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A "GENETICALLY MODIFIED" LIABILITY INSURANCE CONTRACT

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ABSTRACT

This article uses the new technique of genetic programming to discover liability insurance contracts that, in theory, would substantially reduce the effective cost of accidents faced by potential insureds. Specifically, it suggests using formulas containing statistics about the distribution of damages in lawsuits brought against the insured as a way of customizing the per occurrence limit on a case-by-case basis. It further suggests permitting the insurer to modify the conventional duty to settle that American judges have implied into most liability insurance contracts. This modification would permit statistics regarding the distribution of damages expected in a lawsuit materializing against the insured to control the details of any duty to settle. It shows the advantage to the insured of letting lawsuit-specific statistics determine the settlement offer needed to trigger the duty and the maximum amount owed by the insurer in the event it were to breach the duty to settle. The article concludes, however, that capture of the significant savings available in theory from any of these reforms will be extraordinarily challenging due to the absence of procedural mechanisms that would be needed to resolve disputes arising thereunder. Moreover, one should expect potential victims to object that these "genetically modified" insurance contracts reduce their ability to be fully compensated for injuries through the tort system.

INTRODUCTION

The typical liability insurance contract describes broad classes of lawsuits that might befall an insured, and generally obligates the insurer to pay for damages assessed against the insured in that lawsuit up to a certain "per occurrence limit." Although the contract may apply different per occurrence limits depending on various characterizations of the lawsuit, this categorization tends to be quite coarse and based on verbal descriptions of the lawsuit against the insured, such as whether it constitutes "personal and advertising injury" or not. The "statistical" characteristics of the likely damages assessed in that lawsuit, such as the expected amount of damages that will be assessed or the standard deviation of the expected distribution of damages are not used in any direct way to more finely unbundle each class of lawsuits or to more finely fix the per occurrence limit.

Also included in the liability insurance relationship, although generally as a matter of law rather than as a matter of contractual language, is a "duty to settle." Formulation of the duty varies from state to state. Generally, however, it requires liability insurers to accept settlement offers extended by the plaintiff that are "reasonable" and that would cost the insurer less than the per occurrence limit of the liability insurance policy. The law enforces the duty by subjecting insurers who violate it to the possibility of an extremely large obligation.[1] By way of example, the failure of a liability insurer that issued a small liability insurance policy with $10,000 per occurrence limits to accept a $9,000 settlement offer can require the insurer to pay $1 million or more in the event a judgment in that amount is rendered against the insured. This is true even if the insured could not hope ever to pay anything close to $1 million.[2] In some jurisdictions, this is true

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1. The theories behind the duty are as varied as the formulations of the doctrine, but they generally rely on hostility towards what is regarded as "selfish" behavior by an insurer who is thought to owe a duty of good faith to its insured. The notion is that, if the duty did not exist, rational (greedy) insurers would turn down "reasonable" settlements that the insured would desperately want them to accept because the insurer would discount any judgment in excess of the policy limit – the sort that bankrupt insureds – down to the policy limit. Violating this duty is sometimes seen as a species of "bad faith" by the insurer, which is tortious in many states.

2. *See* Med. Mut. Liab. Ins. Soc'y of Md. v. Evans, 622 A.2d 103, 114–16 (Md. 1993) (discussing the "majority rule" that damages bear no relation to an insured's wealth, and citing cases); Ganaway v. Shelter Mut. Ins. Co., 795 S.W.2d 554, 563–64 (Mo. Ct. App. 1990) (finding a specific clause in typical liability insurance contract prevents insurer's attempt to escape liability for breach of duty to settle on theory that insured was now bankrupt).

even if the insurer had a *bona fide*, though, as it turned out, erroneous, belief that there was no coverage under the policy at all.[3] The duty is difficult if not impossible for the insured to waive or disclaim,[4] and appears to exist notwithstanding the sophistication of the insured[5] or the purchase or availability of excess insurance to cover lawsuits larger than the policy limits.[6] The duty clearly exists, not only in the United States, but also in

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3. *Compare* Mowry v. Badger State Mut. Cas. Co., 385 N.W.2d 171, 180–81 (Wis. 1986) (no breach of duty to settle where coverage for claim was "fairly debatable"), *with* Johansen v. Cal. State Auto. Ass'n Inter-Ins. Bureau, 538 P.2d 744, 748 (Cal. 1975) ("an insurer's 'good faith,' though erroneous, belief in noncoverage affords no defense to liability flowing from the insurer's refusal to accept a reasonable settlement offer"). A compendium of cases addressing this issue may be found in STEPHEN S. ASHLEY, BAD FAITH ACTIONS: LIABILITY AND DAMAGES §§ 4:11, 4:13 (2d ed. 1997 & Supp. 2007) (addressing "[d]isputed coverage and insurer's duty to settle . . . [w]hen the insurer considers coverage issues in responding to settlement offers"). A leading treatise suggests that *Johansen* represents the prevailing rule in the United States, though it is not at all clear that this is correct. 22 ERIC MILLS HOLMES, HOLMES' APPLEMAN ON INSURANCE 2D § 137.3[F], at 156 (2003).

4. One could argue that this is an overstatement, because I have discovered no cases or treatises that address whether an adequately clear and conspicuous provision disclaiming any duty to settle would be enforced. I suspect, however, that the absence of case law on the subject may reflect a consensus in the industry that courts would not enforce such a waiver, except perhaps with a sophisticated insured placed on clear notice.

5. One example of the doctrine being applied in favor of a sophisticated insured is litigation in Mississippi between National Union Fire Insurance Company of Pittsburgh, the liability insurance carrier, and its insured, American Management Systems, Inc., a corporation with billions of dollars in assets, risk management experts and various intermediaries who helped it purchase a coordinated stack of liability insurance policies. National Union, it was alleged, failed to take advantage of opportunities to settle a case against American Management for allegedly defective tax collection software it was building for the state of Mississippi. AMS's liability to Mississippi ended up being $185 million, an amount higher than the stack of insurance policies AMS had purchased. National Union ended up paying $43 million to resolve the suit brought against it for breach of the duty to settle. For various documents describing the case and settlement, see *AMS Settles Insurer Suit,* WASH. TECH., Oct. 22, 2001, http://www.washingtontechnology.com/news/16_15/datastream/17323-1.html; American Management Systems Inc., Quarterly Report (10-Q) (Nov. 14, 2001), http://sec.edgar-online.com/2001/11/14/0000950133-01-503274/Section10.asp.

6. No case could be found directly supporting this proposition, so there may be room for the courageous to argue that the availability of excess insurance defeats a duty to settle. There would be two very serious impediments to such an argument, however. The first is that it is simply obvious that, due to the pervasiveness of the excess insurance market and the sophistication of many insureds involved in duty to settle matters, excess insurance was available in many of the cases in which the duty was found. The second obstacle is the one focused on in this article, which is that the insured should not have to purchase "excess insurance" and thereby obtain high per occurrence protection against liability in order to obtain protection against "selfish" insurer behavior during settlement negotiations.

British Columbia,[7] and possibly Ontario.[8] It apparently does not exist (or at least has not been clearly established), however, in a number of countries with advanced commercial and insurance markets, including Australia and Great Britain.[9]

In contrast with the per occurrence limit of the typical liability insurance policy, the duty to settle responds indirectly to statistical characteristics of the lawsuit. The "reasonableness" of a settlement offer is often tied to the expected value of damages assessed against the insured: settlement offers above the expected value of damages are generally not "reasonable."[10] But the duty to settle is also locked in to a statistically invariant policy limit. Offers that would require the insurer to pay more than its "per occurrence limit" generally do not trigger a duty to settle[11] regardless of the statistical characteristics of the lawsuit.

This article examines whether insurers and courts could construct a better liability insurance contract by changing, either individually or in tandem, two features of the current relationship: (1) facilitating use by the insurer and insured of statistical characteristics of the particular lawsuits that manifest themselves under a liability insurance policy to modify the

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Therefore, both as a matter of tradition and policy, an argument centered on the availability of excess insurance is unlikely to succeed.

7. *See* Shea v. Manitoba Pub. Ins. Corp., [1991] 55 B.C.L.R.2d 15.

8. *See* Bond's Décor v. Smith, Petrie, Carr & Scott Ins. Brokers, [2000] 17 C.C.L.I.3d 266 (Ontario Superior Court of Justice apparently acknowledges the existence of a duty to settle, but refuses with some reluctance to strike the insurer's defense that the insured had suffered no loss as a result of any refusal to settle because the insured had no assets with which to satisfy the judgment).

9. E-mails from experts available from author. The doctrine also does not exist in New Zealand or China.

10. *See* ALLAN D. WINDT, 1 INSURANCE CLAIMS AND DISPUTES § 5:1 (4th ed. 2006) (illustrating expected value computation); Seth J. Chandler, *Reconsidering the Duty to Settle*, 42 DRAKE L. REV. 741, 767–71 (1993); Alan O. Sykes, *"Bad Faith" Refusal to Settle by Liability Insurers: Some Implications of the Judgment-Proof Problem*, 23 J. LEGAL STUD. 77, 79, 90 (1994).

11. *See* Motorists Mut. Ins. Co. v. Glass, 996 S.W.2d 437, 453–54 (Ky. 1997); Am. Physicians Ins. Exch. v. Garcia, 876 S.W.2d 842, 848–49 (Tex. 1994); Beck v. Kelly, 323 So. 2d 667 (Fla. Dist. Ct. App. 1975). To be sure, it is sometimes said that "[a]n insurance company is not relieved of its duty to settle simply because the only settlement offer made by the complainant is in excess of the policy limits." WINDT, *supra* note 10, § 5:7. If one reads these accounts more carefully, however, it is clear that (a) there is no case requiring an insurer to pay more than the policy limit in response to a settlement offer exceeding the policy limit and that (b) the "duty to settle" referred to in these passages is a lesser one, simply requiring communication with the insured and some effort to secure a settlement lower than policy limits.

per occurrence limits applicable to the occurrence and, (2) developing a more sophisticated duty to settle. In the more sophisticated duty to settle, the extra amount the insurer potentially owes in the event it rejects a settlement offer is something significantly less than the infinite amount it now can owe. Moreover, the insurer's "safe harbor" against this extra liability does not begin with settlement offers greater than the per occurrence limit but at some readily negotiated dollar figure.

It concludes that, if transaction costs could be overcome, incorporation of statistical concepts into liability insurance contracts could save large amounts of money. Use of statistical characteristics to fine tune per occurrence limits could reduce effective accident costs by 7% using relatively simple statistics, or upwards of 10% using statistics requiring more information about the underlying lawsuit. Reforming the duty to settle likewise has the potential to reduce the effective accident costs faced by insureds on the order of 9% if the contract cannot respond to statistical characteristics of the lawsuit that materialize, and by upwards of 11% if statistical characteristics can be used. Given that liability insurance premiums worldwide are hundreds of billions of dollars every year, the theoretical savings involved have an immense present value, perhaps on the order of half a trillion dollars. The consequence of both reforms is likely to be more frequent purchases of liability insurance, thus reducing some risk to accident victims, but less money available to victims of insured individuals. Thus, although the reforms suggested here definitely work in the interest of insureds, they exacerbate current issues by virtue of the fact that we generally permit people to engage in activities that potentially cause far more damage than they can ever pay for, and do so without requiring them to purchase adequate insurance.[12]

We must also conclude, with some regret, that actual use of statistical concepts in liability insurance contracts will likely need to await new mechanisms for resolution of insurance coverage disputes. We are, in a large sense, held multi-billion dollar hostages to the difficulty our current legal system would have in properly measuring and determining the statistical characteristics of lawsuits needed to implement the reforms suggested here. We do not have procedures in place to accomplish the

12. Compulsory liability insurance is quite rare in the United States. Even in the main domain in which it exists, automobile liability insurance, the amount potential tortfeasors are required to carry is but a fraction of the potential harm they can easily cause. Other methods such as social disability insurance, some unemployment insurance and some government-subsidized health programs are used to mildly reduce the risk of being injured by a tortfeasor with inadequate conventional assets and inadequate liability insurance.

task. We thus face a chicken-and-egg problem: parties to insurance contracts are unlikely to incorporate statistical concepts into their contracts absent the development of satisfactory dispute resolution mechanisms, and sophisticated dispute resolution mechanisms are unlikely to evolve absent reliance on statistical concepts in liability insurance contracts.

Methodologically, it should be noted that the article introduces to the legal literature the relatively new mathematical technique of "genetic programming."[13] This technique, in which one synthetically evolves mathematical functions in a fashion not conceptually dissimilar from that of natural selection, permits functional optimization on complex problems such as that presented here in ways difficult to achieve using more traditional optimization technology such as calculus. The technique should prove useful not only to those doing research on insurance law or insurance theory, but on the bevy of complex optimization problems that are currently avoided because of the inability to derive the cherished closed form solution using traditional techniques.

Part I of this article demonstrates that the insured could theoretically benefit from a further unbundling of lawsuits covered by a liability insurance contract so that different per occurrence limits would apply based on statistical characteristics of the lawsuit. Part II of this article confirms that the current duty to settle in fact benefits insureds but shows how a more nuanced duty to settle – and one that would be relatively simple for courts and insurers to implement – could further enhance insured welfare. It further shows how combining these two reforms – creation of liability insurance contracts that respond to statistical characteristics of the lawsuit that befalls the insured and creation of a more sophisticated duty to settle – could seriously reduce the effective cost of accidents faced by an insured. Part III of the article steps back and discusses the problems in actually capturing the theoretical savings suggested by the findings of this article.

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13. The definitive work on genetic programming is JOHN R. KOZA, GENETIC PROGRAMMING: ON THE PROGRAMMING OF COMPUTERS BY MEANS OF NATURAL SELECTION (1992). Other valuable works include CHRISTIAN JACOB, ILLUSTRATING EVOLUTIONARY COMPUTATION WITH MATHEMATICA (2001) and WILLIAM B. LANGDON & RICCARDO POLI, FOUNDATIONS OF GENETIC PROGRAMMING (2002).

I. BASING PER OCCURRENCE LIMITS ON STATISTICS DERIVED FROM THE DISTRIBUTION OF DAMAGES IN THE LAWSUIT THAT MATERIALIZES

A. THE CURRENT USE OF STATISTICS IN DETERMINING LIABILITY INSURANCE PER OCCURRENCE LIMITS

Right now, by their terms, few liability insurance policies have "lawsuit sensitive" payment clauses. The maximum amount owed by the insurer for an occurrence or claim does not depend on the statistical properties of the lawsuit that materializes against the insured. Nor does it depend on any subsequent alterations of those statistical properties that materialize by virtue of settlement offers that, if accepted, would narrow the distribution of potential outcomes in that suit.[14] Under the language of existing liability insurance contracts, the insurer's obligation to pay does not depend on what *might* have happened in a lawsuit, on the distribution of judgments that *might* have materialized, but rather on what *did* happen: the judgment rendered or the settlement reached. Almost all liability insurance contracts sold for the past one hundred years have the same two dimensional "shapes." The insurer pays the amount the insured becomes legally obligated to pay as damages for a certain class of lawsuits up to a certain limit.[15] Thus, if one draws the payment by the insurer as a function of the amount of damages, the plot almost invariably is conceptualized to look something like this:  .[16] An insurer cannot, for example, reduce the amount it pays on behalf of the insured by proving that there was a good chance that the judgment would be much higher or on grounds that

14. Traditionally, settlement offers narrow the range of possible outcomes to a single value, the "amount" of the offer. But this need not be the case. Some settlement offers, such as those made in "high-low arbitration" narrow the set of outcomes to some truncated range. Others, such as "Final Offer (baseball) arbitration," may narrow the set of possible outcomes to two points.

15. Although they certainly exist, deductibles and coinsurance in traditional primary liability insurance tend, when they exist, to be rather small.

16. The most interesting thing about this shape has nothing to do with its detail but rather its dimensionality. Like the inhabitants of Abbott's Flatland, we believe, without thinking about it much, that the insurance relationship exists in but two dimensions. EDWIN ABBOTT, FLATLAND: A ROMANCE OF MANY DIRECTIONS (Dover Publ'ns 1953) (1884). A judgment is entered against the insured and the size of that judgment determines how much the insurer owes. This article is going to suggest that we escape Flatland and develop insurance functions that cannot be readily compressed into two dimensions, but that account for various statistical features of the lawsuit that materializes.

the plaintiff refused to settle the case. The payment "formula" implicitly contained in the insurance contract basically has a single variable: the amount owed by the insured as damages.

This refusal of the contract to vary policy limits based on statistical properties is somewhat odd. As a general principle, it is a good idea to create contracts that are sensitive to any new information that may develop while awaiting performance, at least where renegotiation of the contract, as in many settings, will prove difficult.[17] The point can be easily illustrated with an example a bit far afield from traditional insurance law. Suppose I face the possibility that it will either snow tomorrow or be warm and sunny (perhaps I am living in Colorado). I could enter into a contract with a rental car company that gave me a standard sedan tomorrow for a certain price on the theory that the sedan would be adequate in either snow or sun and had good gas mileage. It would be better, however, if I could enter into a contract that provided I would receive a four-wheel drive vehicle in the event of snow, and a convertible in the event of sun. Now, truth be told, it would not be so bad for me to enter into the first unconditional contract if, after learning the weather, I could easily renegotiate it. But if, as might be the case for a variety of reasons, renegotiation would prove difficult after the materialization of the contingency, an original contract that provided for differential performance based on the contingency would be superior.[18] And, obviously, liability insurance is an example of the sort of contract that is notoriously difficult to renegotiate after the materialization of a lawsuit.[19]

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17. *See* Herbert A. Simon, *A Formal Theory of the Employment Relationship*, 19 ECONOMETRICA 293, 304 (1951) (discussing advantages in contracting to waiting until uncertainties are resolved).

18. A situation "where agents are asked to make decisions when unforeseen events occur, but cannot renegotiate the contract" is sometimes referred to as an "*ex post* hold-up." W. Bentley MacLeod, *Complexity and Contract*, *in* THE ECONOMICS OF CONTRACTS: THEORIES AND APPLICATIONS 213, 213 (Eric Brousseau & Jean-Michel Glachant eds., 2002) (discussing the terminology and the theoretical implications of this scenario).

19. The premium one must pay after a loss often proves prohibitively high, and there are various legal doctrines, such as the "known loss" doctrine, that courts or commentators occasionally cite to prevent renegotiation even when the parties desire it. *See* Michael Sean Quinn, *Fortuity, Insurance, and Y2K*, 18 REV. LITIG. 581, 616 (1999) ("It would be remarkable to suggest that under those circumstances an insured can purchase liability insurance for a known liability when it is only the amount of the loss that has not been fixed."). Other courts view as inappropriate, at least in some circumstances, renegotiation of an insurance contract in a way that reduces policy limits after an accident has occurred. *In re* Allied Prods. Corp., No. 03 C 1361, 2004 WL 635212 (N.D. Ill. Mar. 31, 2004). It is not clear why, at least absent reliance on the part of the plaintiff, it should be unlawful for

Moreover, it is not as if the notion of lawsuit sensitive insurance contracts is one entirely alien to the industry. Many liability insurance contracts, after all, have different per occurrence limits based on *non-statistical* properties of the lawsuit: limits for "personal and advertising injury," for example, often differ from those for other lawsuits.[20] Indeed, if one can surmount the technicality that the clauses are written as "exclusions" from coverage rather than as "zero limits," insurance contracts often effectively contain wildly different policy limits depending on non-statistical properties of the lawsuit, such as whether it arises out of pollution[21] or whether the insured has cooperated fully with the insurer in the defense of a lawsuit.[22]

Indeed, an argument can be made that the typical liability insurance relationship, at least as courts implement it, *already* contains a payment obligation that is sensitive to the statistical properties of the lawsuit. The duty to settle, with its reliance on the "reasonableness" of settlement offers, implicitly relies on the notion of the expected value of a lawsuit. This is so because a settlement offer that is more than the frequency weighted average of the damages assessed against the insured at trial is almost certainly unreasonable. Indeed, one could write the current duty to settle as setting the per occurrence limit of insurance at some value c unless there is a settlement offer both less than some function of the damages distribution and less than some safe harbor threshold value t (which the current duty to settle happens to set equal to the constant c), in which event the per occurrence limit is infinite.

