.

134. Connolly, *supra* note 126, at *33.

It is those very factual differences, however, that may make reliance on a successful appeal questionable as to whether trusts have an insurable interest in an individual's life.[135]

A. SHORT TERM SOLUTIONS FOR POLICIES CURRENTLY LACKING AN INSURABLE INTEREST

If the *Chawla* holding is broadly applied, the most likely scenario is that many policies will be declared void as a matter of public policy, and the premiums returned.[136] As Mary Ann Mancini notes, it might still be possible to compel payment of the benefit under an estoppel theory if the applicable state law does not prohibit it.[137]

> [N]otwithstanding the lack of insurable interest, there is a contract between the individual or entity who has paid the premiums and the insurance company and as a result of that contract the insurance company must pay out an amount equal to the death benefit under the policy, since that is what the parties agreed to under the contract. If the insurance company is prevented from making the argument that as a result of a lack of insurable interest no death benefit must be paid, and a contract exists in equity, there still may be no life insurance policy for tax purposes. The insurance company may be considered making a payment it is contractually obligated to make, and not paying out a death benefit under the policy (because there is no policy due to the lack of an insurable interest). Accordingly, as a payment under a contract, it is questionable if such payment would be excludable from the taxable income of the recipient under section 101(a)(1). If section 101(a)(1) does not apply, the only tax-free amount the recipient would receive is an

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135. Mancini, *supra* note 107, at 125.

136. *Id.* at 132. Because the contract is void, any and all terms that may have been incorporated will also be nullified. Thus, for example, any provisions relating to non-contestability, choice of law, and the obligation of the insurer to pay out the death benefit will be unenforceable.

137. Mancini, *supra* note 107, at 132. Such was not the case in *Chawla*, as the court expressly held that Maryland law prohibited recognition of a waiver or estoppel defense. Chawla v. Transamerica Occidental Ins. Co., No. 03-1215, 2005 U.S. Dist. LEXIS 3473, at *20 (E.D. Va. Feb. 3, 2005), *aff'd in part and vacated in part*, 440 F.3d 639 (4th Cir. 2006).

> amount equal to the recipient's basis in the policy which would equal the premiums paid on the policy.[138]

An immediate alternative to simply rendering the polices void would be to follow Texas's lead in dealing with corporate-owned life insurance policies lacking an insurable interest: pay out the death benefit into a constructive trust for the benefit of the deceased's estate.[139] While doing so raises the question of whether those proceeds would then be taxable,[140] such an outcome makes sense in light of the rationale underlying the insurable interest requirement. Consider the following comment to one state statute that specifically authorizes the distribution of insurance proceeds to a party equitably entitled to a death benefit, even absent an insurable interest in the named beneficiary:

> The best way to discourage insurers from issuing insurance policies to persons without insurable interest is to make them pay if they do, not to permit them freely to issue such policies knowing that they have a good public policy defense that lets them off the hook whenever a loss occurs.[141]

B. LONG-TERM SOLUTIONS IN LIGHT OF *CHAWLA*

According to Mancini, "[t]he decision in *Chawla* highlights a long-held concern of many estate planning attorneys about how many state laws, whether in statutory form or developed in case law, do not include a trust as a type of entity that has an insurable interest."[142] Since many state insurance codes today contain insurable interest provisions (broad though they may be), it only seems proper that this concern, now identified by the courts, be addressed by state legislatures.

The most obvious long-term solution is simply to abolish the insurable interest requirement with respect to life insurance trusts. Legislation could

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138. Mancini, *supra* note 107, at 132.

139. *See, e.g.*, DeLeon v. Lloyd's London, Certain Underwriters, 259 F.3d 344, 346-47 (5th Cir. 2001) (A policy will not be voided for lack of an insurable interest. Where an insurer pays the proceeds to such a beneficiary, a constructive trust will be imposed. The person without an insurable interest will hold the proceeds of a policy as trustee for the benefit of those persons entitled by law to receive it.).

140. Mancini, *supra* note 107, at 133.

141. WIS. STAT. ANN. § 631.07 cmt. (West 2004).

142. Mancini, *supra* note 107, at 125.

be drafted that would recognize a valid insurance trust even though the beneficiary lacks an insurable interest, so long as the insured himself consents to the arrangement.[143] Allowing such an arrangement would seem to be a logical extension of the current rule that an insured may always acquire a policy on his own life and name anyone he wants as a beneficiary, including someone lacking an insurable interest.[144] If the consent of the insured is what makes such an arrangement permissible and not against public policy, then why shouldn't the insured also be permitted to allow a third-party lacking an insurable interest, e.g., a life insurance trust, to be the initial owner as well?[145]

A more ideal solution, however, is to have states adopt legislation that specifically recognizes a trust's insurable interest in the life of the insured. Delaware's statute does exactly this by explicitly classifying a trust as the fifth type of person with an insurable interest. Specifically, it recognizes that a trust is a separate entity with its own insurable interest in the insured, so long as it was created by the insured.[146] In contrast, if the trust is not created by the insured, Delaware law treats the trust not as a separate entity, but as an aggregation of its beneficiaries, granting the trust an insurable interest to the extent that the proceeds of the trust are allocable to those beneficiaries who have an insurable interest.[147]

In response to the *Chawla* decision, the Trust and Estates Bar in Maryland attempted to enact legislation that would clarify application of

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143. Blattmachr & Graham, *supra* note 43.

144. *Id.*

145. *Id.*

146. DEL. CODE ANN. tit. 18, § 2704(c)(5) (1999) states that

> [T]he trustee of a trust established by an individual has an insurable interest in the life of that individual and the same insurable interest in the life of any other individual as does any person who is treated as the owner of such trust for federal income tax purposes. The trustee of a trust has the same insurable interest in the life of any individual as does any person with respect to proceeds of insurance on the life of such individual (or any portion of such proceeds) that are allocable to such person's interest in such trust. If multiple beneficiaries of a trust have an insurable interest in the life of the same individual, the trustee of such trust has the same aggregate insurable interest in such life as such beneficiaries with respect to proceeds of insurance on the life of such individual (or any portion of such proceeds) that are allocable in the aggregate to such beneficiaries' interest in the trust.

147. *Id.*

the insurable interest requirement. House Bill 1608, sponsored by Delegate Luiz Simmons, would have remedied the issue highlighted by *Chawla* by ordering the courts not to use *Chawla*'s holding as precedent in determining "whether, and under what standard, a trust, a trustee, or the beneficiaries of a trust shall have an insurable interest with regard to a trust procuring an insurance contract" under section 12-201 of the Insurance Article.[148] Without the support of the insurance industry,[149] the bill died in the House Health and Government Operations Committee without a vote.[150] Efforts are underway to re-introduce similar legislation during the next legislative session.[151]

A third solution is to modify the trusts themselves. If possible, the trust could acquire new insurance to replace the existing insurance policies in which an insurable interest is lacking.[152] Where that is not possible, the trustees could consider entering into a separate contract with the insurance company that would dictate that if the policy was voided as lacking an insurable interest, the company would pay the trust not only the returned policy premiums, but also a market rate of return on those premiums.[153]

VI. POSTSCRIPT: THE FOURTH CIRCUIT'S DECISION

Subsequent to the drafting of this Note, the Fourth Circuit issued its opinion affirming the summary judgment award on the basis of the material misrepresentation, but vacating the district court's alternative holding that the Trust lacked an insurable interest in Giesinger's life.[154]

Although the court engaged in an extended discussion of the material misrepresentation issue, it made no substantive comment on the arguments advanced on the insurable interest issue. Given the resolution of the case on the material misrepresentation grounds, the court deemed it simply

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148. Richard A. Montgomery, III, *Legislative Preview 2006-Calm Before the Storm*, Dec. 2005 MD. B. BULL., *available at* http://www.msba.org/departments/commpubl/publications/bar_bult/2005/dec05/legpreview.htm.

149. Mancini, *supra* note 107, at 136.

150. Montgomery, *supra* note 148.

151. *Id.*

152. Mancini, *supra* note 107, at 136. Of course, such a decision involves multiple considerations: the location of the trust in a state with a suitable insurable interest statute, who should acquire the new policy (the insured or an intended beneficiary), and how the policy is transferred to the trust (via sale or gift) and its attendant tax consequences. *Id.*

153. *Id.* at 137.