The duty to settle thus should give us confidence that it is not impossible to base contractual provisions on statistical compressions of the distribution of damages that might result from a lawsuit. So, the question

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insureds to renegotiate limits downwards following an accident when insurance is not compulsory in the first place.

20. The widely used current form of the Insurance Services Organization provides for different limits for damages caused by personal and advertising injury than for other forms of damages. Specimen copies of recent ISO forms may be found in two popular casebooks: KENNETH S. ABRAHAM, INSURANCE LAW AND REGULATION: CASES AND MATERIALS 442 (Foundation Press 2d ed. 1995) and TOM BAKER, INSURANCE LAW AND POLICY: CASES, MATERIALS, AND PROBLEMS 411 (Aspen Publishers 2003).

21. A concise history of the pollution exclusion in liability insurance policies may be found in Timothy M. Gebhardt, *A "Timeless" Interpretation of the "Sudden and Accidental" Exception to the Pollution Exclusion?*, 41 S.D. L. REV. 314 (1996).

22. A useful summary of cooperation clause jurisprudence may be found in WINDT, *supra* note 10, § 3:2, at 66.

arises whether greater use of statistical measures might not be appropriate, even in such a basic feature as the per occurrence limit of liability.

The discussion on this point proceeds in two phases. I first demonstrate that it would, in the abstract, be a "good thing" if liability insurance contracts were highly sensitive to the distribution of damages that might befall its insured in litigation. I do this by creating a tiny two-lawsuit portfolio of potential liability and demonstrating that a contract that provided for different per occurrence limits for each of the two lawsuits would be superior to a contract that provided for a single, unified per occurrence limit. I then use "genetic programming" to determine whether, as any sort of practical matter, a contractual provision could be drafted that based the per occurrence limit on statistical compressions of that damages distribution.

To be sure, the apparent absence of such clauses gives rise to the suspicion that few obvious improvements are possible in the same way that the rarity of mammals with three eyes might imply but does not prove that the addition of an extra optical sensor would not improve performance. Or perhaps there is something particularly problematic with use of statistical properties for determining payment limits under liability insurance policies that confines the currently existing duty to settle in its role as an externally imposed "exotic" in the field of contract law, a seldom invoked safety net against peculiar happenings.

Given the importance of liability insurance, however, to the functioning of the economy,[23] and the centrality of per occurrence policy limits to those contracts, it seems prudent to explore the universe of possibilities. Maybe it would be better, for example, to have a contract that stated that the limit of the policy would be equal to some function of the "standard deviation" of the distribution so that when the standard deviation of a distribution of outcomes was small, either as the lawsuit initially presented itself, or as it so became because of settlement offers, the policy

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23. Worldwide, annual insurance premiums are said to be about $3 trillion. *See* Insurance Information Institute, Commercial Insurance: Introduction, http://www.commercialinsurancefacts.org/commerciallines/introduction/ (last visited Apr. 16, 2007); International Financial Services, London, Insurance: City Business Series, Nov. 2005, at 1, *available at* http://www.ifsl.org.uk/pdf_handler.cfm?file=CBS_Insurance_2005&CFID=359899&CFToken=73003445. It is difficult to come to a precise figure of American liability insurance premiums, but a good ballpark estimate of annual premiums on the sort of insurance contracts likely to be held to contain some sort of duty to settle would be $500 billion. Insurance Information Institute, Property/Casualty: Premiums By Line, http://www.iii.org/financial2/insurance/pcpbl/ (last visited Apr. 16, 2007). This article addresses a contract of immense importance to the economy. *Id.*

limit would be three times what it was otherwise. Perhaps there are far more complex contracts using fancier statistical properties of the distribution of possible judgments in a lawsuit or using combinations of those statistical properties.[24]

B. THE INSURED'S PREFERENCE FOR DISTRIBUTION SENSITIVE LIABILITY INSURANCE POLICIES

1. A Simple Lawsuit Portfolio

I now show that insureds would prefer to have per occurrence limits clauses that depended on the damages distribution of the lawsuit that materializes against them. A more detailed and technical presentation of the mathematics is provided in Appendix II. In particular, consider a lawsuit "portfolio" consisting of two lawsuits: Lawsuit A and Lawsuit B.[25] The two lawsuits are as identical legally as it is possible to be except in the distribution of damages. Indeed, what I wish to show is that, even if we know nothing about the "legal" characteristics of the lawsuit, such as the "peril" implicated, the insured may prefer different limits of insurance based simply on the different distributions.

Figure 1 below shows the different distribution of damages in the two lawsuits that materialize. In Lawsuit A there is a 6/10 probability of a judgment of 0, a 3/10 probability of a judgment of $60,000, and a 1/10 probability of a judgment of $120,000. In Lawsuit B, there is a 1/3 probability of a judgment of $3,000, a 1/3 probability of a judgment of $30,000, and a 1/3 probability of a judgment of $300,000.

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24. Of course it is not really that simple. One would have to figure out whether any aggregate limit or deductible would likewise respond to now variable per occurrence limits that materialized. One would have to figure out how to coordinate this insurance policy with other liability insurance policies, which might themselves have differing formulae for determining the limit in a particular occurrence. One might wish to develop dispute resolution mechanisms to address disagreements in the computation of various formulae on which the per occurrence limit was now based. On the other hand, as I shall argue, we really do all of these things now but do so without guidance from the contract as part of the "duty to settle." An explicitly distribution variant contract might simply make more transparent the utility of resolving these various contingencies using the contract.

25. Lawsuit B, experts in the field may note, is identical to the lawsuit used by Professor Sykes in his work. *See* Sykes, *supra* note 10, at 66. This adoption should facilitate comparisons amongst my work and that of Sykes.

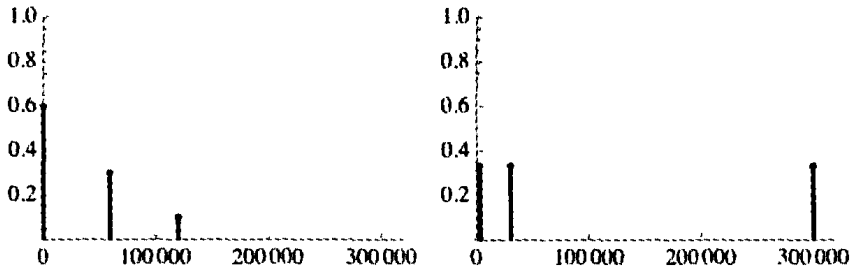

Figure 1

Suppose a contract could be drafted such that the per occurrence limits could vary depending on whether Lawsuit A or Lawsuit B materialized. One can now use expected utility theory to calculate the set of per occurrence limits {c} that best serves the interests of the insured.[26] I can illustrate this process. For concreteness, I assume that the insured has assets of $110,000, of which $100,000 are subject to execution.[27] This means that the insured behaves as if its wealth (after any accidents and any payments by the insurer) is the greater of its actual wealth or $10,000. I

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26. One can now compute the actuarially fair premium $\prod$ for a policy with limit c for this composite lawsuit as follows:

$$\frac{9}{10}\min(0, c) + \frac{1}{20}\left(\frac{3}{5}\min(0, c) + \frac{3}{10}\min(60\,000, c) + \frac{1}{10}\min(120\,000, c)\right) + \frac{1}{20}\left(\frac{1}{3}\min(3000, c) + \frac{1}{3}\min(30\,000, c) + \frac{1}{3}\min(300\,000, c)\right)$$

The coefficients 9/10 and 1/20 result from the 90% probability that no lawsuit will materialize and the 5% probability that Lawsuit A or Lawsuit B will materialize. I can now write the utility of the insured as a gory function of the policy limit c as follows, where wΩ is the minimum amount of wealth the insured can possess, w0 is the initial wealth of the insured, Π is the premium for the policy, and u is the utility function of the insured:

$$\frac{93}{100}\,u[\text{Max}[w\Omega,\ w0 - \Pi + \text{Min}[0,\ c]]] + \frac{1}{60}\,u[\text{Max}[w\Omega,\ w0 - \Pi + \text{Min}[3000,\ c]]] + \frac{1}{60}\,u[\text{Max}[w\Omega,\ w0 - \Pi + \text{Min}[30\,000,\ c]]] + \frac{3}{200}\,u[\text{Max}[w\Omega,\ w0 - \Pi + \text{Min}[60\,000,\ c]]] + \frac{1}{200}\,u[\text{Max}[w\Omega,\ w0 - \Pi + \text{Min}[120\,000,\ c]]] + \frac{1}{60}\,u[\text{Max}[w\Omega,\ w0 - \Pi + \text{Min}[300\,000,\ c]]]$$

27. In undertaking this model, I follow the work of Huberman, Mayers & Smith. *See* Gur Huberman et al., *Optimal Insurance Policy Indemnity Schedules*, 14 BELL J. ECON. 415 (1983).

further assume that the insured has a utility function that exhibits what is known as constant relative risk aversion.[28] And I assume that Lawsuit A has a 5% probability of materializing and that Lawsuit B has a 5% probability of materializing. The remaining 90% of the time, no lawsuit materializes against the insured.

With this information, I can now graph the cost of accidents facing the insured as a function of the per occurrence policy limits. I do this by computing its effective cost of accidents: the difference between the insured's initial wealth and its certainty equivalent wealth with the possibility of lawsuits (as well as liability insurance) taken into account.[29] Certainty equivalent wealth means the amount of wealth that, if held with absolute certainty, would provide the same expected utility to the insured as the expected utility that results from holding the particular insurance policy. We are looking for the combination of per occurrence limits that minimizes the cost of accidents or, equivalently, maximizes the insured's certainty equivalent wealth.

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28. One such function is the natural logarithm function, which I employ here. There is an entire class of constant relative risk aversion utility functions defined by the piecewise function where k is level of risk aversion and x is the level of wealth:

$$\begin{cases} x & k = 0 \\ \log(x)\, c_1 + c_2 & k = 1 \\ \dfrac{c_1\, x^{1-k}}{1-k} + c_2 & k \neq 0 \wedge k \neq 1 \end{cases}$$

29. If eu({c}) is the expected utility of the insured following the purchase of a liability insurance policy, with the set of per occurrence limits {c}, and ieu is the inverse utility function, then the cost of accidents is: $w0 - ieu(eu(\{c\}))$

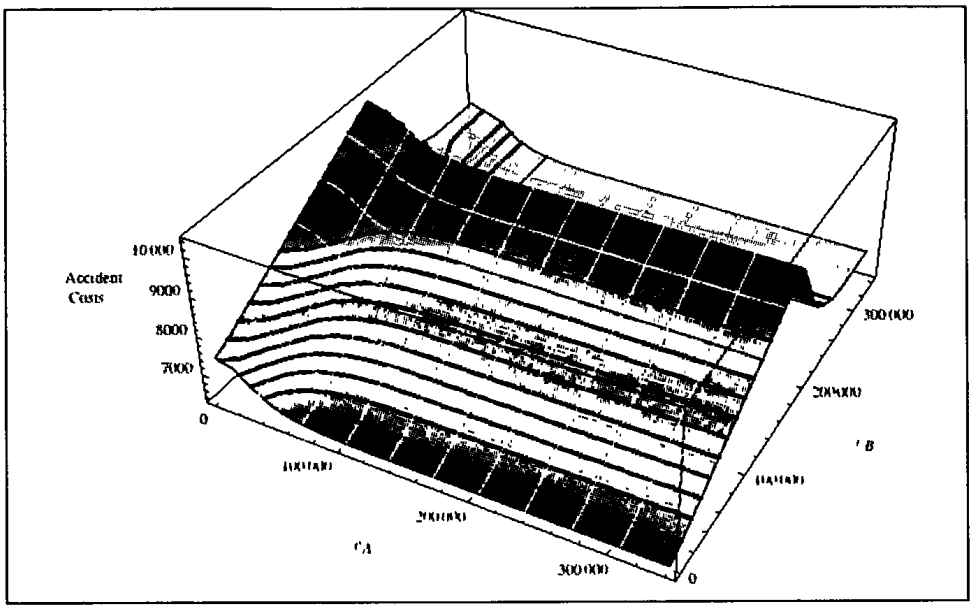

Figure 2

The results of the computation are shown in Figure 2. Notice that the cost of accidents is minimized for this portfolio at about $6336, when the per occurrence limit for Lawsuit A is anything above $120,000 (coverage is full), and the per occurrence limit for Lawsuit B is zero.[30] The insured does not particularly want full coverage for the more fearsome lawsuit because its premium will reflect the fact that the insurer has to pay the full amount of those judgments whereas the insured would only lose limited assets in the event the loss were uninsured. In some sense, the insurance for high amounts is unfairly priced.[31] The optimal insurance contract thus neither fully transfers all inter-lawsuit risk nor all intra-lawsuit risk with respect to Lawsuit B. The insured is better off if no lawsuit or Lawsuit A arises than

30. This is basically a problem in constrained global optimization of a multivariate function. For "ugly" functions such as those involved in the insurance field, in which there are likely to be discontinuities, large numbers of variables and/or large numbers of constraints, the process of finding global optima can be difficult. To insure that the results were correct, I used a variety of algorithms to compute optima, including simulated annealing, differential evolution, and random search. *See* Janos Pinter, Global Optimization, Wolfram MathWorld, http://mathworld.wolfram.com/GlobalOptimization.html (last visited Sept. 20, 2006) (containing an excellent description of various methods of optimization and a list of references).

31. *See* Sykes, *supra* note 10, at 77.

if Lawsuit B arises, and is better off if small judgments materialize in Lawsuit B than if large judgments materialize.

Indeed, if the insured has its way, and if a contract could be written and enforced in a satisfactory fashion, the insured would want zero or even negative insurance for large judgments:[32] the savings in premiums achieved thereby could be used to make the insured wealthier in cases where no lawsuit or a small lawsuit arose.[33] If it could get away with it, the insured

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32. By way of example, the insured's expected costs of accidents under a policy that paid fully for accidents up to $150,000 and paid zero thereafter would result in a cost of accidents of $5705.21, which is considerably lower than the $6336 optimum achievable using insurance contracts constrained to be non-decreasing. The insured's expected cost of accidents under a policy that paid fully for accidents up to $150,000 and required the insured to pay the insurer $90,000 in the event of an accident larger than $150,000 would result in a cost of accidents of $4285.43, assuming that the $90,000 contractual obligation had priority over the tort obligation to the victim in some sort of insolvency proceeding. Indeed, it turns out that one can do even better than this if one relaxes the prohibition against over-insurance. In theory, the insured wants to be somewhat over-insured for small or zero accidents and to deliberately bankrupt itself for larger accidents through "negative coverage." I dwell on this somewhat esoteric point in part because it all ends up being quite related to the liability insurance contract the insured would like when the possibility of settlement is taken into account.

33. There are a number of reasons we tend not to see such contracts. To begin with, they end up being unlawful in most states. *See* Pak-Mor Mfr. Co. v. Royal Surplus Lines Ins. Co., No. SA-05-CA-135-RF, 2005 WL 3487723, at *4 (W.D. Tex. Nov. 3, 2005) (discussing Patricia A. Bronte, *"Pay First" Provisions and the Insolvent Policyholder*, INS. COVERAGE L. BULL. (June 2004), *available at* http://www.jenner.com/files/tbl_s20 Publications/RelatedDocumentsPDFs1252/969/08107040001Jenner2.pdf); Merchs.' Mut. Auto. Liab. Ins. Co. v. Smart, 267 U.S. 126 (1925) (upholding constitutionality of statute prohibiting diminution on account of the insolvency of insured). Moreover, they would create an unseemly incentive for the insurer (who has responsibility to provide a defense to the insured) to make it appear as if the damages its insured created were as large as possible. This is why almost all insurance contracts are now non-decreasing (monotonic) in damages. It should be noted, however, that earlier on in our history, insurance contracts that "escaped" when the insured was unable to pay were relatively common. *See* Annotation, *Bankruptcy or Insolvency of Insured as Affecting Right of Person Injured to Proceeds of Indemnity Insurance, in Absence of Provision in Policy in that Regard*, 59 A.L.R. 1123 (1929 & Supp. 2006) (discussing mostly early twentieth century case law on topic). One occasionally still finds "indemnity" contracts that excuse the insurer from an obligation to pay unless and until the insured has paid off a plaintiff. In maritime insurance, such contracts are fairly common. *See* Gregory Fossion, An Eternal Triangle at Sea (unpublished L.L.M. thesis, Katholieke Universiteit Leuven), *available at* http://www.law.kuleuven.ac.be/jura/39n2/fossion.htm/; Conohan v. Cooperators, [2002] 2002 FCA 60, 2006 F.C. LEXIS 80 (Canadian court enforcing "pay to be paid" clause under maritime insurance policy, which will cause "diminution" if the insured is insolvent). Because the insured is most likely to fail to pay off a plaintiff when the judgment against it is large, these indemnity contracts essentially function as ones in which the insurer escapes liability for large judgments.

would prefer to create an obligation to pay the insurer money in the event of a bankrupting accident in exchange for an agreement by the insurer to pay the insured money in the happier worlds in which no large accident occurred.[34]

The fact that the insured wants no insurance at all for the more fearsome lawsuit also provides a new and important reason for exclusions in a policy. Traditionally, people think of exclusions as being present in order to prevent moral hazard[35] or because the underwriting required for certain types of cases is too specialized to prevent adverse selection[36] or because the risk of fraudulent claims is too high.[37] And these are indeed potent reasons for exclusions. The work done here shows that some exclusions may be present, however, because the insured whose financial resources are incommensurate with the financial harm it can cause is unwilling to pay the premium associated with the high damages those sorts of lawsuits generate. The "exclusion" serves as a substitute for unease at writing a policy with multiple limits.[38]

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34. Perhaps one can think of this as a preference – in the bankruptcy/insolvency sense – created by the tortfeasor in favor of the creditors with whom they can negotiate. The insured would rather give money to the insurer in the event of a bankrupting accident than to its victim because it can ask the insurer for something in exchange (money in case of a non-bankrupting accident) in a way that it cannot do with a victim. The barrier to negotiations with a victim includes the fact that the victim may be a stranger and the fact that such negotiations might well be seen as extortion. Alternatively, one might think of this as a form of presumably unlawful gambling rather than insurance since the insured is in effect gambling that no large judgment will be entered against it.

35. Classic examples are the various intentional act exclusions. Someone who could be insured against the civil consequences of deliberately doing harm to an adversary might generate a lot of injuries.

36. Classic examples are things such as automobile exclusions found in commercial general liability insurance policies. Underwriting liability for automobile accidents takes specialized expertise.

37. An example is the provision of uninsured motorist policies allowing insurers to exclude coverage for hit and run accidents when there is no physical contact with uninsured motor vehicle and no competent proof offered from disinterested witnesses. *See* Clements v. U.S. Fid. & Guar. Co., Inc., 753 P.2d 1274 (Kan. 1988). An additional reason for exclusions is to prevent the insurer from assuming excessive amounts of correlated risk, as in the case of assuming seismic risk in California or hurricane risk along the American Gulf Coast.

38. This may be an additional reason that punitive damages are often not insured under liability insurance policies, particularly excess or umbrella policies with high limits. *See* Tom Baker, *Reconsidering Insurance for Punitive Damages*, 1998 WIS. L. REV. 101, 119 (1998). It may be less because of moral hazard concerns or concerns that permitting insurance undermines the deterrent effect of punitive damages, see Catherine M. Sharkey, *Revisiting the Noninsurable Costs of Accidents*, 64 MD. L. REV. 409, 422-42 (2005)

We can use the same sort of technology employed thus far to emphasize that the insured's optimum lawsuit sensitive contract will be guided by the amount of assets it has at stake in litigation. As shown in Figure 3, if we reduce the insured's initial wealth to $30,000, the insured does best with a "contract" that offers no coverage for either Lawsuit A or Lawsuit B. Basically, the insured would prefer to go bare. Notice two other matters: the cost of accidents has decreased relative to $1757, which is less than what they cost when the insured had additional assets. This decrease occurs because the actual amount paid by the insured in worst-case scenarios declines. Notice also that forcing the insured with lesser assets to purchase full coverage for the lawsuits more than doubles such an insured's cost of accidents.

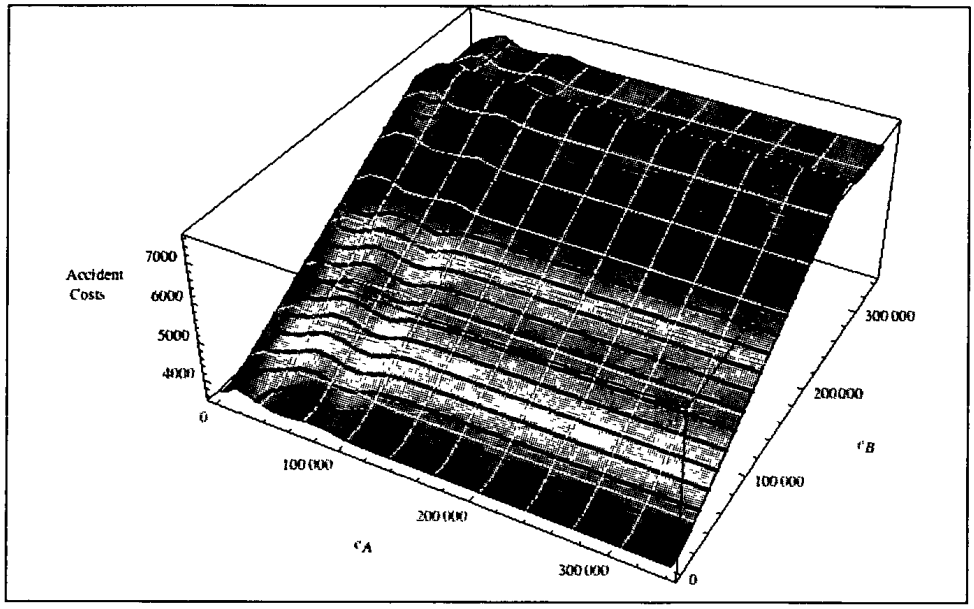

Figure 3

We can also depict the conventional situation in which the liability insurance contract bundles lawsuits together and forces the insured to purchase a contract with a single per occurrence limit that applies to the entire portfolio rather than different limits applying to different members of

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(providing useful "hub" for discussion of issue); but simply because punitive damages are often sufficiently large that the insured, *ex ante*, would prefer to go bankrupt in the remote event that they are invoked rather than pay the insurer a premium to cover them. One could also speculate that the "pollution exclusion" found in many policies is an example of this phenomenon. Damages may be extremely high for lawsuits of this sort. Many insureds might prefer to just go bare with respect to these lawsuits.

the portfolio. The figure below shows the same surface as in the example for $110,000 initial wealth above but "grays out" situations in which per occurrence limits for the two different lawsuits differ substantially. Notice that along the little band – the set of per occurrence limits that are now permitted – the minimum point of $7,050 is achieved when the per occurrence limit for both lawsuits is $300,000 or more. The conventional lawsuit-insensitive contract thus increases the cost of accidents faced by the insured by $714 from $6,336 to $7,050, or 11.3%. The loss is conceptually little different than that which would be suffered by my hypothetical car renter if one had to pick a vehicle not knowing what the weather would be and if car rental contracts were costly to renegotiate. Permitting the insurer's obligations to vary depending on the particularities of the lawsuit that materializes always (in theory) permits the insured to do better than an insurance policy that prohibits the insured from taking advantage of the new information.[39]

39. There is a second way to achieve lawsuit sensitivity, and that is to permit insurance contracts to be renegotiated following materialization of a lawsuit. If, for example, the insured could, upon the materialization of Lawsuit A, renegotiate the limits upwards with its insurer in exchange for an additional premium or go into a specialized insurance market and purchase an excess insurance policy that covered only Lawsuit A, it would do so. Or if the insured could, upon the materialization of Lawsuit B, renegotiate the limit of coverage downwards in exchange for some cash sum from the insurer, it would do so. Although this after-the-fact fix is slightly inferior to getting the limits right in the first place, because it permits transfer only of intra-lawsuit risk and not of inter-lawsuit risk, it may be superior to a market in which only a non-renegotiable policy exists.

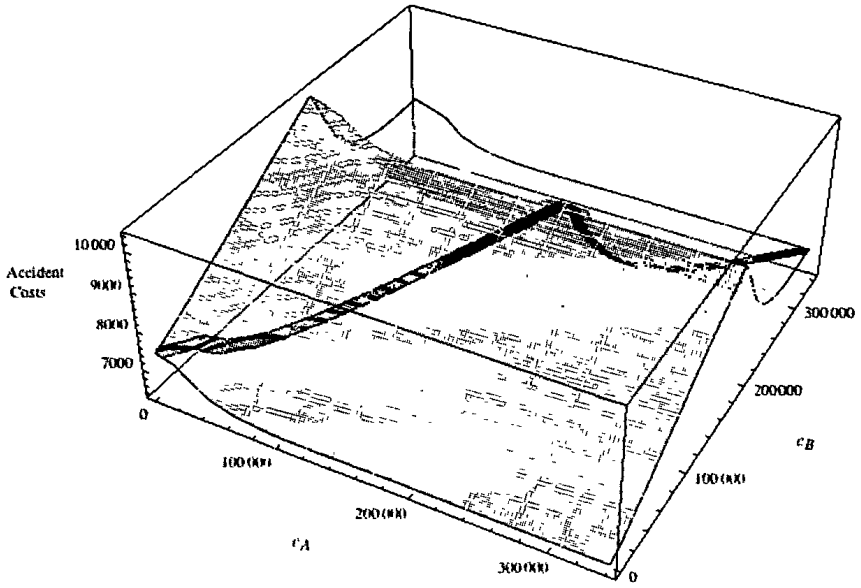

Figure 4

2. A Large Lawsuit Portfolio

It is at this point that the pure economist might stop analysis and write QED. But lawyers live in a more practical world in which contracts have to be written and enforced. And the issue is, how does one use language, even language extended with mathematical concepts, to create a mapping from the distribution of judgments in the case confronting the insured to the size of the policy limit? If the insured just faced the little portfolio used in the example, it might be possible. The contract might define "Lawsuit A" and "Lawsuit B" by virtue of their exact, discrete damage distribution and specify the policy limits for each lawsuit. The problem with this method, however, is that it does not work well when there are more that just a few lawsuits or when the number of possible judgments that might be entered in any given lawsuit starts to grow, as it often would. Most insureds face not Lawsuit A and Lawsuit B but an almost infinite variety of possible lawsuits against them. Furthermore, most lawsuits do not just have three or four possible judgments that might materialize as their result, but thousands or even an infinite number of possible judgments. It is thus impossible to

write "the complete contingent contract"[40] detailing specifications for each lawsuit and to then say what the respective limits of the policy are.[41] Case-by-case optimization is completely impracticable. What is needed is a relatively simple rule of thumb, an algorithm that would permit a per occurrence limit to be calculated readily for any lawsuit that might befall the insured. While the algorithm might not get the perfect answer every time, it might well be superior to insisting on a single per occurrence limit.

To further study this matter, I conduct an experiment. I create a portfolio of one-hundred "random" lawsuits that might befall our insured plus a "null lawsuit." Each lawsuit has up to ten different judgments that can materialize in it and the frequency of each judgment can be anything from zero to one (though the frequency of all judgments in a lawsuit must sum to 1). The aggregate frequency of judgments in the portfolio (excluding the zero judgment), is set forth below in a Log-Log plot[42] in Figure 5.[43]

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40. *See generally* Legal Theory Lexicon 050: Default Rules and Completeness, http://lsolum.typepad.com/legal_theory_lexicon/2006/07/index.html (last visited March 22, 2008) (explaining the concept of a complete contingent contract).

41. *See generally* W. Bentley MacLeod, *Complexity and Contract*, *in* THE ECONOMICS OF CONTRACTS: THEORIES AND APPLICATIONS 213 (Eric Brousseau & Jean-Michel Glachant eds., 2002) (detailing an excellent theoretical discussion of the problem of drafting a complete contingent contract in the face of an exponential growth in its complexity).

42. In a log-log plot, one takes the logarithm of both the x and y coordinates of the graph. These plots are useful ways of visualizing data that scales according to a power law. Thus the equation $\log(y) = \log(a) + b\log(x)$ appears as a line on a log-log plot, where b determines the slope and a determines the x=1 intercept. *See* DUNCAN J. WATTS, SIX DEGREES: THE SCIENCE OF A CONNECTED AGE 106 (2003).

43. I continue with my assumption that the insured has $110,000 in initial assets, of which $100,000 can be taken away via a judgment, and that the insured has a logarithmic utility function.

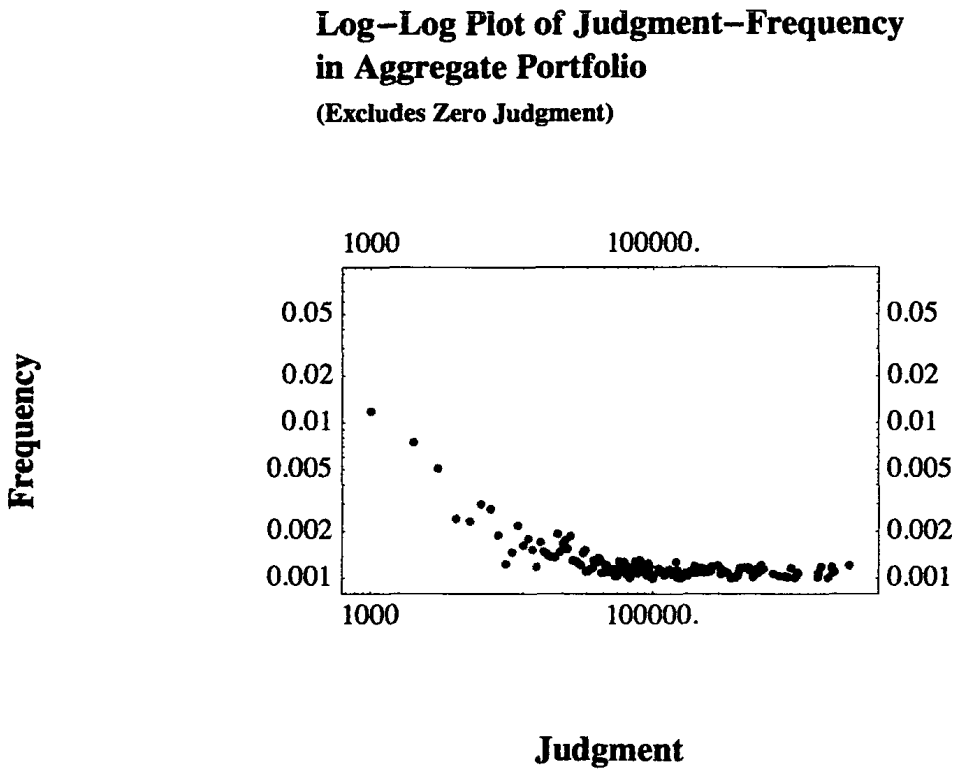

Figure 5

I can plot the accident costs faced by the insured as a function of the insurance contract purchased by the insured assuming that the contract has a simple uniform limit that applies to all lawsuits. As shown in Figure 6, the insured constrained to purchase a conventional liability insurance contract with a single, bundled limit does best purchasing one with a low policy limit of about $23,612, which results in expected accident costs of about $2,678.[44]

44. The main reason the optimal limit is so low is that this portfolio has a number of cases with very large maximum judgments.

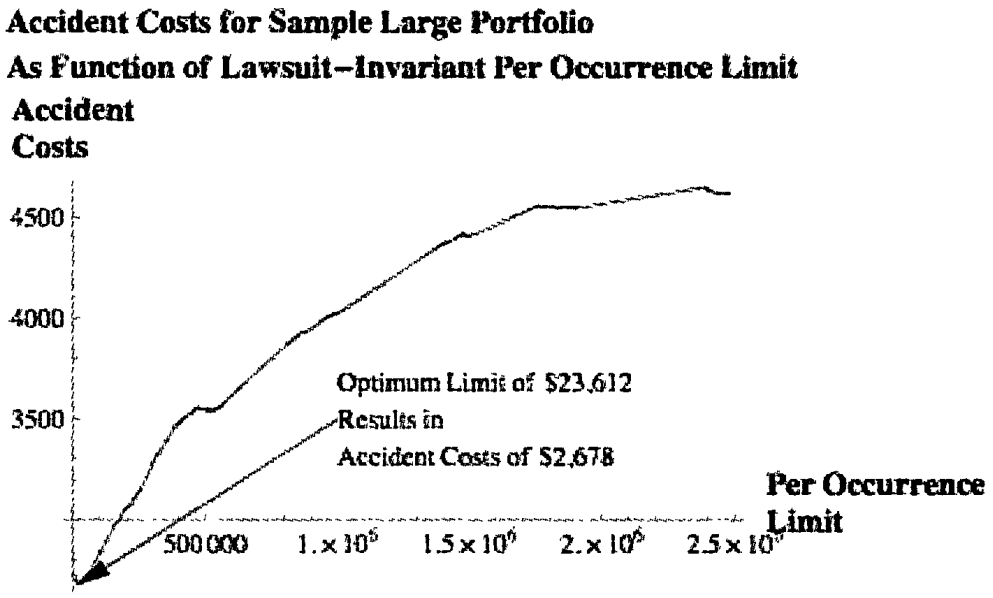

Figure 6

To see if one can do better, I now calculate for each lawsuit in the portfolio various statistics associated with the damages distribution that I believe it is reasonable for the parties to a lawsuit to conceive. I then look for a function that uses those statistics to generate different per occurrence limits for the various lawsuits that might befall an insured and determine the accident costs associated with each function. In particular, I want to find a statistics-based function that substantially lowers the effective costs of accidents for this portfolio below $2,678.

The process of finding a relatively simple function that succeeds using statistical characteristics of the damages distribution is not easy. The problem is not well suited to traditional analytic methods. Basic calculus does not work because the regularity conditions required for optimization[45] are unlikely to be present and because one is attempting to find an optimal function rather than an optimal value. Even extensions such as the calculus of variations and "optimal control"[46] would be extremely challenging

45. Calculus works best when the functions involved are continuous and differentiable and have a relatively small number of values for which the requisite derivatives are zero. The functions here have numerous discontinuities and many places where their derivatives may be zero.

46. Basic calculus looks at functions of variables, whereas the calculus of variations and optimal control basically looks at functions of functions, such as integral transformation

because the problem is so multivariate and the function to be optimized too irregular. [47]

Until recently, then, an effort to develop such an algorithm would generally have to rely on brute force. A relatively new method has been developed, however, that finds "pretty good" functions in just this sort of complex situation. It is called "genetic programming." A full discussion of this process may be found in the Appendix to this article. Suffice it to say here that the process involves using a computer to generate a population of possible formulae or "models," many of which can be highly non-linear, and to then "evolve" those models in a Darwinian, survival-of-the-fittest sense in which the fittest models "breed" with each other or mutate and generate new models. By "fittest" I mean that the formulas are relatively simple and that the accident costs of the insured under these contracts tend to be low. And by "breed" or "mutate" I mean that the formulas are written as a "mathematical" tree whose branches can be interchanged with the branches from other trees or whose branches can simply change. At the end of this evolutionary process, I find what is known as the "Pareto Front" of these models, which are "Pareto Optimal"

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of functions. *See* DANIEL LÉONARD & NGO VAN LONG, OPTIMAL CONTROL THEORY AND STATIC OPTIMIZATION IN ECONOMICS (1992). Calculus-based optimization generally involves constraints of the variables and computation of derivatives. Optimization based on the calculus of variations and optimal control often involves constraints on the functions and computation of "variational derivatives." Classical Mechanics/Lagrangian, *available at* http://en.wikibooks.org/wiki/Classical_mechanics:Lagrangian (last visited Apr. 16, 2007).

47. This is, of course, quite unfortunate. A virtue of various forms of calculus is that it generally yields a solution that is parameterized. That is, it is generally capable of solving not just one optimization problem, but a rather large class of optimization problems. By way of example, calculus helps characterize the optimum solution to the classic problem of maximizing $\log(x) + b\log(y)$ subject to $x + py \le z \wedge x > 0 \wedge z > 0$ as $\left\{\frac{z}{b+1}, \frac{bz}{(b+1)p}\right\}$. Thus, we end up with a solution not for just a particular value of b, z and p but for all positive values of b, z, and p. Thus, when calculus is used in law and economics or in other fields, one often ends up with the ability to draw fairly broad conclusions about optimums. When numerical techniques are used or techniques such as genetic programming are used, however, one ends up with solutions to particular problems. One can enhance one's confidence in the domain over which those solutions are valid by running more experiments, but one has difficulty knowing for certain what would occur for different parameter values. Thus, one has to exercise some care in basing real world decisions on the results of numeric techniques. On the other hand, real world problems are often too complex to be solved by calculus and the idealizations made in order to use that technique may lead to an artificial sense of security.

models where one cannot improve one measure of fitness without sacrificing another measure of fitness.

However, the genetic programming process is neither magical, nor immune to human judgment. Choices must be made in the course of this experiment. In particular, one must choose which of the infinite number of statistics that might be calculated for a particular distribution are appropriate as a basis for a contract. As a first and best guess, I believe it is appropriate for insureds to calculate six statistics: (1) the probability of a "zero judgment,"[48] (2) the size of the median judgment,[49] (3) the "maximum plausible judgment" (the judgment that will be at least as big as 99% of all judgments that might be entered in a case),[50] (4) the probability that the judgment will be greater than the attachable assets of the insured (calculated without reference to insurance), (5) the mean truncated judgment in which one assumes that the judgments in excess of the maximum plausible judgment are treated as equivalent to the maximum plausible judgment, and (6) the standard deviation of the truncated judgments in which one likewise assumes that judgments in excess of the maximum plausible judgment are treated as equivalent to the maximum plausible judgment.[51]

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48. Attorneys regularly calculate for themselves and for their clients the probability that they will win or lose the case.

49. I believe attorneys can generally tell clients the probability is 50% that the judgment will be smaller than some number. In so doing, they describe the "median" of the distribution.

50. I do not believe that attorneys can readily calculate the maximum possible judgment against an insured in most cases. The existence of difficult-to-quantify non-economic damages and, in some cases, punitive damages, makes this hard in the real world. On the other hand, I do believe attorneys can and do calculate a "worst case," by which they mean that they have a hard time imagining that the damages could be higher than some number. I formalize this intuition by using the 99th percentile of the judgment distribution as one of my statistics. Indeed, many court decisions on the duty to settle essentially use such a concept, asking whether there is a possibility of an excess judgment. *See, e.g.*, Motorists Mut. Ins. Co. v. Glass, 996 S.W.2d 437, 451 (Ky. 1997). Other courts ask whether there is a substantial probability of a judgment in excess of policy limits. *See e.g.*, RLI Ins. Co. v. CNA Cas. of Cal., 45 Cal. Rptr. 3d 667, 671 (Cal. Ct. App. 2006); Walbrook Ins. Co. v. Liberty Mut. Ins. Co., 7 Cal. Rptr. 2d 513, 522 (Cal. Ct. App. 1992); Jackson v. Am. Equity Ins. Co., 90 P.3d 136, 142 (Alaska 2004). Still other courts ask whether there is a "reasonable probability" of an excess judgment. *See e.g.*, Haddick v. Valor Ins., 763 N.E.2d 299, 304 (Ill. 2001).