154. Chawla v. Transamerica Occidental Life Ins. Co., 440 F.3d 639, 641 (4th Cir. 2006).

unnecessary, and therefore improper to do so. Under the doctrine of judicial restraint, the Fourth Circuit refrained from deciding more than was necessary to resolve the case at hand, especially in a case such as *Chawla*, where to do otherwise would have required a federal court to address a state law issue of first impression.[155]

Although the case has been decided and the insurable interest holding vacated, the Fourth Circuit's decision does little to address the general problem spotlighted by *Chawla*. By not ruling on the merits of the insurable interest arguments, the court simply avoided setting precedent either way. The general argument remains that, under current Maryland law, an irrevocable trust lacks an insurable interest in the life of the insured. So while trusts with a situs in Maryland may, for the moment, continue to acquire presumably valid life insurance policies, that could change with the next case; where the only ground for recession is the lack of an insurable interest, another lower court may very well adopt the reasoning of the *Chawla* district court. So until an appellate court rules definitely on the merits, or the legislatures act to clarify how the existence of an insurable interest should be determined, estate planners and tax advisors must remain aware of the risk of including life insurance policies as assets of an irrevocable trust and make decisions accordingly.

155. *Id.* at 648.

SHOULD INSURERS IN TEXAS BE PROHIBITED FROM USING STAFF ATTORNEYS TO DEFEND THIRD PARTY CLAIMS BROUGHT AGAINST INSUREDS?: A CLOSER LOOK AT *AMERICAN HOME ASSURANCE*

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INTRODUCTION

Insurance companies have long argued that because independent defense attorneys perceive insurance companies as "deep pockets," they subsequently incur large and often wasteful defense costs when representing insurance companyies' policyholders because they know that insurance companies are contractually obliged to pay the defense fees of their policyholders.[1] To deter this conduct and to reduce costs, insurance companies have been using their own staff attorneys to defend claims brought against their insureds for almost half a century.[2] In fact, reports show that the number of staff attorneys employed by insurance companies has dramatically increased in the last two decades.[3] But while insurance companies contend that the use of in-house counsel results in lower premiums for policyholders,[4] there has been an ongoing debate surrounding the ethical implications of this practice.[5] Indeed, scholars have been debating for years the proper relationship between insurer, insured, and defense counsel, and whether, more specifically, insurers should be permitted to use staff attorneys to defend claims brought against their insureds.[6]

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1. Patrick M. Anthony, Note, *Insurance Defense Litigation: The Ethics and Legality of Insurance Policies that Impose Cost Guidelines on Attorneys Hired by the Insurer to Defend Insurance Claims*, 79 U. DET. MERCY L. REV. 97, 99 (2001).

2. Charles Silver, *Flat Fees and Staff Attorneys: Unnecessary Casualties in the Continuing Battle Over the Law Governing Insurance Defense Lawyers*, 4 CONN. INS. L.J. 205, 237 (1997).

3. *Id.* at 238.

4. *Id.* at 243-44.

5. *See, e.g.*, Daniel M. Martinez, *Comment, Insurance Companies' Use of "Captive" or In-House Counsel to Represent Insureds Constitutes the Unauthorized Practice of Law: Is American Home the Right Decision for Texas?*, 34 ST. MARY'S L.J. 1007 (2003); Nancy J. Moore, *Conflicts of Interest for In-House Counsel: Issues Emerging from the Expanding Role of The Attorney-Employee*, 39 S. TEX. L. REV. 497 (1998); Nancy J. Moore, *The Ethical Duties of Insurance Defense Lawyers: Are Special Solutions Required?*, 4 CONN. INS. L.J. 259, 292-302 (1997); Silver, *supra* note 2; Charles Silver & Kent Syverud, *The Professional Responsibilities of Insurance Defense Lawyers*, 45 DUKE L.J. 255 (1995).

6. *See generally* Thomas D. Morgan, *What Insurance Scholars Should Know About Professional Responsibility*, 4 CONN. INS. L.J. 1 (1997); Tom Baker, *Liability Insurance Conflicts and Defense Lawyers: From Triangles to Tetrahedrons*, 4 CONN. INS. L.J. 101 (1997); David A. Hyman, *Professional Responsibility, Legal Malpractice, and the Eternal Triangle: Will Lawyers or Insurers Call the Shots?*, 4 CONN. INS. L.J. 353 (1997); Kent D. Syverud, *What Professional Responsibility Scholars Should Know About Insurance*, 4 CONN. INS. L.J. 17 (1997).

On the most elementary level, when an individual purchases a liability insurance policy, the insurer takes on the right and the duty to defend and indemnify the insured against any claims brought against the insured which are covered by the insurance policy.[7] Because insurance companies are responsible for defense costs, many courts have held that the insurer's contractual duty to defend encompasses the right to select counsel for the insured.[8] However, as insurers increasingly turn to staff attorneys to defend claims brought against their insureds, two major concerns have surfaced. Specifically, it is contended that (i) this constitutes the unauthorized practice of law by a corporation, and (ii) this is unethical because of the increased likelihood for conflicts of interest given the nature of the relationship between the employer-insurer, the employee-defense counsel, and the client-insured.[9]

Despite these identified concerns, however, the majority of states have held that the use of staff attorneys by insurance companies neither constitutes the unauthorized practice of law nor violates the professional rules of responsibility.[10] In fact, to date, only two jurisdictions have held that there should be a *per se* prohibition on an insurers use of staff attorneys to defend third party claims brought against insureds.[11]

Most recently, this issue was presented to the Texas Supreme Court in *American Home Assurance Company v. Unauthorized Practice of Law Committee*.[12] Prior to going before the Texas Supreme Court, a Texas superior court notably held that the use of staff attorneys by insurers constitutes the unauthorized practice of law because it violates the

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7. Am. Home Assurance Co. v. Unauthorized Practice of Law Comm., 121 S.W.3d 831, 833 (Tex. App. 2003).

8. *See, e.g.*, State Farm Mut. Auto. Ins. Co. v. Traver, 980 S.W.2d 625, 627 (Tex. 1998).

9. *See* Moore, *supra* note 5, at 292-303.

10. *See* Gafcon, Inc. v. Ponsor & Assoc., 120 Cal. Rptr. 2d 392 (Cal. Ct. App. 2002); King v. Guiliani, No. CV92-0290370-S, 1993 Conn. Super. LEXIS 1889 (Conn. Super. Ct. July 27, 1993); *In re* Rules Governing Conduct of Attorneys in Fla., 220 So. 2d 6 (Fla. 1969); Coscia v. Cunningham, 299 S.E.2d 880 (Ga. 1983); Joplin v. Denver-Chicago Trucking Co., 329 F.2d 396, 397 (8th Cir. 1964); Kittay v. Allstate Ins. Co., 397 N.E.2d 200, 202 (Ill. App. Ct. 1979); Cincinnati Ins. Co. v. Wills, 717 N.E.2d 151 (Ind. 1999); *In re* Allstate Ins. Co., 722 S.W.2d 947 (Mo. 1987); *In re* Weiss, Heley & Rea, 536 A.2d 266 (N.J. 1988); Strother v. Ohio Cas. Ins. Co., 1939 Ohio Misc. LEXIS 1184, 14 Ohio Op. 139 (Ohio C.P. Ct.1939); *In re* Youngblood, 895 S.W.2d 322 (Tenn. 1995).

11. *See* Am. Ins. Ass'n v. Ky. Bar Ass'n, 917 S.W.2d 568 (Ky. 1996); Gardner v. North Carolina State Bar, 341 S.E.2d 517 (N.C. 1986).

12. Unauthorized Practice of Law Comm. v. Am. Home Assurance Co., No. 04-0138, 2005 Tex. LEXIS 278 (Tex. Apr. 8, 2005).

longstanding prohibition on the practice of law by a corporation.[13] The Texas Court of Appeals reversed, however, holding that the use of staff attorneys is neither the unauthorized practice of law by a corporation nor unethical because, among other things, staff attorneys do not face any unique ethical conflicts which are not also faced by outside counsel.[14] On September 28, 2005, oral arguments were heard before the Texas Supreme Court and as of the Fall of 2006 a decision was still pending. This Comment focuses specifically on the *American Home Assurance* case and provides an analysis of why the trial court got it wrong when it held that the use of staff attorneys constitutes the unauthorized practice of law.