51. I exclude from consideration more baroque statistics such as the kurtosis of a distribution on grounds that few insureds or attorneys would know what they are, know how to calculate them, or have sufficiently precise information about the lawsuit to be able to do so in a reliable way.

In attempting genetic programming, one must also choose from the infinite number of mathematical operations that could apply to the data. One could, for example, have a contract that sets the limit of insurance equal to the Arctangent of the median, but this seems highly improbable since, understandably, few people associate trigonometry with insurance law. Partly because one can approximate a large number of functions using these primitives and partly because lawyers tend to like relatively simple mathematical operations, I restrict myself to the functions found on the simplest calculators: addition, subtraction, multiplication, division, the square root and squaring operations, as well as a "UnitStep" function (denoted as Θ) that equals zero or one depending on whether its argument is negative or non-negative. I also allow constants from negative ten million to ten million to be used in the model. Finally, I permit a "clipping operator" (Ω) that maps out-of-bounds or non-numeric values generated by the formula to some constant set of values. By way of example, if the formula calls for division by zero, the result is "clipped" to five million or if the formula yields an imaginary number, the result is clipped to zero.

My experiment involved examination of 2.9 million models that evolved from a population of 300 random models over 14 hours on a high-end vintage 2006 personal computer.

This method of genetic programming found very simple formulae that reduce accident costs by 7.5% to 10.5% and a more baroque formula that reduces accident costs up to 11.3%. The table below shows some of the more interesting examples of the 22 models that end up lying on the Pareto Front. The first column labels the model, the second column provides the model, and the third column shows the percent reduction in accident costs achieved.

Model	Formula	Percent Reduction in Accident Costs
1	23719.7	0.
2	$317371. - q99$	7.45039
3	$\frac{309848.-q99}{zJ}$	9.46198
4	$\frac{295421.-q99}{zJ^2}$	10.3477
5	$-\sqrt{295421. - q99} + q99$	10.7592
6	$-\sqrt{296177. - q99} + q99 - tMean + tStDev$	10.7607
7	$med - (-305135. + q99)\ q99\ zJ^5$	10.8634
8	$med - (-297413. + q99)\ q99\ zJ^5$	11.0367
⋮	⋮	⋮
20	$117582. - 262426.\ anw\ zJ^4 \left(357762. - \sqrt{-24183.8 + q99} - \frac{tMean-tStDev}{zJ} + anw\ (-301538. + q99)\ q99\ zJ^4\right)$	11.2764
21	$117582. - 283148.\ anw\ zJ^4 \left(357762. - \frac{tMean-tStDev}{zJ} - zJ + (-301538. + q99)\ (-35940.9 + q99)\ zJ^5\right)$	11.2772
22	$117582. - 262426.\ anw\ zJ^4 \left(357762. - \frac{tMean-tStDev}{zJ} - zJ + anw\ q99\ zJ^4 \left(-\frac{tMean-tStDev}{zJ} + (-301538. + q99)\ (-23719.7 + q99)\ zJ^5\right)\right)$	11.2779

Table 1

Several of the formulae yielded by this process are worth exploring in some detail. Consider, for example, Model 2, which sets the policy limit equal to the greater of zero and $317,371 minus the largest plausible judgment in the case. Use of this extremely simple formula, involving a single statistic, would reduce the effective costs of accidents by about 7.5%. When one considers that annual liability insurance premiums are in the hundreds of billions of dollars, this is a non-trivial result. Indeed, if one is permitted to advance one's level of mathematical sophistication to square roots, one can reduce accident costs by 10.5% simply by using the maximum plausible judgment. Model 5 is close to a linear function of the maximum plausible judgment up to $295,421. If the maximum plausible judgment exceeds $295,421, however, the insured wants no coverage at all. If one allows oneself two statistics: maximum plausible judgment and the probability of a zero judgment, one can reduce accident costs by 9.5% using only the functions found on the simplest calculator. Model 3 says to divide the difference between $309,848 and the maximum plausible

judgment by the probability of a zero judgment. Thus, as the probability of the insured winning the case decreases, the amount of insurance wanted by the insured increases. For example, in a case in which there was a 70% chance of the insured winning and a maximum plausible judgment of $100,000, the insured would want $299,783 worth of coverage.

One can also see that there is little marginal value to additional complexity. Model 23, which involves five statistical variables and involves a sixth degree multivariate polynomial, reduces accident costs by 11.3%.

In general, the experiment shows that the insured tends to want very little insurance for the "worst" cases. This somewhat counterintuitive result follows from our earlier discussion of the sort of lawsuit-invariant liability insurance policy an insured really wants most, one in which indemnity falls to zero (or even negative amounts) if the judgment gets too large. While this sort of policy is likely unlawful in many jurisdictions, we have, in some sense, found a loophole around the prohibition. Rather than lower the insurer's obligation if the judgment gets too large, we lower the insurer's policy limit if the maximum plausible judgment gets too large. In many of these models, the policy refuses to pay at all for lawsuits in which the amount owed has even a slight (>1%) potential of being a large amount relative to the insured's net worth.[52]

It is also worth examining which statistics prove most valuable in lowering effective accident costs. Of the 500 models in the final population able to reduce accident costs below $2,400, the maximum plausible judgment was a factor in all 500 models. The zero judgment probability was the next most frequent variable, appearing in 277 (55.4%) of these 500 models. The truncated standard deviation and the probability of the judgment exceeding net worth appeared much less frequently, in 156 and 81 of the 500 models respectively. A similar conclusion can be reached by examining the subset of variables appearing in these 500 models. The most frequent subset was the maximum plausible judgment variable alone. This variable appeared by itself in 93 of the 500 models.[53] The next most frequent subset was the probability of a zero judgment, the median judgment and the maximum plausible judgment, which appeared in 84 of the 500 models.

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52. The policy thus remains non-decreasing with respect to judgments but is now decreasing with respect to the *ex ante* risk of a very large judgment.

53. No other variable appeared by itself in the 500 models able to reduce accident costs below $2,400.

	Custom	*M1*	*M2*	*M3*	*M4*	*M5*	*M20*	*M21*	*M22*
P1	100	100	93	91	90	89	89	89	89
P2	100	110	96	91	91	90	91	91	91
P3	100	100	97	91	89	89	89	89	89
P4	100	105	91	88	88	88	89	88	88
P5	100	100	86	85	85	84	84	84	84
P6	100	99	96	96	96	95	97	96	96
P7	100	105	90	90	91	86	88	86	86
P8	100	107	91	91	91	88	94	94	94
P9	100	101	90	88	87	86	90	89	89
P10	100	107	101	100	98	98	98	98	98
P11	100	114	96	93	92	93	93	93	93
P12	100	109	96	96	93	91	91	91	91
P13	100	112	95	91	90	89	96	91	91
P14	100	101	93	90	90	89	89	89	89
P15	100	122	103	97	97	97	97	97	97
P16	100	101	95	93	91	91	92	92	92
P17	100	101	97	96	95	94	96	96	96
P18	100	100	92	92	91	90	91	91	91
P19	100	115	101	102	97	96	96	96	96

Table 2

Of course, it could be that the success of these formulae was just "luck" or that they were effectively engineered for the particular portfolio confronting the insured. Therefore, it is necessary to apply these simple formulae to other hypothetical lawsuit portfolios confronting an insured to see if they result in comparable reductions in accident costs. To do this, I generated 18 other 100-lawsuit portfolios. The portfolios were generated by a variety of methods to avoid the possibility that the rules work only for lawsuit portfolios generated in a particular way. For each portfolio, I computed the lowest accident cost available using a conventional bundled, single-limit insurance policy. I then computed the accident cost that would result using each of my simple rules. Table 2 shows the results for selected models on the Pareto Front, where the numbers for each model reflect accident costs as a percentage of accident costs under a non-statistical policy that provided uniform portfolio-optimal limits regardless of the lawsuit that materialized. The rows are labeled "Px" to correspond with each of the 19 portfolios examined. The columns are numbered "Mx" to

reflect the model under examination. Thus 87 in row P9 column M4 means that Model 4 from the Pareto Front of the sample portfolio reduced accident costs for Portfolio 9 to 87% of what they would be for a custom-optimized fixed limit policy.

The table shows that, except for Model 1, which simply sets the policy limit equal to a fixed $23,612, the models succeed in significantly lowering accident costs for all or almost all of the portfolios. Model 4, for example, which involves use of only the maximum plausible judgment and the zero judgment probability and which involves no arithmetic operation more complicated than squaring, lowered accident costs for every portfolio examined, with reductions ranging from 3% to 15%. The more baroque models do not yield better results on average than the simple models such as Model 3 and Model 4. The experiment thus suggests that the results from genetic programming prove robust over a variety of lawsuit portfolios. In short, we can predict with some confidence that, if contracts implementing these models could be drafted and enforced, we could significantly reduce the effective cost of accidents to insureds, perhaps by tens of billions of dollars in annual premiums.

II. REFORMING THE DUTY TO SETTLE

A. INTRODUCTION

Thus far, I have generally presented lawsuits as if they consisted only of some distribution of damages that might materialize. However, one of the things that makes real lawsuits more interesting and more complex than statistical distributions is that the parties can change the distribution of damages through their own independent conduct and, more importantly for my purposes, through settlement negotiation. How the insurer handles settlement negotiations can have a serious impact on the risk and return to the insured from litigation. An insurer who has a strong preference for settlement reduces any residual intra-lawsuit risk to the insured resulting from purchase of a policy with per occurrence limits below the maximum possible judgment. On the other hand, the insured pays a premium for this reduction in risk. An insurer with a strong preference for "hard ball"[54] may

54. "Hard ball" tactics by insurance companies are addressed by John Ellison and Timothy Law in their discussion of punitive damages in the context of bad faith insurance coverage litigation. *See generally* John Ellison & Timothy Law, *Bad Faith and Punitive Damages: The Policyholder's Guide to Bad Faith Insurance Coverage Litigation:*

preserve intra-lawsuit risk resulting from such a policy, although the premium it would need to charge the insured for such a policy would be lower.

The possibility and character of settlements that occur will not only be related to the "culture" of the insurer but also to the terms of the liability insurance contract entered into by the insured. A plaintiff facing a defendant with large amounts of insurance coverage is likely to demand more than would a plaintiff facing a defendant with limited assets and little insurance coverage.[55] Moreover, in the absence of a "duty to settle," and the practical inability of an insured to negotiate with its insurer over allocation of responsibility for any settlement offer extended by the plaintiff, there may be instances in which low per occurrence limits will make it difficult for a case to settle at all. [56]

In theory, the insured can attempt to control the insurer's preference through provisions within the liability insurance contract. Indeed, insurance law in the United States and several other jurisdictions already provides the liability insurer with some direction on how it is to conduct settlement negotiations. It contains a duty to settle, which generally says that if the insurer rejects a settlement offer that is "reasonable" and that is less than a "safe harbor" threshold amount t,[57] then the insurer is responsible for any subsequent outcome of that lawsuit *as if* it had written a liability insurance policy not with the limits c that would otherwise apply, but with a higher post-rejection per occurrence limit of χ. The law generally sets the safe harbor threshold amount t equal to the per occurrence limit c and measures the reasonableness of a settlement offer by asking whether it would be in the financial interest of an insurer to accept it if the insurer had issued an infinite per occurrence limit.

Understanding the Available Recovery Tools, A.L.I./A.B.A. COURSE OF STUDY – ENVIRONMENTAL INSURANCE (2005), *available at* SK095 ALI-ABA 251 (Westlaw).

55. In the United States, the limits of an insurance policy are generally disclosed to the plaintiff as a matter of course. *See* FED. R. CIV. P. 26(a)(1)(D) (2005).

56. There may be more than practical obstacles to such bargaining. In some states and under some circumstances, courts find that a request by the insurer that the insured chip in to some settlement itself constitutes "bad faith." *See* ASHLEY, *supra* note 3, §§ 3:2-3:3 (addressing the factors that indicate the existence of bad faith and the demands upon the insured to contribute to settlement). The fact that the insured could have strengthened its bargaining position immensely in such negotiations by having purchased a policy with higher per occurrence limits, evidently has not impressed those courts finding these sorts of negotiations distasteful or even tortious.

57. One can think of the "safe harbor" threshold as immunizing the insurer from ever having to pay more than c, unless the settlement offer is less than the threshold.

The default duty to settle unquestionably has a major effect on the way litigation is conducted in the United States.[58] It clearly increases the amount paid to settle cases and thus creates a major source of compensation for those injured by persons who could not come close to paying for the amount of harm they create. It clearly increases premiums paid by insureds. And important work done during the 1990s by Professor Alan Sykes strongly suggests[59] that it increases the economic welfare of insureds relative to what would be the case if the rule did not exist and insurers could behave "selfishly" in settlement negotiations.[60] Professor

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58. It is difficult to document this fact in the conventional law review way, yet it is almost certainly true. *See, e.g.*, Chandler, *supra* note 10, at 791–93. Scholarly support for this proposition also exists. *See, e.g.*, Ellen S. Pryor, *The Tort Liability Regime and the Duty to Defend*, 58 MD. L. REV. 1, 2-3 (1999); David A. Fischer & Robert H. Jerry, II, *Teaching Torts Without Insurance: A Second-Best Solution*, 45 ST. LOUIS U. L.J. 857, 874 (2001).

59. Although his work was highly rigorous, Professor Sykes admittedly did not formally prove his belief that the duty to settle was superior to a no duty rule. First, he assumed that only one accident with a known probability could befall the insured. *See supra* note 10, at 87. Second, he assumed that the single accident could have only three manifestations of damages. *Id.* at 87, 106-07. Both these assumptions permitted Sykes to develop, quite brilliantly, a "closed form" analytic solution to the circumstances under which an insured would prefer a duty to settle. *See id.* at 97. Yet the same unrealistic restrictions on the model that permitted Sykes to use algebra to solve his problem also left in doubt whether his conclusions could be extended to a broader set of circumstances. Moreover, Professor Sykes recognized other issues with his model as well, including complications stemming from litigation costs, *id.* at 100-01, the problem that the probability of an accident manifesting or the distribution of damages resulting from an accident might be affected by the insurance contract and any "duty to settle" contained therein, *id.* at 105-06, and the possibility that the parties to litigation would have disparate expectations about the distribution of results, *id.* at 100-01. While Sykes' scholarly opinion that these complications would end up not mattering very much must be given considerable respect, *id.* at 107, it still must create some hesitancy among those who wish to go from beautiful theory to advocacy for a particular legal rule.

60. Professor Sykes examined the economic consequences of a common variant of the duty to settle known as the Crisci rule, which deems the insurer to have issued a policy without limits when the insurer rejects a settlement offer that is (a) less than the limits of the policy and (b) would have cost the insurer less than its expected payoff would have been had it issued a policy without limits. *Id.* at 78-79. Professor Sykes developed a model in which the insured faced inter-lawsuit risk and intra-lawsuit risk. The inter-lawsuit risk was generated by the fact that there was some possibility α of a lawsuit occurring and a 1- α possibility of no lawsuit occurring. *Id.* at 87. The intra-lawsuit risk was generated by the fact that the lawsuit could have three "materializations," one of which would be greater than the initial wealth w of the prospective defendant. *Id.* at 87. The prospective defendant could shift inter-lawsuit and intra-lawsuit risk to an insurer through an actuarially fair contract (p,c) that in exchange for a premium p would pay the lesser of c and the size of the

Sykes accurately characterized the problem with a "no duty rule" as forcing the insured to make a needless choice between: (a) the purchase of low-per-occurrence limits, which results in sub-optimal risk transfer, but has the "positive" effect of externalizing accident costs onto victims; or (b) the purchase of higher limits, which results in more optimal risk transfer, but forfeits the insured's otherwise existing opportunity to externalize accident costs onto the victim. The duty to settle permits the insured "to have its cake and eat it too," as Sykes aptly put it. The insured that wants to eliminate all risk from a lawsuit no longer needs to purchase full coverage against the largest possible judgment and pay the associated high premium. Instead, it can exploit its own limited wealth by purchasing nominally low limits, thereby externalizing risk on to the victim, yet reducing the retention of intra-lawsuit risk by giving the insurer the incentive to settle cases for reasonable amounts.

What has hitherto gone unexplored, however, is whether there might be variants of the duty to settle that would be even more in the interest of the insured. Rather than tightly binding the triggering safe harbor threshold to the policy limit, or setting the post-rejection limits at infinity, the parties might prefer that the safe harbor threshold be set at twice the coverage amount and that the post rejection limit be set at, say, three times the initial limit. And, if these three values (t, c, χ) could be set on a lawsuit-by-lawsuit basis, based on statistical qualities of the lawsuit that materialized, accident costs might be further reduced.

To explore this issue, one must realize that the possibility of settlement converts a lawsuit into what a mathematician would call a "game." In the first phase of the game, the insured selects parameters of the insurance contract: a safe harbor threshold t, a conventional per occurrence limit c, and a post-rejection per occurrence limit χ. In the second phase of the game, random forces determine which lawsuit (including the null lawsuit) in the lawsuit portfolio materializes. The plaintiff then determines its

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judgment. *Id.* at 87. Professor Sykes examined this scenario under the assumption that transaction costs prevented the insured from shifting intra-lawsuit risk through either post-lawsuit renegotiation of the insurance contract or an insured contribution to a settlement, *id.* at 86-87, and then under the assumption that the insured could reduce intra-lawsuit risk through renegotiation of the insurance contract or contribution to a settlement offer. *Id.* at 96.

An implication of Sykes analysis is that the significant number of countries, including those with laws not entirely dissimilar to those of the United States, that do not imply a duty to settle are needlessly depressing their economies and that insureds and insurers should be working in those nations towards making a duty to settle an explicit term of their liability insurance contracts.

settlement strategy in the lawsuit, which will consist of (1) offering to settle for the value of the case to the insurer in the event the conventional per occurrence limit applies (v[c]); (2) offering to settle for the value of the case to the insurer in the event the post-rejection per occurrence limit applies (v[χ]); (3) offering to settle the case for the exact value of the safe harbor threshold t; or (4) refusing to settle all together.[61] The insurer responds mechanically to this optimal settlement offer, accepting it if the settlement offer is less than or equal to the value of the case if it goes to trial following the settlement offer and otherwise rejecting it. The result is a distribution of "damages" that consists either of the original distribution if settlement failed or a distribution in which there is a 100% probability of the case resulting in the amount of the settlement. In addition, since no

61. Here is an inelegant but serviceable proof of the proposition that these are the only settlement offers that need be considered. Let t be the safe harbor threshold value, v[c] be the value of the case to the insurer if the applicable policy limit is c (i.e. the settlement offer is more than t), and let v[χ] be the value of the case to the insurer if the applicable policy limit is χ (i.e. the settlement offer is t or less). Excluding ties, which don't matter, there are six possible orderings of t, v[c], and v[χ]. (1) If the ordering is t<v[c]<v[χ], the insurer will accept v[c] but will not accept anything more because c is the applicable limit for settlement offers above t. There is no reason for the plaintiff to offer anything less because the insurer will accept v[c]. Thus, the plaintiff should offer v[c] or, if v[c] is less than the value of trial (which will enable plaintiff to go after the insured's assets but which will create risk to the plaintiff), the plaintiff should refuse to settle. (2) If the ordering is t<v[χ]<v[c], the insurer will accept v[c] so there is no reason for the plaintiff to offer anything less. The insurer will not accept anything more because c is the applicable policy limit for settlement offers above t. Hence, either the plaintiff should offer v[c] or the plaintiff should refuse to settle. (3) If the ordering is v[c]<t<v[χ], the insurer will not accept anything more than t because c will then be the applicable limit of liability and v[c]<t. The insurer will accept t, however, because offers equal to the safe harbor threshold make χ the applicable policy limit and t<v[χ]. There is no reason for the plaintiff to offer anything less than t. So the plaintiff should offer t or refuse to settle. (4) If the ordering is v[c]<v[χ]<t, the insurer will accept v[χ] because offers less than t trigger a limit of χ. The insurer will not accept anything higher up to t because such offers will be more than v[χ]. The insurer likewise will not accept anything above t because such offers will trigger a limit of c, but v[c] is less than t. So the plaintiff should offer v[χ] or refuse to settle. (5) If the ordering is v[χ]<t<v[c], the insurer will accept v[c] so there is no reason for the plaintiff to offer anything less. The insurer will reject offers in excess of v[c] because such offers will trigger a policy limit of c. The plaintiff should offer v[c] or refuse to settle. (6) If the ordering is v[χ]<v[c]<t, the insurer will accept v[χ], so the plaintiff has no reason to offer anything less. The insurer will not accept anything more because, up through t, the applicable limit is χ. Above χ the applicable limit is c but v[c]<t. Again, the only optimal strategies are v[χ]or a refusal to settle. Thus, the only settlement strategies that can ever be optimal for the plaintiff are to offer v[χ], v[c], t or to refuse to settle or, equivalently, to make an absurdly high offer.

further settlement opportunities exist, the insurance contract simply has an operative per occurrence limit, which is equal to the conventional per occurrence limit c if the settlement offer was more than the safe harbor threshold t or the post-rejection per occurrence limit χ if the settlement offer was less than or equal to the safe harbor threshold. Random forces then determine which "judgment" emerges from the revised damages distribution and the parties make appropriate payments. The premium for the original contract is the same as the premium would be for this revised contract and revised damages distribution.

The only point in this game in which the insured makes a decision is in selecting the parameters of the insurance contract. The insured does this in theory so as to maximize its well being after the plaintiff extends its optimal settlement offer and the insurer responds. The insured makes this choice so as to minimize the cost of accidents after the possibility of settlement is taken into account.

B. THE DUTY TO SETTLE: EXPERIMENTS WITH A SIMPLE LAWSUIT PORTFOLIO

To illustrate how this "game" works, consider the toy portfolio discussed above involving Lawsuit A and Lawsuit B.[62] Assume for the moment that the plaintiff is risk neutral or able, perhaps through contingency fee arrangements, to approximate risk neutrality. When the contract was forced to treat both these lawsuits alike for purposes of a per occurrence limit and when we did not take account of the possibility of settlement, we found that the best the insured could do was to purchase a contract that had a per occurrence limit of $300,000 and that the resulting accident costs was $7050. If, however, the insured could purchase a contract with a per occurrence limit of $66,500, a safe harbor threshold of $66,500, and a post-rejection limit of infinity, the insured could reduce its accident costs to $4825. This is so because, with this contract in place, the insured will accept settlement offers of $30,000 to settle the first lawsuit and $66,500 to settle the second lawsuit. The insured no longer has to purchase $300,000 worth of coverage in order to eliminate all inter-lawsuit and intra-lawsuit risk. To be sure, the insured could accomplish the same elimination in risk if it purchased, say, a policy with parameters t=70,000, c=70,000 and χ=300,000, but all this would do is encourage the plaintiff in lawsuit B to make a $70,000 settlement offer, which the insurer would

62. These lawsuits are described on page 12.

accept but which would result in higher premiums ($5,000) to the insured. Any policy with lower safe harbor threshold and conventional per occurrence limit parameters would prevent Lawsuit B from settling and therefore create significantly higher risk costs to the insured. Thus, the conventional duty to settle, which binds the value of the safe harbor threshold to the value of the conventional per occurrence limit and which creates essentially limitless liability for an insurer that rejects low settlement offers cuts the cost of accidents in our toy example by a rather remarkable 31.5%. It even reduces it 24% over the unbundled contract in which different conventional per occurrence limits applied to lawsuit A and lawsuit B.

What is perhaps more remarkable, however, is that the insured can do even better with a variant on the conventional duty to settle. Consider the contract with a safe harbor threshold of $44,333.33, a conventional per occurrence limit of zero (or something approaching zero), and a post-rejection limit of $120,000. The conventional per occurrence limit has now detached from the safe harbor threshold and the post-rejection limit is no longer infinite. In lawsuit A, the plaintiff will do best to offer to settle for $30,000, which the insurer will accept. Lawsuit B, the one the insured really worries about, will also settle. The plaintiff will be impelled to settle lawsuit B for only $44,334, which the insurer will accept. The insurer will accept this settlement because, with $120,000 of its own money potentially at stake following an offer equal to the $44,334 threshold, the insurer would expect to pay $51,000 after a trial.[63] It does not help the plaintiff to make an offer in excess of the $44,334 threshold because, with none of its own money at stake, the insurer will reject it and, left to collect only from the $10,000 of the insured's money, the plaintiff can do no better than $44,334.[64] Since the insurer only has to payout $30,000 for lawsuit A and $44,344 for lawsuit B, it can lower its premium, and the correlative cost of accidents, to $3717. This variant on the duty to settle thus reduces the cost of accidents by 47% from a contract with no duty to settle and by 16% from the conventional duty to settle. Again, given the hundreds of billions spent on liability insurance premiums, this is a non-trivial sum.

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63. Indeed, if only lawsuit B were involved, the post-rejection limit could be as low as $100,000 without jeopardizing settlement. Below a post-rejection per occurrence limit of $120,000, however, lawsuit A will not settle because plaintiff's recovery from trial will exceed what the insurer will pay: (3/10)*60,000 + (1/10)*Min[120,000, (100,000 + c)] >(3/10)*60,000 + Min[c, 120,000]/10 for all c<120,000.

64. Obviously, it makes no sense for the risk neutral plaintiff to offer less than $44,334 because he or she can expect to get that much at trial.

It is worth spending a little time considering further why this works. The "trick" is for the insured to pre-commit to a strategy under which, unless the plaintiff makes a fairly low settlement offer, there is zero insurance coverage on which to draw in the event the plaintiff wins a large judgment. Indeed, one can set the safe harbor threshold – the number below which the plaintiff must offer in order to have any rights to the insurance policy – at an amount just an infinitesimal hair more than the plaintiff's expected recovery from trial from the most threatening case in the face of no available insurance.[65] The plaintiff thus does a tiny bit better to offer the safe harbor threshold rather than go to trial. And all one has to do to get the insurer to accept such an offer is to set its post rejection limit at an amount equal to an amount a little greater than the attachable assets of its insured, in the case above: $120,000. There is no need to set the post-rejection limits to infinity, as current law effectively does in most states.

The character of this solution to the optimization problem appears to be robust against various changes in our simple scenario. Regardless of whether we vary the risk aversion of the plaintiff, the risk aversion of the insured or the amount of assets the insured has at stake, the insured tends to want a policy with a very low or zero conventional per occurrence limit, a modest threshold, and does just fine with a non-infinite post-rejection limit.

C. THE DUTY TO SETTLE: EXPERIMENTS WITH THE LARGE PORTFOLIO

1. Contracts That Do Not Vary Based on Statistics About the Lawsuit That Materializes

One can also perform this experiment on our larger sample portfolio of 100 lawsuits, recalling that the best we could do with a bundled simple contract with a risk neutral plaintiff was $2678 and the best we could do with an unbundled simple contract under similar circumstances was 11.3% less or $2,376. It turns out that if one writes a contract in which the per

65. There is a potential problem with strategies that depend on pre-commitment. If the other side pre-commits first, the pre-commitment strategy can backfire. If, for example, tort victims could enter into some sort of contract under which they would be punished if they ever made a low settlement offer, an insurance contract that offered no coverage if they made a higher-than-expected settlement offer could be a disaster. This article assumes, with some reason, that victims tend not to develop such pre-commitment strategies, though one supposes some of them might in the event the reforms suggested in this article were ever adopted.

occurrence limit c is \$0, the post-rejection limit χ is \$547,858, and the threshold t is about \$37,660, the accident costs facing the insured are reduced to \$2119.[66] This represents a 21% decrease from accident costs under the bundled simple contract and an 11% decrease from accident costs under the unbundled simple contract. There is no need to determine any statistics about the distribution; one simply has a contract with three parameters in place of the single parameter that characterizes the traditional liability insurance contract.

There are a few things worth noting about the optimal solution. First, it is superior to a traditional duty to settle under which the post-rejection limit is infinite and the threshold is pinned to the per occurrence limit. The lowest accident cost attainable if the post-rejection limit is held infinite is \$2126, which requires the threshold to be set at zero and the per occurrence limit to set at \$37,660. If one further requires the threshold to be pinned to the per occurrence limit then the best the insured can do is \$2364. Thus, the duty to settle is a "good thing" from the perspective of the insured, but not as good as it could be. Either permitting the post-rejection limit to be lower or decoupling the settlement threshold from the per occurrence limit would improve the well being of the insured.

The results obtained from our larger portfolio are no fluke. One can perform the same experiment on each of the 19 other portfolios created for this article. For each portfolio, the effective cost of accidents was reduced between 10% and 32%. For all portfolios, the optimal conventional per occurrence limit was 0. The optimal threshold ranged between approximately \$20,000 and \$54,000 and the optimal post-rejection limit ranged between \$267,000 and \$2 million. On average, the three-parameter contract results in accident costs 21% lower than the best that could be done with the single-parameter contract.

We can also run our experiment under the assumption that victims are risk averse and are not able to diversify lawsuit risk away through contingency fees or other arrangements. We find that, if the insured invariably confronted risk averse victims, it would actually prefer a policy in which the per occurrence limit was lower if the victim made a settlement offer above a threshold amount. More specifically, on the sample portfolio, the insured did best with a threshold of \$31,462, a per occurrence limit of \$97,399 and a post-rejection limit of \$61,610. This inversion of the traditional duty to settle occurs because the insured wishes to use the

66. This computation was done using the global optimization techniques described in Pinter, *supra* note 30, at 1.

settlement offer as a screening device. Large settlement offers are associated with the sort of large lawsuits for which the insured may not want much in the way of coverage. Thus, notwithstanding the fact that it reduces the likelihood of settlement and thus leaves substantial risk with the insured, the contract described here works best for the insured because it reduces the premium it has to pay to insure against losses from lawsuits sufficiently "bad" that the plaintiff is simply unwilling to settle for the threshold amount or less. Again, then, it is simplistic to say that insureds would invariably want the sort of duty to settle that presently exists.

2. Contracts That Can Vary Based on Statistics About the Lawsuit That Materializes

Thus far I have shown that one can reduce the cost of accidents either by (1) unbundling the contract and using statistical features of the lawsuit creating case-by-case per occurrence limits or (2) adopting a modified duty to settle in which the safe harbor threshold and post-rejection limit is determined contractually in addition to the traditional per occurrence limit. I now examine whether a combination of these techniques could reduce accident costs to the insured yet further. That is, for each lawsuit we would have two per occurrence limits: one if the plaintiff fails to make a settlement offer below a certain safe harbor threshold and the other (presumably higher limit) if the plaintiff does make a settlement offer below that threshold. Our SUV/convertible analogy suggests that use of additional information as it becomes available should be helpful to the insured, but one needs to confirm both the existence of this effect and get some sense of its magnitude.

It is easy to show that the insured can improve its position at least somewhat through a combination of a modified duty to settle and contracts that respond differently based on the different damages distributions in the lawsuits that materialize. Consider again the little portfolio with the null lawsuit, lawsuit A and lawsuit B. I showed earlier that a contract with a safe harbor threshold of $44,333.33, a conventional per occurrence limit of $0 and a post-rejection per occurrence limit of $120,000 could reduce accident costs down to $3717. If we unbundled the contract, however, so that the safe harbor thresholds are $28,000 for lawsuit A and $44,333.33 for lawsuit B, the per occurrence limits are both $0 and the post rejection limits are both $100,000, the insured can get its accident costs down to $3617, a savings of $100, or about 3%. The insured does better through unbundling because it need no longer choose between a safe harbor a threshold that is higher than necessary to settle lawsuit A in order to settle

lawsuit B. As a result, lawsuit A now settles for $28,000 rather than $30,000. The plaintiff accepts $28,000 because it can do no better than that if it makes a settlement offer higher than this amount, since coverage would drop to zero and the plaintiff would be left to chase only the limited assets of the insured.

Notice, however, that the savings are quite small relative to what can be achieved by a duty to settle that is modified but that does not require classification of lawsuits. This suggests that the administrative costs needed to classify lawsuits may outweigh whatever savings are attainable. To test the magnitude of the savings, I now use genetic programming to find functions that use statistics about the damages distribution in each lawsuit in our sample large lawsuit portfolio to develop values for the safe harbor threshold, the conventional per occurrence limit and the post-rejection limit. As discussed further in the Appendix, the concept is implemented by developing techniques for partitioning a single mathematical expression into three parts and using each part to represent the formula for each of the three components of the contract. Thus, when one evolves the main mathematical expression using genetic programming techniques, one likewise evolves the formulas used for determining each component of the insurance contract.

An experiment that examines half a million models evolving from an initial population of 300 models shows that a very simple formula can reduce accident costs significantly in the face of risk neutral plaintiffs. One sets the safe harbor threshold to a fixed amount that does not depend on the statistical characteristics of the lawsuit, here $37,660, one sets the traditional per occurrence limit essentially to zero,[67] and one sets the post-rejection limit to the maximum plausible judgment in the lawsuit that materializes.[68]

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67. Technically, the genetic program that emerges from this experiment actually says to set the per occurrence limit equal to the probability that the judgment will exceed the net worth of the insured, but this number is bounded between zero and one. Hence the model is essentially telling us to set the traditional per occurrence limit to zero.

68. One can ask why the plaintiff does not just offer the threshold amount every time in the hopes of triggering the high post-rejection limits or receiving the threshold amount. The answer is that in cases that do not have much value, the insurer will reject the offer and the plaintiff will thus lose the opportunity to avoid risk through settlement. Moreover, having higher insurance limits does not help the plaintiff unless there is a significant probability of a judgment in excess of the sum of policy limits and the insured's assets available for attachment. *But cf.* Tom Baker, *Blood Money, New Money and the Moral Economy of Tort Law in Action*, 35 LAW & SOC. REV. 275 (2001) (noting traditions against aggressive collection of insured defendant's personal assets).

This contract discovered through genetic programming differs from the current default duty to settle in several ways: first, it does not set the post-rejection limit to infinity; rather it caps it at what one would be, prior to the materialization of the judgment, the maximum plausible judgment that would be entered against the insured. Second, it does not require the plaintiff to have made a settlement offer that is "reasonable" in light of the lawsuit; rather the duty to settle is triggered by a settlement offer less than a lawsuit-independent amount. And third, it induces low settlement offers from the plaintiff by setting the per occurrence limit to zero if the plaintiff fails to make a settlement offer lower than the threshold. This new contract reduces the effective cost of accidents down to $2,118, which is only one dollar less than achieved by a contract in which the post-rejection limit did not depend on statistics about the lawsuit but was simply set to the fixed amount $549,474.

The experiment just conducted suggests that, if all one were facing was a single known portfolio of lawsuits to be brought by risk neutral plaintiffs, conditioning obligations of the insurer on statistical characteristics of the lawsuit that materialized would not be particularly worthwhile. One could achieve virtually all of the same savings through a contract with a modified yet simple and invariant safe harbor threshold, traditional per occurrence limit (of zero) and a high but not infinite post-rejection limit. Before this preliminary conclusion can be hardened, however, one needs to conduct a few more experiments.

The first follow-up experiment relaxes the assumption that all plaintiffs are risk neutral and permits plaintiffs to have differing levels of risk aversion. In addition, the genetic programming process was varied to accord additional fitness to models that used the easier-to-compute statistics, such as the maximum plausible judgment and the zero judgment probability, rather than statistics such as the truncated standard deviation requiring greater knowledge about the distribution of judgments likely to occur in the underlying litigation.

Model	Contract		Accident Costs
1	contract	[17095, 17095, ∞]	1688
2	contract	[16217, 0, 11606]	1526
3	contract	$\left[18812.2, -q99, \frac{q99}{\sqrt{10}}\right]$	1483.3
4	contract	[21137.1, 4 med, tStDev]	1379.99

Table 3

The table above shows interesting models that emerge from an experiment implementing this idea in which 300 initial models evolved over half a million iterations. Model 1 in the table is the best traditional insurance contract for this portfolio. By traditional, I mean that the safe harbor threshold is tied to the per occurrence limit and the post rejection limit is infinite. The per occurrence limit in this model is $17,095 and the cost of accidents under this model is $1,668.[69] Model 2 is the best lawsuit-invariant solution that could be found for this portfolio. The insured does best with a zero traditional per occurrence limit, a relatively low safe harbor threshold of $16,217, and a post-rejection limit of $11606. This contract reduces accident costs down to $1,527, showing again that a modification of the current duty to settle will often be in the insured's best interest. Model 3 is the best solution that could be found in which the only statistic relied upon is the maximum plausible judgment. By setting the threshold equal to $18,811 the traditional per occurrence limit to 0 and the post-rejection limit to a fraction of the maximum plausible judgment, the cost of accidents can be reduced down to $1,483. Model 4 is the model that most reduced the cost of accidents. It sets the threshold at $21,137, the per occurrence limit at four times the median judgment, and the post-rejection limit at the standard deviation of the judgment. Figure 7 below shows the traditional per occurrence limit and post-rejection limit that would result from applying this formula to the sample large lawsuit portfolio. One can see that the post-rejection limit tends to be well above the traditional per occurrence limit but is hardly infinite.

69. I also examined a model in which the safe harbor threshold was the lesser of a specified amount and the truncated mean of the distribution. Arguably such a contract would best track the modal duty to settle now prevailing in the United States. The results did not differ greatly, however. The insured could get accident costs down to $1,656 via a contract that set the per occurrence limit at $17,090, the safe harbor threshold at the lesser of $17,090 and the truncated mean of the judgment distribution, and the post-rejection limit at infinity.