First, this Comment provides an overview of the relationship between insurer, insured, and defense counsel (commonly known as the tripartite relationship) and discusses the ethical dilemmas that arise as a result of this dynamic. Additionally, this section provides a summary of the majority and minority views on the use of staff attorneys by insurers in defending claims brought against insureds. Specific attention is paid to how the use of staff attorneys, as opposed to outside counsel, impacts the relationship between insurer, insured, and defense counsel.

Second, this Comment outlines the background to the *American Home Assurance* case, providing a detailed discussion of the relevant facts as well as an objective analysis of the courts' holdings. In addition, this Section examines the unpublished decision of the trial court as well as the decision of the Texas Appellate Court. This Section also includes a brief discussion of the significance of this case both within the State of Texas as well as throughout the United States.

Finally, this Comment discusses why the trial court in *American Home Assurance* got it wrong when it held that the use of staff attorneys by insurers to defend third party claims against insureds constitutes the unauthorized practice of law and is unethical. Given the nature of the contractual relationship between insured and insurer, there should not be a *per se* prohibition on the use of staff attorneys in insurance defense. The Texas Supreme Court should therefore uphold the decision of the Texas Appellate Court. In any event, if the state of Texas wishes to create a *per se* prohibition on the use of staff attorneys by insurance companies in defending third-party claims brought against insureds then the Texas legislature, and not the Texas judiciary, should be making that decision.

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13. Am. Home Assurance Co. v. Unauthorized Practice of Law Comm., 121 S.W.3d 831, 833 (Tex. App. 2003).

14. *Id.* at 845.

I. BACKGROUND

A. THE TRIPARTITE RELATIONSHIP

The relationship between insurer, insured, and defense counsel, commonly known as the tripartite relationship, is unique because "[i]n no other area of the law are individuals consistently represented by attorneys who are selected and paid for by a third party."[15] Generally speaking, liability insurance policies serve to protect the insured from (i) the risk of having to defend a lawsuit and (ii) the risk of having to pay a money judgment as result of that lawsuit.[16] As the ethical and corporate concerns are discussed, it is helpful to keep these underlying purposes in mind.

In nearly all instances, the driving force behind the tripartite relationship is the insurance contract entered into between the insured and the insurer.[17] The insured must pay insurance premiums, comply with contractual provisions, and is bound by the financial coverage of his or her policy.[18] At the same time, typical policies, including those of American Home Assurance Company, Inc. and The Traveler's Indemnity Company (both of whom were parties to the *American Home Assurance* case) state that the insurer has both a right and a duty to act in good faith to defend and indemnify the insured against any third party claims brought against the insured which fall within the ambits of the insurance policy.[19]

As previously noted, the right to defend, which entails taking complete and exclusive control over the insureds defense, generally permits the insurer to select defense counsel to represent the insured.[20] As a result of this unique relationship, defense counsel is in a somewhat precarious position; the insured is the client yet the insurer has tactical and financial control over the insured's defense and is responsible for paying defense counsel's attorneys fees. Professor Stephen Pepper identified the problem as follows:

> When a lawyer is hired by an insurance company to represent an insured in a liability matter, who does the

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15. Anthony, *supra* note 1, at 99.
16. *Am. Home Assurance Co.*, 121 S.W.3d at 833.
17. Baker, *supra* note 6, at 102.
18. *See* Martinez, *supra* note 5, at 1013.
19. Baker, *supra* note 6, at 102; Am. Home Assurance Co. v. Unauthorized Practice of Law Comm., 121 S.W.3d 831, 834 (Tex. App. 2003).
20. Baker, *supra* note 6, at 107.

> lawyer represent? The insured, the insurance company, or both? Does the lawyer have one client or two? These questions are really sub-issues of broader questions: How ought the lawyer in this situation behave? What are the lawyer's obligations to the insured and the insurer, and how do those obligations interact?[21]

Much of the debate surrounding the tripartite relationship focuses on these conflicts and the use of staff attorneys brings an added wrinkle to this already somewhat strained relationship.

B. BRIEF OVERVIEW OF THE ARGUMENTS AGAINST THE USE OF STAFF ATTORNEYS IN DEFENDING THIRD PARTY CLAIMS BROUGHT AGAINST INSUREDS

Interestingly, in addition to the insurance contract binding the parties, the insurer also has ethical obligations to its clients, including a duty to act with loyalty, in good faith, with proper skill, and with due care when taking complete and exclusive control over the insured's defense.[22] Likewise, the defense counsel selected by the insurer (regardless of whether they are staff attorneys or outside counsel) are bound by the applicable professional rules of responsibility governing the attorney-client relationship. The Model Rules, which are for the most part applicable in Texas, require that an attorney act competently[23] and diligently[24] when representing a client. In addition, an attorney must inform the client of any decisions or circumstances surrounding the client's case, consult with the client regarding the client's objectives, keep the client informed, and explain information so as to assist the client in making informed decisions.[25] In the

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21. Stephen L. Pepper, *Applying the Fundamentals of Lawyers' Ethics to Insurance Defense Practice*, 4 CONN. INS. L.J. 27, 27-28 (1997).

22. Boling v. New Amsterdam Cas. Co., 46 P.2d 916, 919 (Okla. 1935).

23. MODEL RULES OF PROF'L CONDUCT R. 1.1 (2003) ("[a] lawyer shall provide competent representation to a client. Competent representation requires the legal knowledge, skill, thoroughness and preparation reasonably necessary for the representation").

24. *Id.* R. 1.3 ("[a] lawyer shall act with reasonable diligence and promptness in representing a client").

25. *Id.* R. 1.4. Model Rule 1.4 states:

> (a) A lawyer shall:

absence of some extraneous circumstance as listed in Model Rule 1.6, an attorney is also bound by confidentiality rules, which require that an attorney not reveal information relating to the representation of the client without first receiving the informed consent of his or her client.[26]

In the case of the tripartite relationship, the concern is that an attorney's ethical obligations will potentially be compromised because the attorney must simultaneously represents two clients (in this case, the insured and the insurer) having potentially conflicting interests. Indeed, it would seem almost inevitable that an attorney representing an insured on

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(1) promptly inform the client of any decision or circumstance with respect to which the client's informed consent, as defined in Rule 1.0(e) is required by these Rules;

(2) reasonably consult with the client about the means by which the client's objectives are to be accomplished;

(3) keep the client reasonably informed about the status of the matter;

(4) promptly comply with reasonable requests of information; and

(5) consult with the client about any relevant limitation on the lawyer's conduct when the lawyer knows that the client expects assistance not permitted by the Rules of Professional Conduct or other law.

(b) A lawyer shall explain a matter to the extent reasonably necessary to permit the client to make informed decisions regarding the representation.

Id.

26. *Id.* R. 1.6. Model Rule 1.6 states:

(a) A lawyer shall not reveal information relating to the representation of a client unless the client gives informed consent, the disclosure is impliedly authorized in order to carry out the representation or the disclosure is permitted by paragraph (b).

(b) A lawyer may reveal information relating to the representation of a client to the extent the lawyer reasonably believes necessary:

(1) to prevent reasonably certain death or substantially bodily harm;

(2) to secure legal advice about the lawyer's compliance with these Rules;

(3) to establish a claim or defense on behalf of the lawyer in a controversy between the lawyer and the client, to establish a defense to a criminal charge or civil claim against the lawyer based upon the conduct in which the client was involved, or to respond to allegations in any proceeding concerning the lawyer's representation of the client; or

(4) to comply with other law or a court order.