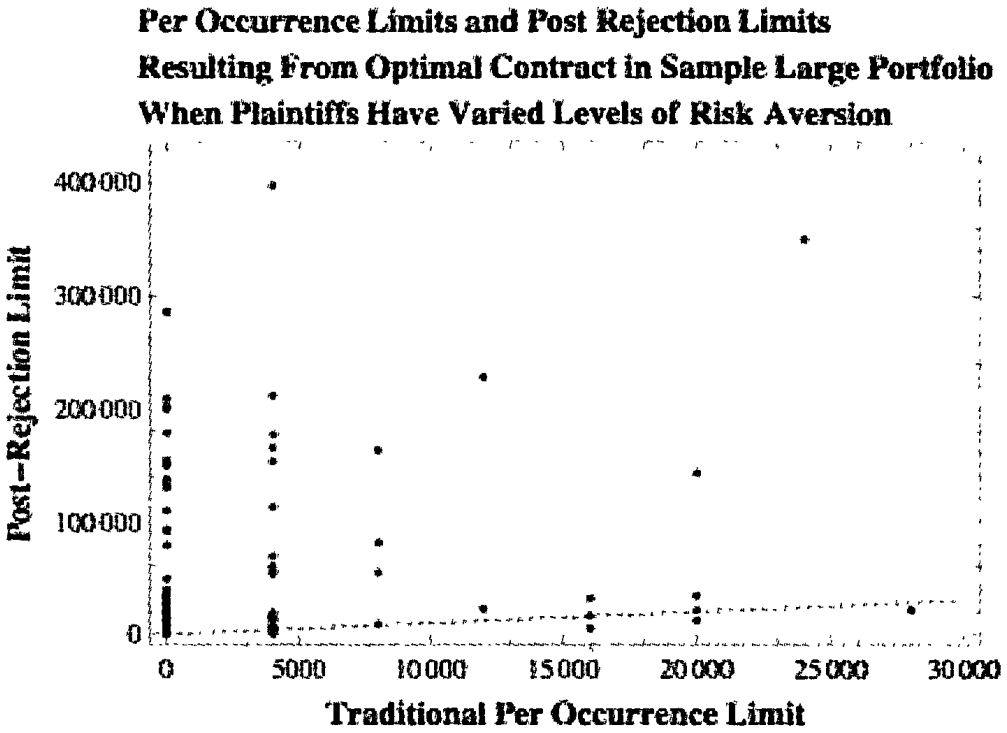

Figure 7

III. BARRIERS TO IMPLEMENTATION

Right now, if one wants different per occurrence limits to apply to different sorts of lawsuits or different duties to settle to apply to different sorts of lawsuits, one basically has to purchase multiple insurance contracts, the coordination of which would be extremely difficult. Moreover, the classifications used by those insurance contracts, relying as they likely would on verbal characterizations of the lawsuits alone rather than verbal characterizations supplemented by statistical analysis, would probably map poorly into the sort of classification scheme the insured would prefer. And so, if I could summarize what I have done in this article thus far, it is to show that there would be significant savings to insureds and probable benefits to the economy if liability insurance contracts incorporated statistical concepts into both their obligation to pay judgments on behalf of the insured, and in determining the extent of any duties to settle. To use a physics analogy, we could release vast amounts of economic energy if we could use statistics to "split" the insurance contract so that it responded to statistical features of the lawsuit.

And yet, I must now confess that statistical penetration of the liability insurance contract will require the creation of an infrastructure that does not presently exist and whose creation may prove rather difficult. It may be that this article is more a lament for transaction costs than a recipe for practical reform. And this is so because the obstacles to creating liability insurance contracts that respond to statistical features of lawsuits are significant. The issues are partly about the particular features of the statistical formulas suggested here, but more about the use of statistical formulas at all.

The first implementation problem is one of "ordering:" use of statistical formulas would either create additional uncertainty about the amount of liability insurance coverage available in each underlying case, or would require a mechanism that would conclusively fix variables in statistical formulas in advance of any resolution of the underlying dispute between insured and alleged victim. If the per occurrence limit under a liability insurance contract were, for example, $300,000 minus the maximum plausible judgment, and the insurer was claiming the maximum plausible judgment to be $500,000 and the insured was claiming the maximum plausible judgment to be $160,000, one would not know if the amount of insurance assets available to resolve the litigation were zero or $140,000. One would thus be forced to live with uncertainty or to develop a mechanism to resolve insurance issues ahead of the underlying litigation.

Before jumping to the conclusion that this difficulty renders the whole issue moot, it must be realized that the dilemma I have described is one already present in the field. When coverage is, as frequently occurs, disputed on the basis of some traditional exclusion or otherwise, all sorts of problems exist.[70] If the underlying litigation is resolved ahead of coverage issues, the parties have difficulty knowing what assets are available to resolve the dispute. The insurer often has difficulty settling because amounts paid to the plaintiff will, as a practical or legal matter, be difficult to recoup in the event the coverage issues are resolved in its favor.[71]

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70. For more on the nature of these problems arising from such disputes, see Ellen S. Pryor & Will Pryor, *Concurrent Mediation of Liability and Insurance Coverage Disputes*, 4 CONN. INS. L.J. 485, 486, 520 (1998).

71. A number of authorities address this issue. *See, e.g.*, Excess Underwriters at Lloyd's, London v. Frank's Casing Crew & Rental Tools, Inc., No. 02-0730, 2005 WL 1252321 (Tex. May 27, 2005) (discussing interplay between recoupment rules and settlement doctrine), *reh'g granted*, (Jan 6, 2006); Michael F. Aylward, *Timing and Settlement Considerations When Recoupment is Sought in Buss Cases*, 65 DEF. COUNS. J. 508, 508-09 (1998); John Dexter Marble et al., *Recent Developments in Insurance Coverage Litigation*, 39 TORT, TRIAL & INS. PRAC. L.J. 493, 505-10 (2004).

Insistence on resolution of coverage first, however, is likely to delay any recovery due plaintiff, increase the costs of litigation[72] (particularly if the underlying case proves meritless)[73] and heighten conflict-of-interest problems among counsel because disposition of the coverage lawsuit may, as either a practical or legal matter, affect disposition of the underlying lawsuit. And yet, we have had this dilemma for years, with different states resolving the dilemma differently,[74] and our system of civil justice has not entirely collapsed. We have, instead, learned how to cope with it, albeit with considerable discomfort and often inconsistent emphases.

What use of statistics might do, however, is vastly increase the percentage of cases in which the ordering problem existed. For even if traditional coverage were otherwise clear, which is often the case in lawsuits not making their way into insurance textbooks, the value of various statistical variables used in the formula might well not be. Hence, the ordering dilemma that presently infuses modern American civil litigation could be made worse. Moreover, although there is often overlap between resolution of insurance issues and resolution of the underlying lawsuit,[75] insurance disputes based on statistical valuations of the underlying lawsuit are particularly problematic. Suppose, for example, that a court, or some alternative dispute resolution mechanism backed by the court, determines that the expected value of a judgment in the underlying case is $100,000, that determination is likely to have a major effect on settlement and resolution of the underlying lawsuit. It will also require some care to keep such valuations of the underlying lawsuit from prejudicing the finder of fact in any subsequent trial of the underlying lawsuit.

An additional problem with insurance policies whose obligations are conditioned on statistical features of the lawsuit that materializes is that our legal system does not have an infrastructure in place to resolve disputes arising thereunder. We have created precedents, authorities and experts

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72. *See* Montrose Chem. Corp. v. Super. Ct., 31 Cal. Rptr. 2d 38, 43 (Cal. Ct. App. 1994).

73. If the underlying case is meritless and the defendant wins, there is generally no need to resolve coverage issues because the insurer has no payment obligation.

74. Authorities are collected in Robert H. Jerry II, UNDERSTANDING INSURANCE LAW 943-45 (3d ed.2002).

75. An example would be a determination that the conduct of the defendant was sufficiently intentional as to activate an "intentional conduct" exclusion in the liability insurance policy. Such a determination is said to have a significant effect on the underlying litigation. *See* State Farm Fire & Cas. Co. v. Shelton, 531 N.E.2d 913, 917 (Ill. App. Ct. 1988).

about the application of various liability insurance provisions to particular disputes. There is an "industry" devoted to resolution of pollution exclusion issues or occurrence counting or the coordination of layers of insurance over time. The system with respect to statistical variables is far less developed. While insurers and attorneys in litigation frequently do "value" lawsuits by back-of-the-envelope computation or rule-of-thumb determinations of such things as the expected value of damages or the maximum plausible judgment, generally little turns on whether they got these amounts "exactly" right. It would be rare for these determinations to be challenged outside of unusual malpractice cases in which an attorney makes an atrocious settlement recommendation or in the relatively infrequent breach of the duty to settle cases. If statistical variables were used to compute per occurrence limits or settlement duties, however, these computations would always matter. This is not to say that an industry of valuation experts could not be developed – indeed, its creation might be useful for many reasons – simply that the absence of an existing industry will make it challenging for early adopters.

Finally, there would be a serious question of when the statistics would be measured. Estimates of damage distributions in a lawsuit change all the time as new information develops. Would one have the policy limits change in a corresponding fashion? And if one attempted to fix a time for when the statistics were to be computed, what would that time be? Would it be when the complaint is filed at a moment before trial, or some intermediate time? These are not trivial implementation questions, and despite some effort on my part, I cannot say I have developed any resolution of this issue that strikes me as perfectly satisfactory.

The difficulties thus mentioned will exist regardless of which statistics are used to determine insurance obligations. Some difficulties, however, will depend on which statistics are selected for inclusion in a formula. Fortunately, the statistics that appear to matter – the maximum plausible judgment and probability of a defense (zero) judgment are numbers and ideas with which attorneys and insurers have experience. And this is particularly so where the "prize" for success is potentially so very large. Attorneys frequently speak of a defendant's maximum "exposure" or "the worst case." And in many cases, so long as reasonable people would agree that the worst case exceeds some threshold value ($317,371 in my example), the same limit would apply regardless of whether some people thought the worst case was $400,000 and others thought it was $1 million. One would have to find an expert who could testify that the worst case was

less than $317,371 before a real controversy would arise.[76] Moreover, a virtue of the maximum plausible judgment formula is that it requires calculation of only one number and does not require the parties to agree, really, on the value of any of the smaller judgments that might occur in the lawsuit.

Adding the probability of a defense (zero) judgment to the formula makes matters more complex, but perhaps not fatally so. Lawyers estimate all the time: it is the probability that the defendant will "win."

This is not, of course, to deny that there would be significant issues that would arise in moving to statistics-based limits. The difficulty with the maximum plausible judgment formula is that a little difference in the value of the 99th percentile judgment can have a drastic effect on the position of the insured. Could anyone distinguish with any confidence, for example, a lawsuit in which the largest realistic judgment was $317,000 and a lawsuit in which the largest realistic judgment was $318,000? Probably not. Yet, whether the insured had maximum coverage or zero coverage would depend on such a tenuous distinction. On the other hand, perhaps our discomfort with resting contractual obligations on such a tenuous distinction is simply a function of novelty. Billions of dollars, for example, have rested on the dubious metaphysics of occurrence counting[77] or distinctions amongst various meanings for the word "sudden."[78]

Finally, some formulae based on statistics are likely to force parties and attorneys into the sort of contortions with which our judicial system feels extremely uncomfortable. Consider, for example, an insurance policy in which insurance coverage increased as the mean value of the expected judgment increased.[79] The defendant would likely argue in the coverage litigation that his conduct could generate a really large judgment while in

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76. It is often said that one can find an expert to testify to anything. *See* Samuel R. Gross, *Expert Evidence*, 1991 WIS. L. REV. 1113, 1115 (1991). However, there may be some class of cases in which testimony stating that the applicable behavior was below some threshold will be difficult to find, or simply not credible.

77. *See* World Trade Ctr. Props., LLC v. Hartford Fire Ins. Co., 345 F.3d 154 (2d Cir. 2003) (determining the number of "occurrences" for recovery purposes when terrorists destroyed the World Trade Center); Charles V. Bagli, *Towers' Insurance Must Pay Double*, N.Y. TIMES, Dec. 7, 2004, at A1 (finding two "occurrences" and thus increasing insurer liability by $3.6 billion).

78. *See* Kenneth S. Abraham, *The Rise and Fall of Commercial Liability Insurance*, 87 VA. L. REV. 85, 97–98 (2001).

79. To be sure, the research done for this paper suggests that such a policy would likely be unwise. But once the "cat is out of the bag" and use of statistical variables is accepted, there is little telling what sort of formulae might evolve.

the underlying litigation the defendant would likely argue that its conduct should generate a minimal judgment. Although American courts appear to have accommodated themselves over the years to inconsistent pleading, our tolerance for inconsistent testimony is not yet so high.[80]

CONCLUSION

This article has developed two basic mechanisms for reducing the cost of accidents through improved liability insurance contracts. The first method relies on classification of lawsuits, using statistics about the distribution of damages in any lawsuit that materializes in order to tailor parameters of the liability insurance contract such as the per occurrence limit. The research conducted here suggest that this method of classification can theoretically reduce the cost of accidents on the order of 10% but that there are significant practical obstacles to implementation of such a scheme, including issues about when the various statistics would be measured and procedures for resolving the inevitable disagreements about the values of the statistics on which the formula would be based.

The second method relies on developing a liability insurance contract that had a modified duty to settle built in. The contract would declare a conventional per occurrence limit, a safe harbor threshold and a post-rejection limit. In any lawsuit that materialized, if the plaintiff extended an offer that was less than or equal to the safe harbor threshold and the insurer rejected it, the per occurrence limit would become the post-rejection limit. Otherwise, the conventional per occurrence limit would continue in effect.

The experiments conducted for this article suggest that the reduction in the effective cost of accidents from this modification of the contract are of an order of magnitude that cannot be ignored. Moreover, the modified duty to settle would significantly reduce administrative costs associated with insurance disputes. No longer would there be any requirement that the "reasonableness" of a settlement offer be evaluated ex post in order to determine whether an effectively infinite policy limit had been triggered. Instead, one would just mechanically compare the settlement offer with the safe harbor threshold: if it was a "real settlement offer,"[81] and it was lower

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80. *See* State Farm Fire & Cas. Co. v. Gandy, 925 S.W.2d 696, 712-15 (Tex. 1996) (court criticizes parties' changing shadings of their stories that occur as a natural result of insurance settlement).

81. By real settlement offer, I simply mean that the body of law that currently exists dictating what constitutes a settlement offer for purposes of the duty to settle would need to persist. A settlement offer that was open for five minutes and made before the insurer had a

than the safe harbor threshold and the insurer rejected it, the post-rejection limit would apply. Moreover, since the post-rejection limit would be finite rather than the open ended obligation that currently exists, insurers might be more accepting of the duty to settle and litigation on the subject might decline.

The experiments show that a modest additional reduction in the cost of accidents can be achieved through a combination of a modified duty to settle and classification of lawsuits. Unfortunately, however, in the most realistic settings in which the risk aversion of victims varied, significant results could not be obtained without use of statistics that may prove somewhat difficult to ascertain, such as the median judgment, or quite difficult to fix with any precision or consensus, such as the mean judgment or standard deviation of judgments.

Although implementation of the specific reforms suggested by the experiments conducting for this article may well not be immediately practicable, they nonetheless provide important direction for the contemporary regulation of insurance both in the United States and elsewhere. First, courts should not be at all hostile to liability insurance contracts that provide different limits or even exclusions from coverage based on statistical characteristics of the lawsuit that materializes or proxies for those statistical characteristics. There may well be good reason for the insured to want to have relatively low limits for some class of cases and relatively high limits for others. And, counter-intuitively, and reinforcing the conclusion of Professor Sykes and others who have published in this field, the class of cases for which insureds may want relatively low limits are precisely the cases that ex ante would be most threatening to the insured.

Second, in the event courts see contractual modifications to the traditional duty to settle, such as a contractual cap on damages for its violation, they should restrain any reflexive hostility to such a modification. For sophisticated insureds, such a modification may very well have been intended by the parties and very much in the ex ante interest of the insured.[82]

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chance to evaluate the case likely would not count. Similarly, a settlement offer that did not resolve the litigation would need to be treated differently than a settlement offer that conclusively ended litigation.

82. The story would be considerably more complex for insureds that lack realistic access to the resources that are utilized under which to appraise the content of their contracts. For these insureds, differential limits would recapitulate traditional insurance law concerns about the quality of assent and the ability to negotiate for different terms. If a

Third, domestic and foreign jurisdictions that have not yet hardened their law in this area should not leap towards adoption of the prevailing American model regarding the duty to settle. The experiments conducted for this article strongly suggest that, while some duty to settle is likely appropriate, the modal formulation of the law in the United States will frequently not be optimal.

Fourth, legislators in those jurisdictions that have adopted a traditional duty to settle, characterized by the potential for unlimited damages in the event of a breach, should not feel restrained in re-examining the wisdom of their current rules. By way of example, just as various multiples have been used in limiting non-economic damage recovery in some classes of tort cases, legislators (or courts unburdened by a heavy emphasis on *stare decisis*) might consider use of a treble damages remedy for breach of the duty to settle under which the most the insurer could be liable for in the event it failed to accept a "reasonable" settlement offer within limits was thrice the original per occurrence limit. Although this limitation would not force insurers totally to internalize the cost of their settlement decisions, it might do so sufficiently to reduce the otherwise existing conflict of interest substantially while not providing plaintiffs with an unlimited pot of gold from which to recover for wrongs done to them. Given the administrative difficulties associated with classification of lawsuits and the fact that one can obtain 90% or so of the benefits discussed in this article without classification of lawsuits, the best course of action would appear to be fostering the more complex duty to settle described here. The greatest impediment would not appear to be technical, but rather those of policy. Those jurisdictions that have made it a tort to violate a duty to settle or who seem, as one might infer from reading some of the opinions, to have developed the notion that the duty to settle represents some sort of moral obligation on the part of the insurer, although curiously not one shared in other presumably moral parts of the globe, will have difficulty moving to a regime in which the contours of a duty to settle are the subject of a negotiation. Tempering any movement in favor of this limitation, however, must be a recognition that, while such a change might well be in the

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change were made in liability insurance policies sold to unsophisticated insureds, some sort of educational process should occur in which insureds have the opportunity to understand the concept of a duty to settle, the remedies available for breach, and the opportunities to reduce vulnerability through purchase of liability insurance with higher traditional per occurrence limits. *See generally* JeffreyW. Stempel, *Reassessing the "Sophisticated" Policyholder Defense in Insurance Coverage Litigation*, 42 DRAKE L. REV. 807, 849-857 (1993) (discussing ways in which sophistication of insured can be assessed and improved).

interests of insureds, it would be against the interests of victims who currently use the duty to settle as a kind of state-imposed third party beneficiary provision in insurance contracts palliating our legal system's inability to prevent people from causing far more harm than they can possibly every pay for.

Moreover, although the more complex duty to settle discussed here will unquestionably reduce the cost of accidents to the insured, we are talking, to some extent, about a zero sum game in which the reduction comes at the expense of accident victims. Indeed, the ability of the more complex insurance contract to "better" externalize the cost of accidents by permitting the insured to better exploit its own inability to pay for all the harm it is capable of causing may result in slightly higher rates of accidents. And the notion of doing so via an "in-your-face" kind of scheme in which the victim has access to little or no insurance unless it makes a fairly low settlement offer is likely to highlight rather than obfuscate the transfer of wealth that is occurring. This raises the age-old question of the extent to which government should regulate private contracts in order to benefit non-parties. It raises the question of whether government should more directly assure victim compensation. It would be interesting, though certainly not unprecedented, if government were to forbid the improved liability insurance contract created in this article through "genetic modification" not because it failed to give insureds value, but precisely because it did.

APPENDIX

I. GENETIC PROGRAMMING

The key to genetic programming is to recognize that mathematical expressions such as various formulae can all be represented by what mathematicians refer to as a tree (or acyclic graph). Thus, the Newtonian expression for gravitational force ($F=G\frac{Mm}{r^2}$) can be visualized as follows in Figure 8:[83]

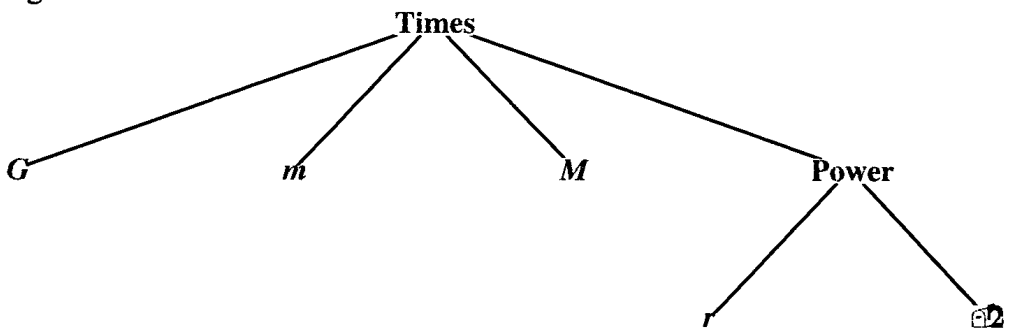


Figure 8

The figure shows that the children of the multiplication operator are Power (the exponentiation operator) and the symbols G (a gravitational constant), M (the mass of the first object) and m (the mass of the second object). The children of Power are in turn r (the distance between the two objects) and -2.

83. Graphics for this appendix were generated using a pre-release version of Evolved Analytic's "Data Modeler" package, which extends the capabilities of the Mathematica programming language. The Data Modeler package was also used to conduct the genetic programming used in the body of this article.

The first thing to see is that one can "mutate" a tree by changing one or more of its branches. In

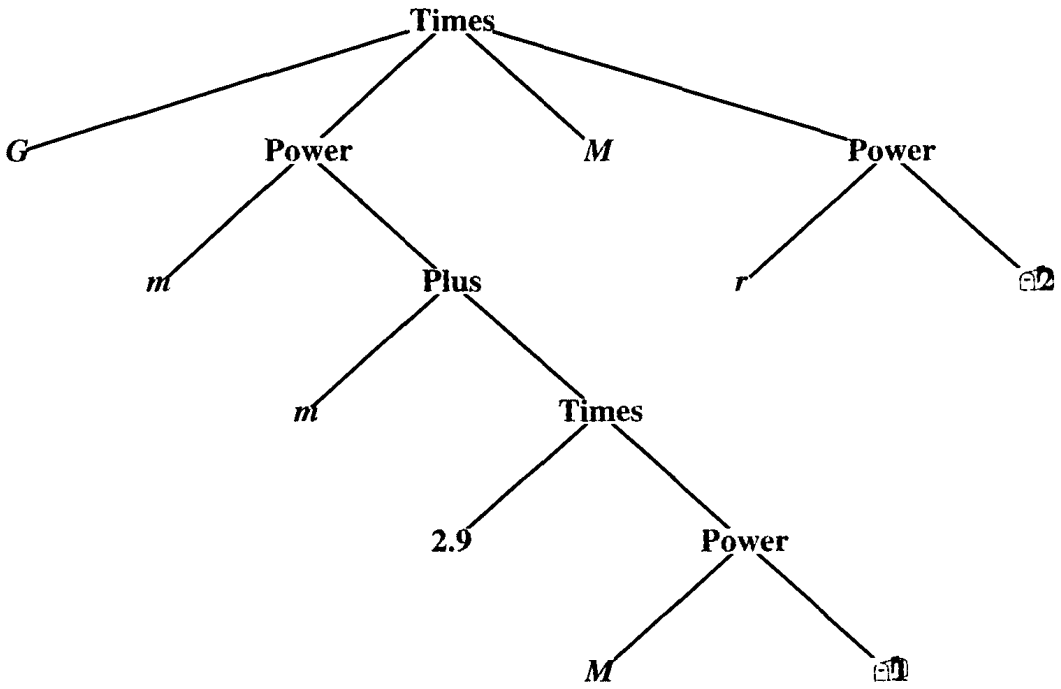
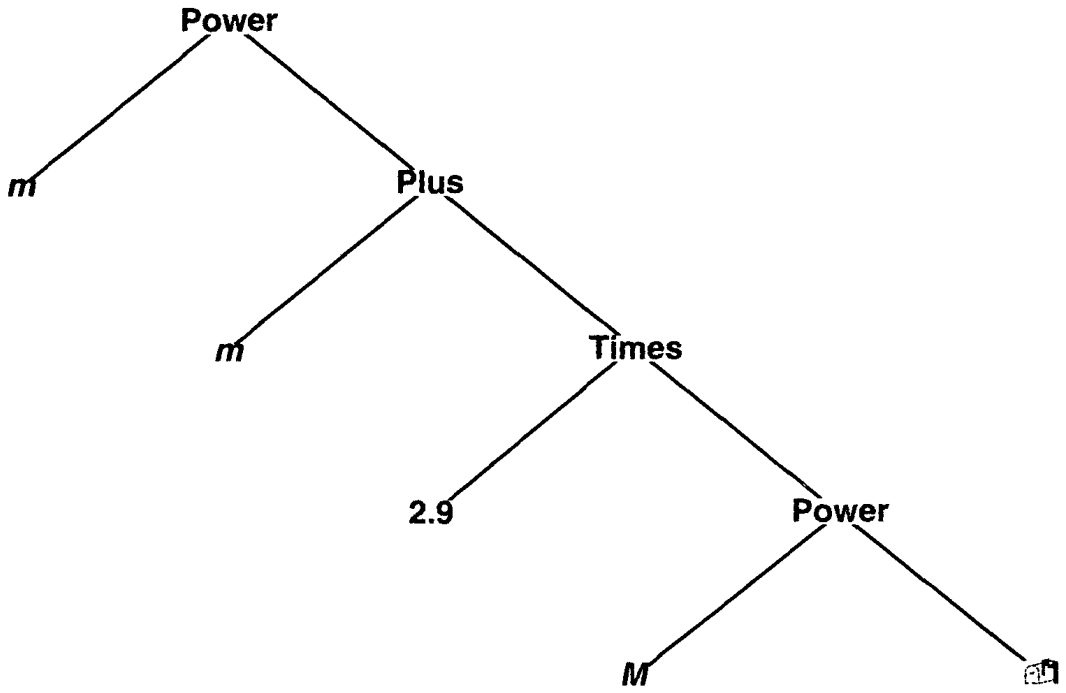


Figure 9, we see the expression in Figure 8 has mutated by lopping off the child m and replacing it with the expression on the following page



so that the result is:

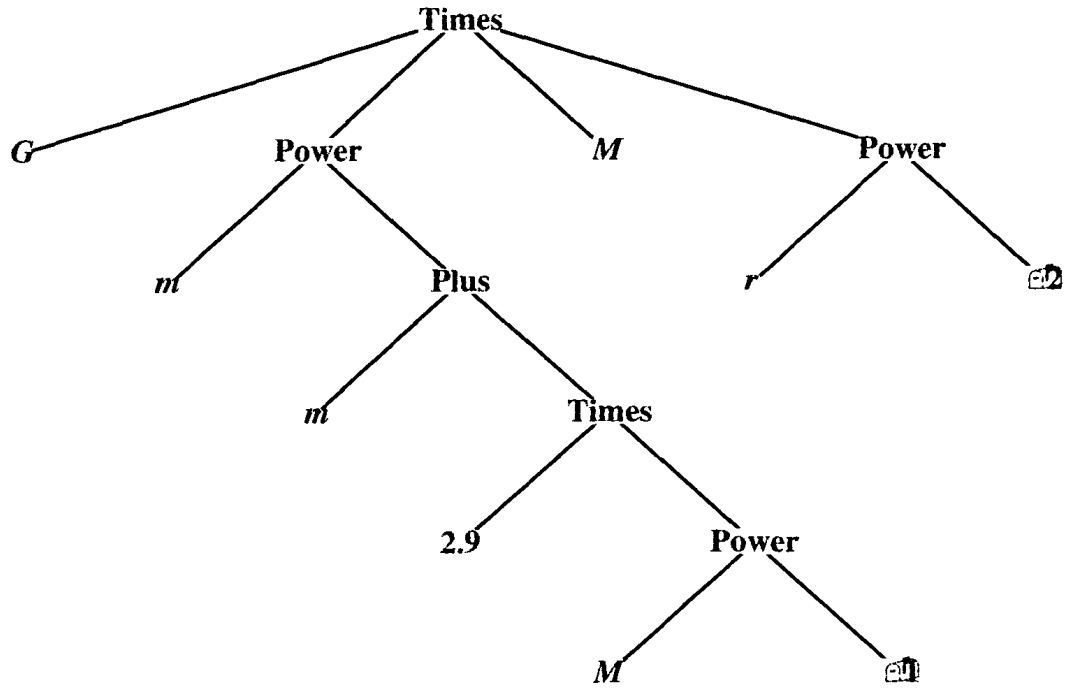


Figure 9

Moreover, mathematical expressions can have "sex" by exchanging branches. In Figure 10 below, I show the results of an exchange of parts between the original expression for Newtonian Gravity and its mutant offspring.

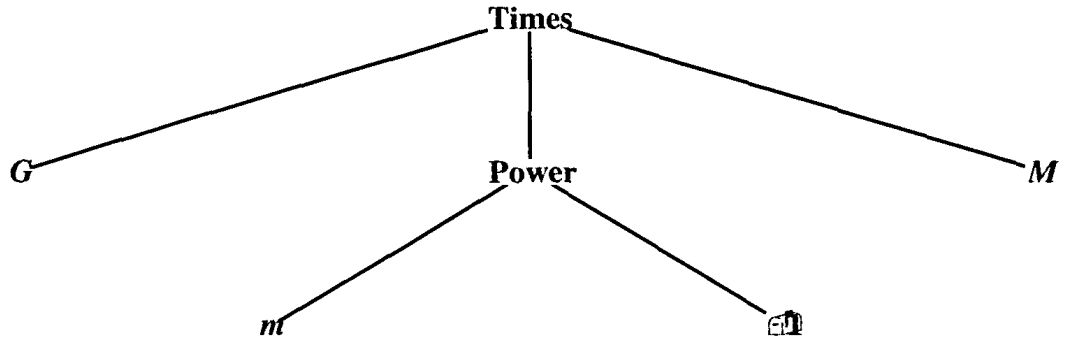


Figure 10

If we were writing this last tree as a conventional formula, it would G M/m.

So, the idea of genetic programming is to randomly create a large number of these tree-structured mathematical expressions out of some grammar of permissible operations (such as addition, multiplication, logarithm), some variables (such as G, M, m, r, t1 and t2 in my example here or various statistical measures, as is done in the main text), and some "terminals" such as integers or ranges of real numbers. Figure 11 on the following page shows a sample of eight such initial random expressions.

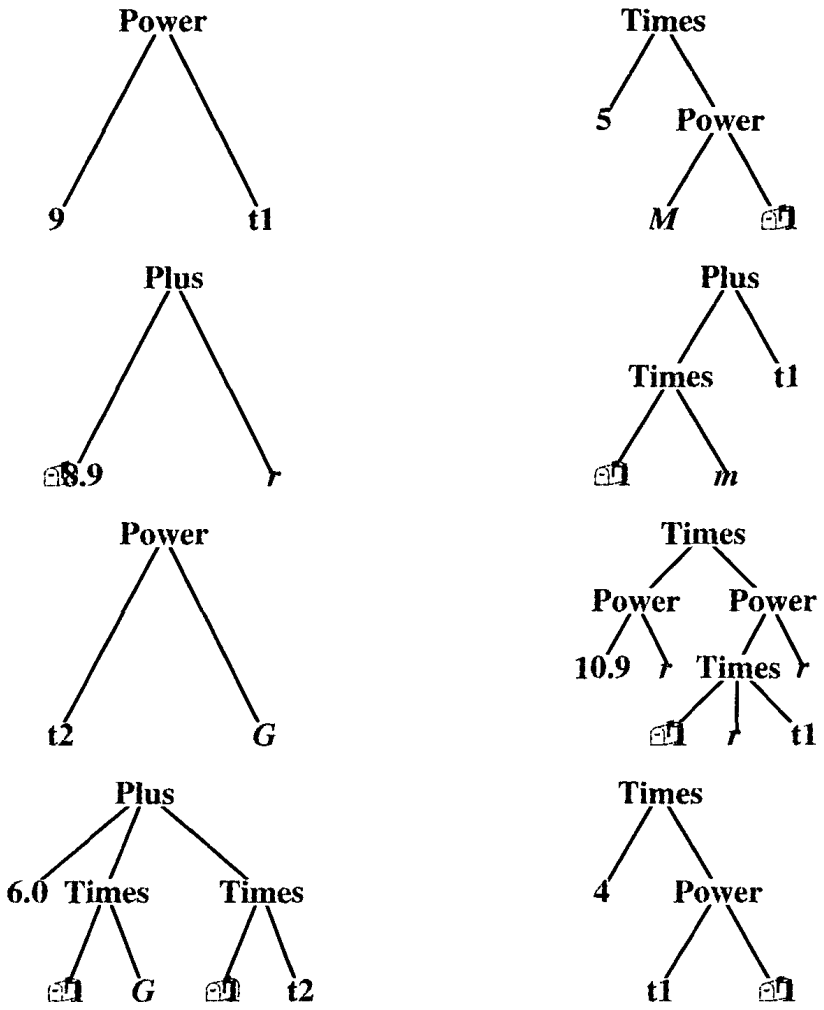


Figure 11

Each expression is then associated with several "fitness values," such as the complexity of the expression (those with many branches and leaves are more complex), or its integral over some range, or, as in the example in text, the accident costs faced by an insured when per occurrence limits of a policy are chosen on the basis of the expression.

Although the details vary from implementation to implementation, basically at this point one looks to see which models are doing well on the various fitness measures and permits those expressions either to continue on into the next generation, have sex with another successful expression or mutate. And the process continues until various criteria are met.

Of course, it gets very complicated. Choices must be made about which mathematical functions to permit in the tree or about the maximum permissible size of trees or the maximum number of children a part of an expression can have. And choices must likewise be made in the evolutionary process about how exactly to determine who gets to have sex with whom, whether mutations are to preserve the "depth" of various expressions, and other technical matters. Moreover, various problems must be addressed along the way such as how to handle expressions whose fitness values cannot be computed.

If the matter is done with some care and patience, however, the results are often remarkable.[84] One tends to find functions that do extremely well on various fitness values.

II. GENERATING A CONTRACT FROM AN EXPRESSION

The genetic programming ultimately undertaken for this article requires construction of a contract that uses multiple formulas to respectively determine the traditional per occurrence limit, safe harbor threshold and

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84. By way of example, in drafting this appendix, I wondered whether genetic programming – starting with essentially zero knowledge of physics – could "deduce" Newton's formula for the gravitational force between two objects. I thus created 500 records of sample data containing the mass of two objects and the distance between them and several pieces of data that end up being irrelevant such as the temperature of the objects. For each record, I calculated – using the correct formula – the Newtonian gravitational force between the objects. I then evolved an initial population of 200 models with fitness being determined by the parsimony of the model and its ability to predict correctly the gravitational force between the pairs of objects. In less than five minutes on a modern laptop computer, genetic programming was able to calculate the formula as 2.418667689282812*^-20 + (6.67419999999999*^-11*m1*m2)/r^2, which is accurate to better than one part in 100 quintillion. Not only did the process come up with the correct functional form for gravity, it also successfully avoided inclusion of the extraneous temperature data. Here is the Mathematica code that accomplishes this task.

gravitydataset = Map[Flatten[{#, 6.6742*^-11*#[[1]]*#[[2]]/((#[[3]])^2)}] &, Table[{RandomReal[{0, 100000000000}], RandomReal[{0, 100000000000}], RandomReal[{0, 5000000000}], RandomReal[{1, 700}], RandomReal[{1, 700}]}, {500}]];

srgravity = SymbolicRegression[Most /@ gravitydataset, Last /@ gravitydataset, DataVariables -> {m1, m2, r, t1, t2}, PopulationSize -> 200, TerminalSet -> {1, {"Random"[Integer, {1, 10}], "Random"[Real, {0, 1*^-10}]}}, TimeConstraint -> 300];

InputForm[ModelExpression[OptimizeModel[Last@ParetoFront@srgravity, Most /@ gravitydataset, Last /@ gravitydataset, DataVariables -> {m1, m2, d, t1, t2}]]]

post-rejection limit. This proves a bit difficult since the package used to conduct genetic programming is presently designed to evolve only a single mathematical expression, not to separately evolve each of its constituent parts. What is needed is a transformation that decomposes a single mathematical expression (represented as a tree) into multiple parts each of which can be used separately in computing the fitness of a particular expression. This turns out to be relatively easy. If the expression has fewer than the requisite number of parts, one simply "pads" the parts of expression with its last part until it has the requisite number of parts and sticks a desired "expression head" at the top of the expression tree. If the expression has the correct number of parts, one simply replaces the original expression head with the desired expression head. And if the expression has more than the requisite number of parts, one simply lops off the excess parts and replaces the original expression head with the desired expression head. Thus, to conduct multi-expression genetic programming, one evolves a single expression in the usual way, but one makes the fitness of that expression depend on a function of the transformation of that single expression into one with multiple parts.

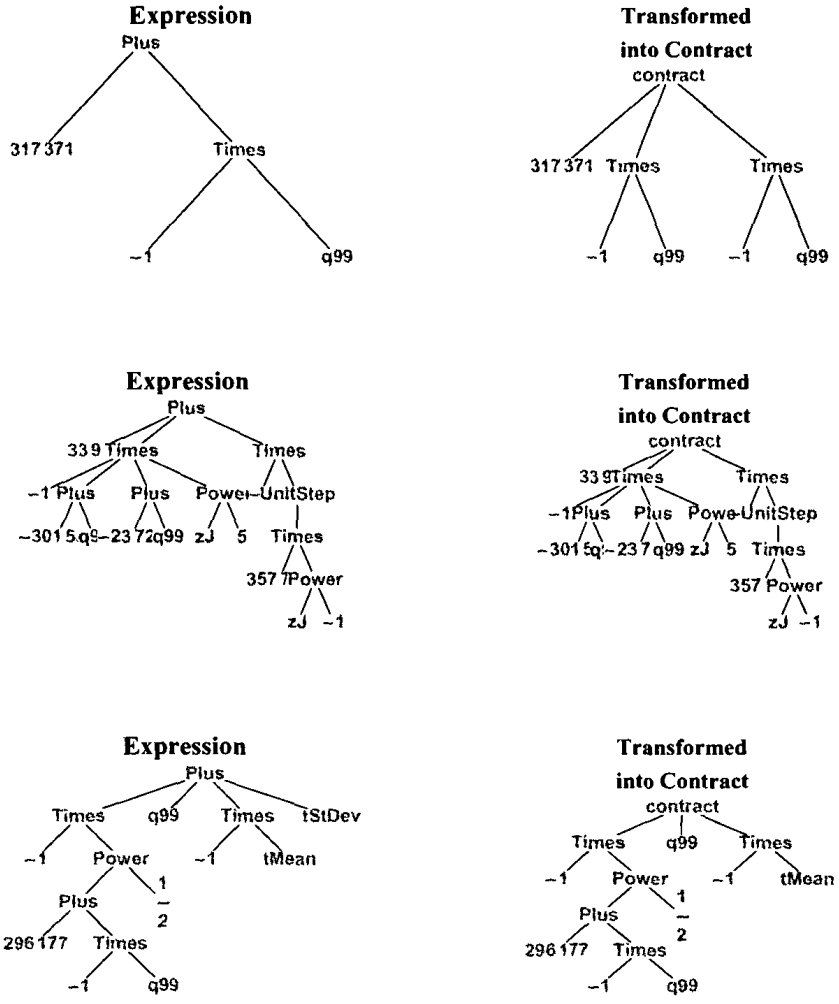


Figure 12

Figure 12 above illustrates the transformation. The expression in the top left panel (Model 2) has only two parts. To convert it into a three part contract, therefore, one simply replicates the last part and makes "contract" the head of the expression. The new expression is shown in the top right panel. One can now apply each of the formulae in the contract to the lawsuit statistics data and determine actual numeric values for the per

occurrence limit, the safe harbor threshold and the post-rejection limit.[85] The expression in the middle left panel has three parts. To convert it into a three part contract, one just replaces the expression head with contract. Again, one can now apply each of the formulae in the contract to the lawsuit statistics and determine actual numeric values. Finally, the expression in the bottom left panel has four parts. To convert it into a three part contract, one simply eliminates all but the first three parts and makes "contract" the head of the expression. The formulae are then applied to the lawsuit statistics and one determines the fitness of the contract.