Id.

behalf of an insurer would have some conflict in juggling the interests of the insured and the insurer. In addressing conflicts of interest in simultaneous representation, Model Rule 1.7 states:

> (a) Except as provided in paragraph (b), a lawyer shall not represent a client if the representation involves a concurrent conflict of interest. A concurrent conflict of interest exists if:
>
> (1) the representation of one client will be directly adverse to another client; or
>
> (2) there is a significant risk that the representation of one or more clients will be materially limited by the lawyer's responsibilities to another client, a former client, or a third person, or by a personal interest of the lawyer.
>
> (b) Notwithstanding the existence of a concurrent conflict of interest under paragraph (a), a lawyer may represent a client if:
>
> (1) the lawyer reasonably believes the lawyer will be able to provide competent and diligent representation to each affected client;
>
> (2) the client representation is not prohibited by law;
>
> (3) the representation does not involve the assertion of a claim by one client against another client represented by the lawyer in the same litigation or other proceedings before a tribunal; and
>
> (4) each affected client gives informed consent, confirmed in writing.[27]

The Comments to Rule 1.7b emphasize the importance of attorney loyalty[28] and the Rules themselves require that an attorney obtain the informed consent of a client whenever a potential conflict of interest arises.[29] However, the Rules do not expressly speak to the issue of insurance defense and the tripartite relationship. In the case of the tripartite relationship, in order to comply with the Model Rules, it would seem that the insured would have to consent to its attorney because of the insurer's

27. *Id.* R. 1.7.
28. *Id.* R. 1.7 cmt. 1.
29. MODEL RULES OF PROF'L CONDUCT R. 1.7 (2003).

financial and strategic control over their defense. Given the contractual nature of the liability policy and the overarching purposes behind obtaining this type of policy, this would not appear to be a difficult task to complete.

Another source of concern has been the issue as to whom defense counsel owes an ethical obligation. In applying the Model Rules to the context of insurance defense litigation, it is unclear conceptually whether defense counsel has one client or two,[30] or as Professor Nancy Moore points out, possibly even "one-and-a-half" clients.[31] It seems that making this determination would assist in conceptually understanding what duties are owed to whom and by whom.[32]

The "one-client" approach is characterized by the view that insurance defense counsel represents only one client, namely the insured.[33] As such, defense counsel represents the interests of the insured, and not the insurer. Most proponents of the one-client approach believe that it is unethical for an attorney to represent both the insured and the insurer and it is therefore prohibited under the rules of professional conduct.[34] The rationale supporting this view seems to be that either (i) joint representation violates the professional rules of conduct *per se* or (ii) joint representation does not necessarily violate professional rules of conduct but that there is a high likelihood that attorneys will do so when representing more than one client at a time and, thus, the practice should be prohibited as a prophylactic measure.[35]

Those who oppose the "one-client" view argue that by not classifying the insurer as a client, the insurer loses its right to sue defense counsel for malpractice.[36] In addition, the insurer has no ethical right to settle cases

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30. *See, e.g.*, Pepper, *supra* note 21, at 28 (1997) (noting that although it has its flaw, the one client approach is preferable); Charles Silver, *Does Insurance Defense Counsel Represent the Company or the Insured?*, 72 TEX. L. REV. 1583, 1590 (1994) (arguing that the insurance company can be a client jointly with the insured and that lawyers can represent both the insured and the insurer so long as it is provided in the retainer agreement); Scott L. Machanic, *Insurance Defense Counsel: Who Is the Client?*, 43 FED'N INS. & CORP COUNS. Q. 45 (1992) (arguing that it is typically assumed that defense counsel represent both the insured and insurer).

31. *See* Moore, *supra* note 9, at 264 n.8.

32. *See, e.g.*, Am. Home Assurance Co. v. Unauthorized Practice of Law Comm., 121 S.W.3d 831, 837-39 (Tex.App. 2003).

33. Pepper, *supra* note 21, at 58.

34. Moore, *supra* note 9, at 264.

35. *Id.* Interestingly, however, the Tennessee Supreme Court held that Tennessee was a one-client state, yet went on to hold that the use of staff-attorneys by insurance companies. *In re* Youngblood, 895 S.W.2d 322 (Tenn. 1995).

36. *See, e.g.*, Silver, *supra* note 30, at 1602.

within its policy limits or determine how much spending on defense is cost-effective.[37] This seems to conflict with the contractual right of the insurer to have "complete and exclusive control" over the insured's defense. Consequently, viewing the insurer as a second-client alleviates some of these potential concerns because defense counsel would owe the insurer (as well as the insured) all the duties owed under the Model Rules.[38]

The major flaw with the "two-client" approach, however, is that it is unlikely that an attorney can fulfill all of his or her ethical duties to both clients all the time.[39] For example, the likelihood of disagreement between insurer and insured is relatively high and, in such instances, how is the attorney to act? Examples of potential conflicts between insurer and insured include:

> (1) the insured's concern over the side effects of litigation, such as publicity, reputation or about a personal or business relationship with the plaintiff; (2) the preference of the insured for a more expensive effort than the insurer is willing to make; (3) the possibility that the insurer has some additional interest in the outcome of a particular lawsuit, such as its desire to obtain a precedential ruling that will benefit the insurer in other cases; and (4) the possibility that either insurer or insured will seek to manipulate or coerce the other into agreeing to perform beyond its requirements under the insurance contract.[40]

As previously noted, if both the insured and insurer are considered clients of defense counsel, the Model Rules do not provide much guidance in terms of how defense counsel is to ethically act. While Rule 1.7b requires that an attorney serving two clients must receive the informed consent of the client whenever the representation "may be materially limited by the lawyer's responsibilities to another client,"[41] those who oppose the "two-client" view contend that in the case of dual representation, it is virtually impossible for the attorney to ethically meet the needs of either client, let alone both.[42]

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37. *See, e.g.*, Morgan, *supra* note 6, at 6-7.
38. Moore, *supra* note 5, at 265.
39. *Id.*
40. *Id.* at 266.
41. MODEL RULES OF PROF'L CONDUCT R. 1.7 (2003).
42. Moore, *supra* note 5, at 266.

Ultimately, there are no settled answers as to how the tripartite relationship should be viewed.[43] Courts and ethics committees vary on how they view this relationship, as is evident in the next Section of this Comment. In addition, the relevance of the "one-client" versus "two-client" distinction is somewhat unclear.[44] Professor Charles Silver, for example, argues that the professional responsibilities of insurance defense lawyers should be dictated by contract law, rather than by classifying the relationship as "one-client" or "two client."[45] According to Silver, when the insurer retains counsel for the insured, the insurer establishes a contractual relationship with defense counsel, which permits the insurer to exercise certain powers over the insured's case.[46] This retainer agreement, Silver contends, controls regardless of whether the insurer is considered a client or not.[47] The contract, of course, should specify who the attorney represents and for what purposes.[48]

Another source of ethical concern with the tripartite relationship stems from the fact that a third party, namely the insurer, is paying for the insured's defense. Model Rule 1.8f states that an attorney can receive payment from a source other than the client, but conditions this third-party payment on the premise that an attorney's professional judgment and the attorney-client relationship cannot be interfered with or compromised as a result of the third party payer.[49] Following the logic of Silver's argument, however, it would appear that, again, the contractual nature of the relationship should control and it should not be considered *per se* unethical.

Another source of concern, although not clearly delineated as an ethical one, has been the argument that the use of staff attorneys by insurance companies constitutes the unauthorized practice of law by a corporation. Most jurisdictions, including Texas, have statutes which specifically prohibit the practice of law by a corporation other than a professional

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43. *See* Silver, *supra* note 30, at 1584.

44. Am. Home Assurance Co. v. Unauthorized Practice of Law Comm., 121 S.W.3d 831, 838-39 (Tex. App. 2003).

45. *Id.*

46. *See* Silver, *supra* note 30, at 1604-05.

47. *Id.*

48. *Id.* at 1604.

49. MODEL RULES OF PROF'L CONDUCT R. 1.8(f) (2003). Rule 1.8(f) states: "A lawyer shall not accept compensation for representing a client from one other than the client unless: (1) the client gives informed consent; (2) there is no interference with the lawyer's independence of professional judgment or with the client-lawyer relationship; and (3) information relating to the representation is protected as required by Rule 1.6." *Id.*

corporation.[50] Pursuant to these statutes, a corporation may hire a lawyer to perform legal services on behalf of the corporation, but the lawyer typically cannot perform legal services on behalf of others.[51] Although insurance companies have been using staff attorneys to defend third-party claims against insureds for some time, it has not been until recently that the practice has been challenged on these grounds.[52] As is evident in the next Section, the vast majority of jurisdictions have held that the use of staff attorneys by insurance companies to defend insureds is not the unauthorized practice of law because the insurer, through its attorneys, is acting to protect its own financial interest.[53] Those who oppose this view often contend that if defense counsel is acting to protect the insurer, there is no way an attorney can simultaneously represent the best interests of the insured.[54] So it follows that the ethical concerns permeate this line of argument as well.

Notably, much of the above discussion speaks generally to the topic of insurance defense and the tripartite relationship. When staff attorneys, as opposed to outside counsel, are used to defend third party claims against insureds, the previously discussed concerns regarding the tripartite relationship are compounded, particularly the aforementioned ethical concerns. If the insurer hires its own employees to defend third party claims, won't their loyalty rest with their employer, rather than the insured? Isn't there more of a concern when the lawyer is actually an employee of the insurer rather than merely an outside contractor?

Despite these concerns, however, some contend that challenges to eliminate the practice of using staff attorneys are unfounded because they take away the freedom of clients and lawyers to enter into consensual, contractual relationships.[55] The next Section discusses in detail how courts have decided the issue of whether the insurer's use of staff attorneys to defend claims against insureds is unethical or constitutes the unauthorized practice of law. It provides a detailed review of the minority and majority positions on this issue. It also provides the analytic framework and a sense of context and background to the major issues surrounding the use of staff attorneys in insurance defense litigation.

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50. Nancy J. Moore, *Conflicts of Interest for In-House Counsel: Issues Emerging from the Expanding Role of the Attorney-Employee*, 39 S. TEX. L. REV. 497, 509 (1998).

51. *Id.*

52. *Id.* at 510.

53. *Id.*

54. *Id.* at 511.

55. Moore, *supra* note 5, at 295.

C. RELEVANT CASE LAW

In an attempt to prohibit the use of staff attorneys in insurance defense, two main contentions have been brought, namely (i) it results in impermissible conflicts of interests and, thus, there should be a *per se* prohibition on the practice, and (ii) it violates the ban on corporations practicing law and thus constitutes the unauthorized practice of law. This Section provides an overview of how courts have dealt with these arguments.

1. Majority View: The Use of In-House Counsel Is Neither Unethical Nor Constitutes the Unauthorized Practice of Law by a Corporation

The majority of jurisdictions that have decided the issue of whether the use of staff attorneys by insurers to defend third party claims against insureds is permissible have held that this practice neither constitutes the unauthorized practice of law nor is unethical. [56] In attaining this result, most jurisdictions recognize the potential for conflicts of interest, yet reject the notion that the use of staff attorneys requires a *per se* prohibition.[57] Some states even expressly authorize the use of staff attorneys in the context of insurance defense litigation through statutory provisions.[58] Regardless of this almost universal agreement, however, courts vary in their analysis in reaching this decision.

In addressing the first issue of whether the use of in-house counsel violates the ban on corporations practicing law, most jurisdictions have explicitly held that because the insurer has a financial interest in the outcome of the insured's claim, the insurer is entitled to select counsel of

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56. *See supra* note 10 and accompanying text.

57. *See, e.g., In re* Youngblood, 895 S.W.2d 322, 330 (Tenn. 1995); King v. Guiliani, No. CV92-0290370-S, 1993 Conn. Super. LEXIS, at *1889 (Conn. Super. Ct. July 27, 1993); *In re* Allstate Ins. Co., 722 S.W.2d 947, 952 (Mo. 1987); Gafcon, Inc. v. Ponsor & Assoc., 120 Cal. Rptr. 2d 392, 392 (Cal. Ct. App. 2002).

58. *See* Kittay v. Allstate Ins. Co., 78 Ill. App. 335, 202 (1979). The relevant Illinois statute states:

> Nothing contained in this act shall prohibit a corporation from employing an attorney or attorneys in and about its own immediate affairs or in any litigation to which it is or may be a party, or in any litigation in which any corporation may be interested by reason of the issuance of any policy or undertaking of insurance, guarantee or indemnity.

Id.

its choosing to represent the insured.[59] Because the insurer has a "direct and pecuniary" interest in the outcome of the litigation, the insurer has a right to protect that interest and the ability to protect that interest includes the right to select counsel, including in-house counsel, to defend any claims brought against the insured.[60]

As an interesting side note, several jurisdictions which have held that the use of staff attorneys in insurance defense does not constitute the unauthorized practice of law have cited a Texas case[61] as persuasive authority.[62] In fact, *Utilities Insurance Company v. Montgomery* is cited for the very proposition that an insurance company which defends cases through the use of staff attorneys does not, as a matter of law, engage in the unauthorized practice of law.[63] Interestingly, even courts that follow that minority view have recognized that Texas has a unique statutory rule that expressly permits insurance companies to hire in-house counsel to represent third party claims against insureds.[64] At the time of publication, however, it seems unlikely that the *Montgomery* decision is being properly cited.

In the *American Home Assurance* case, for example, the Texas Appellate Court cites *Montgomery*, yet distinguishes it from *American Home Assurance* because in that case a third party sued the insurer after receiving judgment against the insured.[65] The third party argued that because the insurer provided a defense for the insured, it could not later counter that the claim did not fall within the ambits of the insureds policy; if the insurer did, then the insurer was engaged in the unauthorized practice of law because it no longer had a pecuniary interest in the matter.[66] In deciding the case, the Texas Supreme Court held that the insurer was not

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59. *King*, 1993 Conn. Super. LEXIS 1889, at *15-17; *In re* AllState Ins. Co., 722 S.W.2d at 952; Strother v. Ohio Cas. Ins. Co., 1939 Ohio Misc. LEXIS 1184, 14 Ohio Op. 139, *9 (Ohio C.P. Ct. 1939).

60. *Strother*, 1939 Ohio Misc LEXIS 1184, at *10.

61. Utils. Ins. Co. v. Montgomery, 138 S.W.2d 1062 (Tex. 1940).

62. *See, e.g.*, Coscia v. Cunningham, 299 S.E.2d 880, 882 (Ga. 1983); Cincinnati Ins. Co. v. Wills, 717 N.E.2d 151, 155 (Ind. 1999); *In re Allstate Ins. Co.*, 722 S.W.2d at 950.

63. *In re* Allstate Ins. Co., 722 S.W.2d at 950.

64. Gardner v. North Carolina State Bar, 316 N.C. 285, 293 (1986). The *Gardner* court also notes that Illinois has a specific statute authorizing the use of in-house counsel by insurance companies in defending third party claims against insureds. *Id. See also* Kittay v. Allstate Ins. Co., 78 Ill. App. 3d 335, 338 (1979).

65. Am. Home Assurance Co. v. Unauthorized Practice of Law Comm., 121 S.W.3d 831, 840 (Tex. App. 2003).

66. *Id.*

engaged in the unauthorized practice of law because the insurer had a continued pecuniary interest in the case despite the fact that it was alleging that the underlying claim was not covered by its policy.[67]

Overall, it seems that many courts reject the argument that the use of in-house counsel violates the ban on corporations practicing law because they do not see a clear distinction between the use of in-house counsel and the use of outside attorneys.[68] In *In re Allstate*, for example, the Missouri Supreme Court held that the primary purpose of the relevant Missouri statute which places a ban on corporations practicing law is to "preclude a corporation with non-professional shareholders from having a proprietary interest in or sharing in the emoluments of a law practice."[69] Using in-house counsel in insurance defense does not necessarily threaten or violate this principle. In support of its decision, the court cited a lack of instances in which a person may lawfully do something through an independent contractor but not through an employee.[70]

In contrast, a Pennsylvania court noted that the primary concern with using in-house counsel rather than outside attorneys to defend claims brought against insureds is the potential for the insurer to have undue influence over staff attorneys to the detriment of the attorney-client relationship between defense counsel and the insured.[71] Ultimately, however, the court held that the use of staff attorneys does not violate the

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67. *Id.*

68. *See, e.g., In re* Allstate Ins. Co., 722 S.W.2d 947, 950 (Mo. 1987); Schoffstall v. Nationwide Ins. Co., 58 Pa. D. & C.4th 14, *27-28 (2002).

69. *In re* Allstate Ins. Co., 722 S.W.2d 947, 950 (Mo. 1987).

70. *Id.*

71. Schoffstall v. Nationwide Ins. Co., 58 Pa. D. & C.4th 14,*35 (2002). The Pennsylvania court also notes several ethical factors to consider when determining whether a corporation is practicing law. These factors include:

> (1) Does the staff trial attorney maintain independent professional judgement in all phases of the representation of the insured?
>
> (2) To what degree are there restrictions, imposed by the insurance company employer, upon the staff trial lawyer in either the scope of the representation of the insured-client or upon the strategy and tactics involved in the representation?
>
> (3) Is there a contract between the insurance company and the insured-client which imposes upon the insurance company a duty to indemnify the insured -- giving rise to an interest in the litigation held by the insurance company -- and a duty to defend the insured?
>
> (4) Is there a direct financial benefit to the insurance company in staff trial lawyer's representation of the client?

Id. at *35.

ban on corporations practicing law because the insured was protecting its financial interest and the relationship between the insurer and in-house counsel does not necessarily create a "temptation to violate or disregard ethical rules."[72]

The second grounds upon which the use of staff attorneys in insurance litigation is challenged is based upon the notion that it is unethical. Just as with the unauthorized practice of law argument, courts address the conflicts of interest argument somewhat differently as well. A few courts follow the "one-client" approach, whereby defense counsel's only client is the insured.[73] In *In Re Youngblood*, for example, the Tennessee Supreme Court held that the employment of in-house counsel to defend third party claims against an insured does not create an attorney-client relationship between the attorney and the insurer.[74] Following this "one-client" approach,[75] the Court added that "a conflict will not occur unless the attorney is obligated by the terms or circumstances of employment to protect the interest of the employer even to the detriment of the insured."[76]

In addition, the Tennessee Supreme Court noted the flexibility of the relationship between the employer-insurer and the employee-attorney: "Some of the usual characteristics incident to that relationship cannot exist between the insurer and the attorney representing an insured. The employer cannot control the details of the attorney's performance, dictate the strategy or tactics employed, or limit the attorney's professional discretion with regard to the representation."[77] Ultimately, the Court drew no distinction between the use of in-house counsel and the use of outside defense counsel; both owe "complete loyalty to the insured regardless of the circumstances"[78] and both are bound by the professional rules of responsibility.[79]

In contrast to the "one client approach" followed by the Tennessee Supreme Court, most other courts that have upheld the use of in-house

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72. *Id.* at *34.

73. *In re* Youngblood, 895 S.W.2d 322, 328 (Tenn. 1995).

74. *Id.*

75. Although it has been argued that if a state adopts a "one-client" approach then it will also hold that the use of in-house counsel constitutes the unauthorized practice of law, *In re Youngblood* rejects this proposition, making Tennessee one of the few states to use the "one-client" view yet still accept the use of in-house counsel in defending claims against insureds. *Id.*

76. *Id.*

77. *Id.*

78. *Id.*

79. *In re* Youngblood, 895 S.W.2d 322, 328 (Tenn. 1995).

counsel in insurance defense litigation have followed the "two client" approach.[80] As one court explained: "Even though the insured may be interested in minimizing liability and damages, perhaps because of apprehension about insurance coverage and rates, this concern introduces no conflict and there is no reason why the same lawyer may not represent both interests."[81]

Although there may be the potential for conflicts of interest between defense counsel's two clients, there is no need for a *per se* prohibition on the practice because the likelihood for conflict is no higher than it would be if the insurer employed outside defense counsel.[82] In both cases, the insurer hires counsel, pays attorneys fees, and controls the insured's defense. The likelihood that conflicts of interest will arise, namely that counsel will favor the interests of the insurer over the insured, are not cured by banning the use of in-house counsel largely because the likelihood that counsel will favor the interests of the insured is present even when outside counsel is used.[83] Ultimately, it is the responsibility of the attorney (staff attorney or outside counsel) to ensure that this does not happen.[84] In addition, if a conflict does arise between insurer and insured, it is the responsibility of the defense attorney to resolve the conflict by "dropping" one (or both) of their clients.[85] Similarly, civil remedies are available to a client who suffered damages as a result of an attorney's conflict of interest.[86]

2. Minority View: The Use of In-House Counsel Is Unethical and/or Constitutes the Unauthorized Practice of Law by a Corporation

Presently, only two jurisdictions, namely North Carolina and Kentucky, have banned the use of staff attorneys by insurers in defending

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80. *See, e.g.*, Am. Home Assurance Co. v. Unauthorized Pratice of Law Comm., 121 S.W.3d 831, 838 (Tex. App. 2003); Schoffstall v. Nationwide Ins. Co., 58 Pa. D. & C.4th 14,*35 (2002); *In re* Allstate Ins. Co., 722 S.W.2d 947, 952 (Mo. 1987); Employers Cas. Co. v. Tilley, 496 S.W.2d 552, 558 (Tex. 1973).

81. *In re Allstate Ins. Co.*, 722 S.W.2d at 952.

82. *Id.*

83. *Schoffstall*, 58 Pa. D. & C.4th at 34.

84. *Id.* at *26-27.

85. *In re* Allstate Ins. Co., 722 S.W.2d at 953.

86. *Id.*

third party claims against insureds.[87] In both cases, the courts cited two reasons in support of their decisions. First, the use of in-house counsel to defend third party claims against insureds violates the ban on corporations practicing law.[88] Second, there is an increased risk for a conflict of interest to arise when using in-house counsel rather than outside attorneys.[89]

In the first case, the North Carolina Supreme Court conducted a two-pronged analysis in determining that this practice constituted the unauthorized practice of law.[90] First, the court inquired as to whether the use of in house counsel in representing insureds against third party claims constitutes an appearance by a corporation.[91] Second, after concluding that this practice does constitute the appearance of a corporation, the North Carolina Supreme Court then inquired as to whether the corporation's appearance was prohibited.[92]

In both parts of the analysis, the North Carolina Supreme Court found in the affirmative. The court stated: "When a corporation's employees perform legal services for the corporation in the course of their employment, their acts have been held to be the acts of the corporation so that in the law, the corporation itself is performing the acts."[93] In the case of staff attorneys representing insureds, the insured has been named a party to the action, not the insurer.[94] Any judgments rendered in excess of the insurance coverage are the responsibility of the insured.[95] When a staff attorney defends an insured, they are representing the interests of the insured and not their employer-insurer.[96] As a result, the North Carolina Supreme Court explained, because staff attorneys are the employee-agents of the insured and are acting to represent the interests of the insured (rather than the insurer), the use of in-house counsel constitutes the practice of law by a corporation.

Because the insurer has no pecuniary interest in the outcome of the claim against the insured (i.e. because it is the insured bearing most of the risk), the corporation's presence, through the actions of its employee-staff

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87. *See* Gardner v. North Carolina State Bar, 341 S.E.2d 517 (N.C. 1986); Am. Ins. Ass'n v. Kentucky Bar Ass'n, 917 S.W.2d 568 (Ky. 1996).

88. *See Gardner*, 341 S.E.2d at 518; *Am. Ins. Ass'n*, 917 S.W.2d at 569-70.

89. *See Gardner*, 341 S.E.2d at 519; *Am. Ins. Ass'n*, 917 S.W.2d at 569.

90. *See Gardner*, 341 S.E.2d at 520.

91. *See id.*

92. *See id.*

93. Gardner v. North Carolina State Bar, 341 S.E.2d 517, 520 (N.C. 1986).

94. *Id.* at 521.

95. *Id.*

96. *Id.*

attorneys, is prohibited under North Carolina corporate law.[97] According to the North Carolina Supreme Court, "[s]ince a corporation cannot practice law directly, it cannot do so indirectly by employing lawyers to practice for it."[98]

The court also emphasized that the interests of the insured and the insurer are not identical and because of the precarious position between the insurer and in-house counsel, there would be an increased likelihood for conflicts of interest.[99] Rather than leave the door open for such conflict, the North Carolina Supreme Court prohibited the practice in its entirety.

The Kentucky Supreme Court similarly prohibited the use of in-house counsel in defending claims against insureds as "a prophylactic device to eliminate the potential for a conflict of interest or the compromise of an attorney's ethical and professional duties."[100] The Kentucky Supreme Court rejected the notion that insured and insurer share a common interest, stating "no man can serve two masters."[101] In addition, the court cited several instances in which a conflict of interest would arise between insured and insurer.[102]

As evidenced in the North Carolina and Kentucky opinions, both jurisdictions support the "one client" approach, whereby the sole client of defense counsel is the insured. Although many of the majority view jurisdictions note the possibility for conflict in the use of in-house counsel, the minority view takes a more preemptive approach by banning the practice all together.[103] Although the decisions in North Carolina and Kentucky represent the minority position on the use of in-house counsel in defending third party claims, they are particularly important because they suggest the possibility for change in the way insurance companies defend claims brought against their insureds.

The remaining portion of this Comment focuses specifically on the Texas case, *American Home Assurance*. A decision to ban the use of in-house counsel, as supported by the Texas trial court, would be groundbreaking and could potentially have profound impacts on the insurance industry in Texas.

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97. *Id.*
98. *Id.* at 521(citation omitted).
99. Gardner v. North Carolina State Bar, 341 S.E.2d 517, 521 (N.C. 1986).
100. Am. Ins. Ass'n v. Kentucky Bar Ass'n, 917 S.W.2d 568, 573 (Ky. 1996).
101. *Id.* at 571.
102. *Id.* at 573. *See also* Section II.A *infra*.
103. *Id.* at 571.

II. TEXAS CASE STUDY: *AMERICAN HOME ASSURANCE CORPORATION V. UNAUTHORIZED PRACTICE OF LAW COMMITTEE*

A. OVERVIEW OF THE *AMERICAN HOME ASSURANCE* CASE: TRIAL AND APPELLATE COURT OPINIONS

On May 20, 2002, Judge Gary Hall of the 68th District Court in Dallas, Texas held that the use of in-house counsel by insurance companies to defend its policy holders constitutes the unauthorized practice of law.[104] In this case, American Home and Travelers sought a declaratory judgment against the Unauthorized Practice of Law Committee (UPLC), a state agency authorized to police against the unauthorized practice of law, that the use of in-house counsel by insurance companies in the representation of its policy holders in liability claims does not constitute the unauthorized practice of law by a corporation. The UPLC counterclaimed for a declaratory judgment and injunction enjoining American Home and Travelers from continuing the use of in-house counsel in defense claims.

Notably, a similar suit was filed in a Texas federal court to answer the question of whether the use of staff attorneys to defend insureds constitutes the unauthorized practice of law.[105] In that case, the Fifth Circuit applied the principles of Pullman abstention to dismiss the case.[106] The Fifth Circuit held that the Texas State Bar Act was "fairly susceptible to a reading that would make it unnecessary for [the court] to rule on the federal constitutionality of its unauthorized practice of law provisions."[107] Thus, choosing an alternative venue, American Home and Traveler's filed suit in Texas state court seeking a declaratory ruling on the issue.

Under the liability policies of both American Home and Traveler's, it was provided that "the insurer promises to defend and to indemnify the insured against certain risks up to stated limits of liability."[108] Prior to that case, the Texas Supreme Court held that a liability policy may grant to the

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104. Martinez, *supra* note 5, at 1011 (citing Am. Home Assurance Co. v. Unauthorized Practice of Law Comm., No. DV-99-08673-C (68th Dist. Ct. Dallas County, Tex., May 20, 2002)).

105. Nationwide Mut. Ins. Co. v. Unauthorized Practice of Law Comm., 283 F.3d 650 (5th Cir. 2002).

106. *Id.*

107. *Id.* at 657.

108. Am. Home Assurance Co. v. Unauthorized Practice of Law Comm., 121 S.W.3d 831, 834 (Tex. App. 2003).

insurer the right to take complete and exclusive control over the insured's defense, as is granted American Home and Travelers in their present policies.[109] However, despite other state's interpretations of the *Montgomery* decision,[110] the Texas Supreme Court has been notably silent on the issue of whether insurance companies can hire its own attorneys to defend such claims.

In seeking a declaratory judgment, American Home and Travelers argued that the use of in-house counsel is permissible because although defense counsel has a duty to both the insured and the insurer, there is no conflict of interest because the interests of the insured and the insurer are aligned.[111] In addition, the insurers argued that it does not constitute the unauthorized practice of law by a corporation.

Under Texas law, no corporation may transact business if one or more of its purposes is to engage in any activity which it "cannot lawfully be engaged in without first obtaining a license under the authority of the laws of [Texas] to engage in such activity and such license cannot lawfully be granted to a corporation."[112] The relevant case law specifically states that "[w]hen a staff or outside attorney represents his or her corporation's interest in a matter, the corporation is not practicing law."[113] The principle purpose underlying the prohibition of the unauthorized practice of law arises from "a perceived need to protect individuals and the public from the mistakes of the untrained and the schemes of the unscrupulous, who are not subject to the judicially imposed disciplinary standards of competence, responsibility and accountability."[114] Based on this provision, the practice of law by a corporation as its primary purpose is unlawful.

In challenging the UPLC's claims, American Home and Travelers argued that its purposes (i.e. the purposes of the insurers) are not to practice law, but to indemnify insureds; "the agreement to defend and pay attorneys fees for the insured is purely contractual and collateral to that purpose."[115] As a result, their use of staff attorneys to defend claims brought against their policyholders does not constitute the unauthorized practice of law by a

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109. State Farm Mut. Auto. Ins. Co. v. Traver, 980 S.W.2d 625 (Tex. 1998).

110. *See supra* note 61 and accompanying text.

111. *Am. Home Assurance Co.*, 121 S.W.3d at 835.

112. TEX BUS. CORP. ACT ANN. art. 2.01(B)(2005).

113. *Am. Home Assurance Co.*, 121 S.W.3d at 832.

114. V.T.C.A., GOVERNMENT CODE § T. 2, Subt. G, App. A, Art. 10 § 9, Rule 5.05 cmt.1.

115. Am. Home Assurance Co. v. Unauthorized Practice of Law Comm., 121 S.W.3d 831, 839 (Tex. App. 2003).

corporation. Because defense counsel is acting on behalf of the insured, defense counsel's actions as employees of the insurer are merely secondary to the insurer's primary purpose of indemnifying insureds. American Home and Travelers argued that although there remains the concern for potential conflicts of interest, nothing distinguishes the use of in-house counsel with the use of outside defense counsel. American Home and Travelers supported their argument by noting that other jurisdictions have upheld the tripartite relationship on similar arguments of "dual representation."[116]

In opposition, at both the trial and appellate court levels, the UPLC argued, among other things, that the conduct of American Home and Traveler's constitutes the unauthorized practice of law because such action violates the principle that a corporation cannot practice law in the State of Texas.[117] Based on an alternative reading of Texas corporate law, the UPLC argued that because staff attorneys report directly to supervisors who are not authorized to practice law and because their primary purpose is to represent third party claims against insureds, American Home and Traveler's are engaged in the unauthorized practice of law; the insurers are rendering legal advice and appearing on behalf of third parties in court through the actions of their in-house counsel.[118] The Texas Appellate Court summarized the UPLC's argument as follows: "The UPLC's statutory and case-law argument is based on the following syllogism: (1) a corporation cannot practice law; (2) staff attorneys, whose sole client is the insured, are agents of the insurance corporation; and (3) therefore, the insurance company is practicing law."[119]

At the trial court level, Judge Gary Hall agreed with the UPLC and held that this practice constitutes the unauthorized practice of law because it violates the ban on corporations practicing law.[120] On appeal, however, the Texas Appellate Court reversed, holding that the use of in-house counsel does not violate the Texas Disciplinary Rules of Professional Conduct nor the ban on corporations practicing law. First, the Texas Appellate Court held that the status of in-house counsel as employees of

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116. *See, e.g.,* Shelby Mut. Ins. Co. v. Kleman, 255 N.W.2d 231, 235 (Minn. 1977); Mitchum v. Hudgens, 533 So. 2d 194, 198 (Ala. 1998).

117. *See* Martinez, *supra* note 5, at 1011.

118. *Id.* at 1029.

119. *Am. Home Assurance Co.*, 121 S.W. 3d at 836.

120. Martinez, *supra* note 5, at 1011 (citing Am. Home Assurance Co. v. Unauthorized Practice of Law Comm., No. DV-99-08673-C (68th Dist. Ct. Dallas County, Tex., May 20, 2002)).

the insured was not an irreconcilable conflict, and noted that there was no distinction between the use of in-house counsel and the use of outside defense counsel. In both cases, the *insurer* is not subject to Texas Disciplinary Rules of Professional Conduct because corporations are not subject to these rules.[121] However, in both cases, the *attorneys*, regardless of whether they are staff attorneys or outside counsel, are subject to the Disciplinary Rules of Professional Conduct. Therefore, the Texas Appellate Court held, there is nothing on its face that makes the use of in-house counsel unethical. In so holding, the Court relied on opinions by both the ABA and the Texas Ethics Committee.[122]

The Texas Appellate Court then addressed the issue of whether Texas is a "one client" or "two client" state and the Court noted that the Texas Supreme Court has not expressly decided this issue. While the Texas Supreme Court previously held that "the lawyer owes unqualified loyalty to the insured" and "the lawyer must at all times protect the interests of the insured if those interests would be compromised by the insurer's instructions," this does not necessarily mean that Texas is a one client state.[123] Nor did the Texas Appellate Court seem to infer that this determination was necessary to deciding the issue at hand.

The Texas Appellate Court next addressed the UPLC argument that the use of in-house counsel by insurers violates state corporate law because it violates the rule that corporations cannot practice law.[124] Essentially, the UPLC argued that because staff attorneys are the employee-agents of the insurer, when staff attorneys represent insureds, the insurer is practicing law through the actions of its employee-agents. The Texas Appellate Court rejected this argument on grounds of *stare decisis*. Instead, the Texas Appellate Court decided that the use of in-house counsel does not violate state corporate law because the purpose of an insurance company is to defend and indemnify its insureds; "when [an] insurance company provides a staff or outside attorney to the insured, it is seeking to protect its own

121. Am. Home Assurance Co. v. Unauthorized Practice of Law Comm., 121 S.W.3d 831, 837 (Tex. App. 2003).

122. *Id.*

123. *Id.* at 838. It should be noted that whether a state is a "one client" or "two client" state is not necessarily indicative of whether the state will permit the use of in-house counsel by insurers. While the UPLC seems to argue (incorrectly, I believe) that because Texas is a "one client" state, the use of in-house counsel is therefore prohibited. In fact, other jurisdictions that do consider themselves to be "one-client" states have held that the use of in-house counsel by insurers does not constitute the unauthorized practice of law. *See, e.g., In re Youngblood*, 895 S.W. 2d 322, 330-31 (Tenn. 1995).

124. *See* TEX BUS. CORP. ACT ANN. art. 2.01(B)(2005).

interests."[125] Ultimately, the Texas Appellate Court based its decision on the fact that the insurer has a direct financial interest in the litigation brought against its insureds by third parties. Because of this legitimate business purpose, it does not constitute the practice of law by a corporation and therefore is not the unauthorized practice of law.

B. PENDING CASE BEFORE THE TEXAS SUPREME COURT

Oral argument was heard in this case before the Texas Supreme Court on September 28, 2005.[126] Since the case was set for oral argument on August 29, 2005, at least seven amicus curiae briefs were received by the Texas Supreme Court and placed with the record. As of the Fall of 2006, a decision by the Texas Supreme Court was still pending.

IMPLICATIONS AND CONCLUSION

With a decision pending, it is difficult to speculate as to how the Texas Supreme Court will decide. It is, however, possible to opine as to how the Texas Supreme Court *should* decide. As it has been discussed throughout this Comment, there are several ethical and legal concerns with the use of staff attorneys by insurers in representing third party claims against insureds. Yet despite the potential for these ethical and legal dilemmas, individuals continue to purchase liability insurance policies and insurance companies (in the vast majority of states) continue to hire staff attorneys to defend third party claims brought against their policyholders. The Texas Supreme Court should uphold the decision of the Texas Appellate Court and hold in accord with the overwhelming majority of other jurisdictions that have previously decided this issue because the use of staff attorneys to represent third party claims against insureds does not constitute the unauthorized practice law and is not *per se* unethical. Ultimately, if the State of Texas wants to ban the use of staff attorneys in insurance defense, then the Texas Legislature should adopt legislation to that extent.

The unauthorized practice of law argument is, in my opinion, unpersuasive for two reasons, both of which have been previously referenced. First, it is hard to distinguish between the use of staff attorneys and the use of outside counsel. If a corporation can engage in the

125. *Am. Home Assurance Co.*, 121 S.W.3d at 842.

126. Texas Judiciary Online, Case Search Results on Case # 04-0138, *available at* www.supreme.courts.state.tx.us/opinions/Case.asp?FilingID=24713.

unauthorized practice of law through the acts of its employees as well as the acts of its independent contractors, why is it solely the use of staff attorneys which is being challenged on grounds that it constitutes the unauthorized practice of law? Wouldn't it follow that there should be a ban on all instances where an insurer is paying for the legal fees of their insured? In all such cases, the insurer would be hiring attorneys (either as employees or independent contractors) to represent their policyholders and in all such instances there would be the concern that the insurer could be "practicing law" through its attorneys. If that is the case, it seems highly impractical and inefficient to create such a ban, particularly when the insurer has a financial interest in adequately providing representation for its insureds.

In addition, stemming from this, the unauthorized practice of law argument also undermines the ability of individuals to enter private contracts. As was previously stated, liability insurance policies are designed to protect individuals from potential liabilities. By collecting premiums and taking on the duty to defend insureds, insurers subsequently inherit a direct, pecuniary interest in any and every claim brought against their policyholders. As a general premise, it would seem that both contracting parties are getting what they bargained for.

In many ways, the conflict of interest issues seem far more disconcerting and bothersome than the unauthorized practice of law challenges because they call into question the ability of attorneys to ethically represent their clients. One could imagine that conflicts would regularly arise whereby an attorney would be torn between its client, the insured, and his or her employer, the insurer. Again, this tension exists regardless of whether the attorney is a staff attorney or outside counsel, for ultimately in both cases it is the insurer who is paying the attorneys fees. Yet although there is the *potential* for conflict, the presence of actual conflict appears to be minimal, perhaps even non-existent. As a result, it would seem that a *per se* prohibition on the use of staff attorneys would be unnecessary to avoid potential conflicts of interest for staff attorneys.

In light of the Model Rules, it is not necessary to create a prophylactic device prohibiting the use of staff attorneys. All attorneys, including insurers' staff attorneys, are governed by the Rules of Professional Responsibility and because of this, the Texas Supreme Court should hold in accordance with the majority of jurisdictions and uphold the decision of the Texas Appellate Court. If a staff attorney acts unethically, then he or she should face repercussions for those actions, as would any other attorney. It should not, however, be presumed that a staff attorney will act unethically

and that, therefore, all staff attorneys should be prevented from representing insureds.

If the Texas Supreme Court were to hold that the use of staff attorneys constitutes the unauthorized practice of law and/or is unethical, such a decision could potentially impact other jurisdictions and, potentially, the entire insurance industry. Further, because several of the majority courts rely upon the *Montgomery* case,[127] it would be interesting to see what impact this decision would have upon those cases if the Texas Supreme Court finds that the use of staff attorneys by insurers constitutes the unauthorized practice of law or is unethical. Potentially, it could allow courts that have relied upon *Montgomery* to revisit the issue.

Given the current state of the case law on this topic, it seems unlikely that the Texas Supreme Court will hold that a *per se* prohibition is necessary. Ultimately, insurance companies are able to offer lower premiums because they can pay lower rates to hire staff attorneys rather than outside counsel to represent their insureds. The individual ethical responsibilities of attorneys should be taken seriously and, in the event that an attorney violates his or her responsibilities to the insured, there should be consequences for that attorney. The potential for ethical concerns, however, does not mean that the Texas Supreme Court should create a *per se* prohibition on the use of staff attorneys in insurance defense.

127. *See supra* Part II(C)(1).