This appendix provides the mathematics lurking behind the scene in this article. The notation used in this appendix is as follows.

Ω is the set of judgments that can befall an insured. ω is an element of Ω. S is the set of lawsuits that can befall an insured and s is an element of S. The function Φ determines the probability that event ω will occur. $\ell[\omega]$ is the size of the loss to the insured created by event ω assuming no insurance were to exist. u is the utility function of the insured; in general, it is assumed that the utility function has conventional properties $u'>0$ and $u''<0$. u^{-1} is the inverse utility function. w_0 is the initial wealth of the insured and wmin is the value of the insured's assets that are exempt from execution by judgment creditors. p is the premium the insured charges for the insurance. The insurance market is assumed to be basically competitive so that any premium that makes the insurer a non-negative profit is available.

The conventional liability insurance optimization problem may be written as shown below on the following page. Notice that the insurer is constrained to offer a "conventionally shaped" policy that pays fully up to some per occurrence limit and then pays the per occurrence limit for judgments in excess of that amount. We thus have a low-dimensional global optimization problem in which we are seeking to minimize the premium (a real number) and a single per occurrence limit, also a single real number.

85. Thus, if a lawsuit had a maximum plausible judgment (q99) of $100,000, the threshold value would be $317,370, the per occurrence limit would be -$100,000 (which would be clipped to zero) and the post-rejection limit would be -$100,000 (which would likewise be clipped to zero).

$$\min_{\{p\in\mathbb{R},\,q\in\mathbb{R}\}} w_0 - u^{-1}\left[\sum_{\omega\in\Omega} \phi[\omega]\ u[\mathrm{Max}[w_0+\mathrm{Min}[q,\ell[\omega]]-p,w_{\min}]]\right]$$

$$\text{s.t. } p \geq \sum_{\omega\in\Omega} \phi[\omega]\ \mathrm{Min}[q,\ell[\omega]]]$$

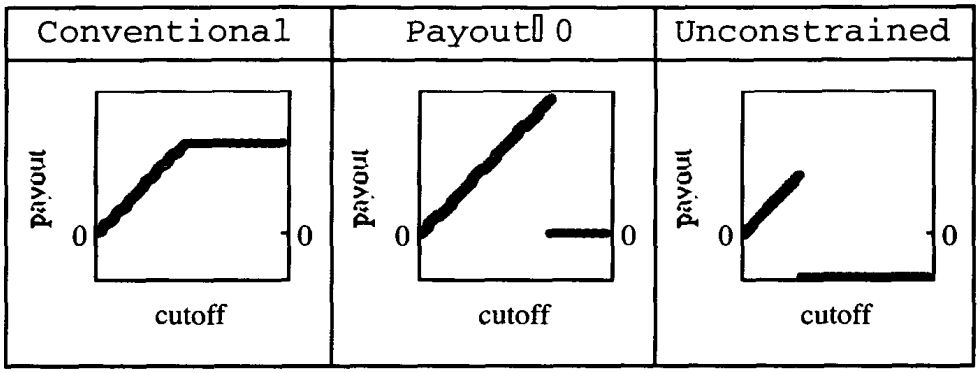
A more complex liability insurance optimization problem frees us from having a conventionally-shaped policy and instead permits a free-form insurance function that can provide different payments for different judgments. Conventionally, these payments would be bounded by zero from below and by the amount of the judgment from above, though this constraint can be relaxed. Notice that what we are seeking to minimize here is again the premium, but now we are seeking to minimize a set of values with the same cardinality as Ω.

If this mapping could in fact be created, it would provide highly optimized liability insurance for the insured. Unfortunately, this effort suffers two problems. This sort of high dimensional "global optimization" problem turns out to be extremely challenging to solve numerically. Various methods of approximation must generally be used such as simulated annealing, differential evolution, or genetic algorithms. Second, the mappings that emerge are often not non-decreasing: the insurer will pay *less* for a higher judgment than it will for a lower judgment. This means that, contrary to the incentives that generally now exist, the insurer will have a difficult-to-police incentive to maximize the liability of the insured. Moreover, under existing law, a mapping that would make the insurer pay less in the event of the insured's insolvency might well be unlawful. It is often the case that excellent solutions to this free-form optimization problem often do not assume the non-decreasing shape of conventional liability insurance shown in the left most panel of the graphic below on the following page, but something like the middle panel (if a non-negativity constraint is imposed) or the right panel if a non-negativity constraint is not imposed.

$$\min_{\{p\in\mathbb{R},\, q\in\mathbb{R}^{|\Omega|}\to\mathbb{R}\}}$$

$$w_0 - u^{-1}\left[\sum_{\omega\in\Omega} \phi[\omega]\, u[\mathrm{Max}[w_0 + q[\ell[\omega]] - \ell[\omega] - p, w_{min}]]\right]$$

$$\text{s.t. } p \geq \sum_{\omega\in\Omega} \phi[\omega]\ q[\ell[\omega]]$$



To avoid the impracticability of developing a complex payment function and to avoid the legal and practical problems associated with liability insurance that would go to zero (or lower) if the judgment exceeded some amount, one could instead theoretically write a payment *function* q that had a conventional non-decreasing shape but that had a different per occurrence limit for each lawsuit. The idea would be to create an optimal mapping q from lawsuit to per occurrence limit.

$$\min_{\{p\in\mathbb{R},\, q\in s\to\mathbb{R}\}}$$

$$w_0 - u^{-1}\left[\sum_{\omega\in\Omega} \phi[\omega]\ u[\mathrm{Max}[w_0 + \mathrm{Min}[q[s[\omega]], \ell[\omega]]\right.$$

$$\left. - \ell[\omega] - p, w_{min}]]\right.$$

$$\text{s.t. } p \geq \sum_{\omega\in\Omega} \phi[\omega]\ \mathrm{Min}[q[s[\omega]], \ell[\omega]]]$$

This is again a multi-dimensional optimization problem, but one that is perhaps simpler in that one is optimizing over "only" the s possible lawsuits rather than the larger set of all possible events. And, indeed, this process is what is visualized in Figure 4 in the text. The problem, as noted in the text, is that while this process is mathematically possible in the artificial setting in which one can give a discrete label to each possible

lawsuit that might befall the insured, it is difficult to implement in practice precisely because of the difficulty of giving discrete labels to lawsuits.

To get around the problem of labeling lawsuit, this paper proceeds by determining statistical characteristics associated with each lawsuit and then examining function q that maps from the set of statistics to a per occurrence limit. The idea of this paper is to use genetic programming as a technique for exploring intelligently the immense if not infinite space of all possible functions in order to find those that optimally trade off parsimony against minimization of the cost of accidents (premiums + residual risk).

$$\min_{\{p\in\mathbb{R},\, q\in\{x_1,\ldots,x_n\}\to\mathbb{R}\}} w_0 - u^{-1}\left[\sum_{\omega\in\Omega}\phi[\omega]\; u[w_0+\mathrm{Min}[q[x_1,\ldots,x_n],\ell[\omega]]-\ell[\omega]-p]\right]$$

$$\text{s.t. } p\geq\sum_{\omega\in\Omega}\phi[\omega]\; \mathrm{Min}[q[x_1,\ldots,x_n],\ell[\omega]]$$

THE ECONOMIC CASE FOR GENDER-NEUTRAL LIFE INSURANCE

Richard A. Booth[*]

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INTRODUCTION

If there is any situation in which sex discrimination seems to be justified, it is in the pricing of life insurance. Women live longer than men on the average.[1] Accordingly, it is cheaper for an insurance company to

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1. While there is no doubt as a matter of statistics that women live longer than men, several commentators have questioned (1) whether this statistical fact is a matter of gender or other factors, (2) whether it is true at all times and in all cultures, and (3) indeed whether

insure the life of a woman, because the benefits will be paid out later and the cost in terms of the present value of the payout is therefore less. Thus, it is argued that to charge men and women the same price for life insurance would amount to a subsidy running from women to men.[2] As a result, men would buy too much insurance.[3]

Despite this seemingly compelling argument, the Supreme Court has held that gender-based insurance rates constitute illegal sex discrimination.[4] Legal scholars have condemned the Court's position as inconsistent with the principle that individuals should bear their own identifiable costs.[5]

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it is true as a predictive matter at present in the United States. *See generally* Lea Brilmayer et al., *Sex Discrimination in Employer-Sponsored Insurance Plans: A Legal and Demographic Analysis*, 47 U. CHI. L. REV. 505 (1980) [hereinafter Brilmayer, *Sex Discrimination*]; Lea Brilmayer et al., *The Efficient Use of Group Averages as Nondiscrimination: A Rejoinder to Professor Benston*, 50 U. CHI. L. REV. 222 (1983) [hereinafter Brilmayer, *Efficient Use*]; Barbara D. Underwood, *Law and the Crystal Ball: Predicting Behavior with Statistical Inference and Individualized Judgment*, 88 YALE L. J. 1408 (1979). As I argue here, it makes no difference anyway. Thus, I do not address this question in any detail.

2. *See generally* Kenneth S. Abraham, *Efficiency and Fairness in Insurance Risk Classification*, 71 VA. L. REV. 403 (1985).

3. Similarly, an annuity should cost more for a woman than for a man because the longer an annuitant is likely to live the more costly it is for the insurance company to pay the annuity. With unisex pricing, women would buy too much in annuities and men would buy too little.

4. In *Arizona Governing Comm. for Tax Deferred Annuity & Deferred Compensation Plans v. Norris*, 463 U.S. 1073 (1983), a bare majority of the Court agreed that the Civil Rights Act of 1964, 42 U.S.C. 2000e-2(a) (2005), prohibits an employer from offering a privately administered retirement plan that pays lower monthly benefits to women than to men who have made the same contributions. *See Norris*, 463 U.S. at 1098-99. *See generally* Craig Joseph Robichaux, Note, Norris v. Arizona: *A Move Toward Unisex Insurance*, 45 LA. L. REV. 149 (1984); Note, *Sex and the Single Mortality Table*, 8 GEO. MASON U. L. REV. 149 (1985). *See also* City of L.A. Dep't of Water v. Manhart, 435 U.S. 702 (1978) (same result under state administered plan). In *Manufacturers Hanover Trust Co. v. United States*, 775 F.2d 459 (2d Cir. 1985), the Second Circuit upheld the use of gender based mortality tables by the IRS in connection with the valuation of reversionary interests of a decedent's estate. Notably, the IRS had adopted a unisex mortality table the previous year. Martha Chamallas, *Questioning the Use of Race-Specific and Gender-Specific Economic Data in Tort Litigation: A Constitutional Argument*, 63 FORDHAM L. REV. 73, 121 n.311 (1994).

5. *See generally* Abraham, *supra* note 2; Regina Austin, *The Insurance Classification Controversy*, 131 U. PA. L. REV. 517 (1983); George J. Benston, *The Economics of Gender Discrimination in Employee Fringe Benefits:* Manhart *Revisited*, 49 U. CHI. L. REV. 489 (1982); Merton C. Bernstein & Lois G. Williams, *Title VII and the Problem of Sex Classifications in Pension Programs*, 74 COLUM. L. REV. 1203 (1974); Spencer L. Kimball,

It is the thesis here that the argument for gender-based rates is wrong *as a matter of economics.* The mistake in the argument is that consumers do not buy life insurance ultimately for the lump sum benefit (which is the measure of the cost to the insurance company). Rather, consumers tend to buy life insurance for the *income* it will generate for the beneficiary.[6] To be sure, consumers often think and talk of insurance in terms of the lump sum benefit. But they live life month to month. As I demonstrate, gender-based rates result in dramatically divergent outcomes for men and women when measured in terms of income. Thus, although the *cost* of writing insurance quite rightly concerns the insurance company, cost is not the measure of the *value* perceived by the consumer. From the point of view of the consumer, the insurance company's cost is irrelevant. What matters is the income that can be generated with the proceeds.[7] Because it is value and not cost that motivates someone to buy something, and because the value of insurance inheres in the income it will generate for the beneficiary, the idea that there is a subsidy implicit in gender-neutral insurance rates is mistaken. In other words, there is no reason to think that unisex rates will

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Reverse Sex Discrimination: Manhart, 1979 AM. B. FOUND. RES. J. 83 (1979); George Rutherglen, *Sexual Equality in Fringe-Benefit Plans*, 65 VA. L. REV. 199 (1979); Leah Wortham, *The Economics of Insurance Classification: The Sound of One Invisible Hand Clapping*, 47 OHIO ST. L.J. 835 (1986). *But see generally* Brilmayer, *Sex Discrimination*, *supra* note 1; Brilmayer, *Efficient Use*, *supra* note 1; Robert H. Jerry, II & Kyle B. Mansfield, *Justifying Unisex Insurance: Another Perspective*, 34 AM. U. L. REV. 329 (1985). *See also* Ann E. Freedman, *Sex Equality, Sex Differences, and the Supreme Court*, 92 YALE L.J. 913 (1983); Bergmann & Gray, *Equality in Retirement Benefits*, CIV. RIGHTS. DIG., Fall 1975, at 25.

6. To be sure, people often buy life insurance with the idea that the proceeds will be used to pay off debts (such as a mortgage). But, even though one might think of this rationale as tied to the lump sum value of the policy, the ultimate reason for (say) paying off a mortgage is to relieve one's heirs of the need to make periodic payments that will reduce income. Moreover, although the focus here is on term insurance (that is, pure life insurance without a savings or investment component), the same is true of whole life and universal life, which build up cash value over time and are used by many consumers (usually unwisely) as a vehicle for retirement planning. That is, although a consumer may think in terms of the lump sum value of the policy as of the date it is paid up, the value of the policy inheres in the income it can generate. Finally, I do not here consider the various possible uses of insurance for purely tax planning purposes. Suffice it to say that the peculiar tax attributes of insurance benefits (which are generally tax free to the recipient) are ultimately derived from a tax policy that is based on treating insurance differently *because* it is insurance and not some sort of investment.

7. The effect on the income of the consumer, that is the *expense* of purchasing insurance, also matters for the same reason, namely that it reduces the amount of periodic income available for other uses.

cause men to buy too much insurance. Indeed, there is every reason to think that gender-based rates distort the market. [8]

I. AN EXAMPLE

Suppose that Fred and Wilma, who are husband and wife, are both 40 years old and work at comparable jobs for comparable pay. They each have $5000 to buy a single-premium paid-up life insurance policy. How much can they buy under a system of gender-based rates? The answer depends primarily on life expectancy and prevailing interest rates. Ignoring administrative expenses and profit margin, the insurance company can provide coverage equal to the amount it can earn with the premium paid over the insured's expected life. At age 40, Fred has a life expectancy of 37 more years, and Wilma has a life expectancy of 41 more years.[9] Assume further that the rate of return that the insurance company can obtain on its investments is eight percent. The insurance company can expect Fred's premium to increase to $86,228 by the time he dies, while the

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8. This is not to say that present value does not matter to individuals. Indeed, present value is the most basic tool for evaluating an investment. But, there is a critical difference between life insurance products (including annuities) and investments. With life insurance or an annuity, a portion of the benefits derives from the failure of other policyholders (or their beneficiaries) to collect some or all of the benefits that might have been paid to them. With life insurance, the benefits paid out to an individual's beneficiary will usually exceed the premiums and investment returns attributable to that individual. This is because many policyholders will survive beyond the term of the insurance and their premiums together, while the returns generated on them may be paid out to those who collect. The insurance value of an annuity is perhaps more obvious. With an annuity, the annuitant typically pays a lump sum up-front, in exchange for a guaranteed periodic payment. Under the most common type of annuity, if the annuitant lives longer than expected, the insurance company continues to make the periodic payments even though the amount paid to the annuitant exceeds the contribution and the returns on it. This mortality benefit is the essential factor that distinguishes an insurance product from a mere investment. It is critical under tax law in gaining taxfree treatment for benefits, and under securities law in gaining an exemption from registration and reporting requirements. *See* SEC v. United Benefit Life Ins. Co., 387 U.S. 202 (1967); SEC v. Variable Annuity Life Ins. Co., 359 U.S. 65 (1959) (both holding that insurance company must assume meaningful mortality risk for contract to viewed as insurance); Kess v. United States., 451 F.2d 1229 (6th Cir. 1971) (holding that a life insurance contract must impose some insurance risk on insurance company in order to be treated as life insurance for tax purposes).

9. *See* U.S. CENSUS BUREAU, STATISTICAL ABSTRACT OF THE UNITED STATES 85 (2000) (1997 data). Life expectancies are here rounded to the nearest whole year for ease of presentation. The precise expectancies are 36.7 for Fred and 41.3 for Wilma.

value of Wilma's premium will increase to $117,313 by the time she dies.[10] Thus, under a system of gender-based pricing, Fred can buy only about 70 percent of the amount of insurance that Wilma can buy.

Consider what would happen (1) if Fred or Wilma died on the day after taking out the policy and (2) the surviving spouse decided to purchase an annuity with the proceeds from the insurance policy. If Wilma died, Fred would have in hand $117,313 and could buy a lifetime (37-year) annuity for about $11.7752 for each dollar of income he would receive yearly thereafter.[11] Thus, Fred could provide himself with an annual income of $9963 for the rest of his life. On the other hand, if Fred died, Wilma would receive only $86,228 from the proceeds of Fred's policy and because of her longer life-expectancy she would need to pay about $11.9672 for each dollar of income she would receive under a lifetime (41-year) annuity.[12] That means that Wilma could provide herself with an income of $7205 for the rest of her life, or about 72 percent of the income that Fred would enjoy. The chart on the following page sets forth these results.

10. That is, $5000 invested at 8% compounded annually will have grown to the respective amounts during Fred's and Wilma's expected lives. *See* ROBERT W. HAMILTON & RICHARD A. BOOTH, BUSINESS BASICS FOR LAW STUDENTS 6-9 (4th ed. 2006). A single premium lifetime term insurance policy is not a common sort of insurance contract (if indeed any such policies are commercially available) in that it has no expiration date. It is used here only to illustrate the concept of present and future value and how an insurance company would go about determining the amount of the benefits it could pay. In other words, these numbers are not intended to reflect actual premium rates, but only to illustrate the underlying principles.

11. *See id.* at 22-28. The example is based on a non-refundable annuity (an annuity under which one or one's estate has no right to any return of principal in the event of early death). There are many other types of annuities, but non-refundable annuities are the most basic and illustrate the point most simply.

12. *Id.*

	FRED	WILMA
Premium	$5000	$5000
Life Expectancy (Rounded to Nearest Whole Year)	37 years	41 years
Value at Predicted Date of Death (8%)	$86,228	$117,313
Amount Available for Purchase of Annuity	$117,313	$86,228
Annuity Premium / Dollar of Lifetime Income (8%)	$11.7752	$11.9672
Lifetime Income / Year (Amount Available / Annuity Premium)	$9963	$7205
Interest Income on Principal if Invested (8%)	$9385	$6898

As this simple calculation demonstrates, Fred and Wilma end up in very different circumstances if the other dies. On the other hand, with unisex pricing Fred and Wilma could buy the same amount of coverage and would end up with the same annual income.[13]

A. A NEGOTIATED SOLUTION

Although one could argue that Fred and Wilma are treated equally under gender-based pricing, would they willingly pay the same amount for this result? Fred might argue that life is not necessarily fair and that he wants the biggest benefit he can get no matter how he gets it. But Wilma has a say in the argument too. The enhanced benefit Fred gets comes as much from Wilma's ability to afford more insurance as from Fred's own ability to buy a cheaper annuity. Thus, if Wilma were free to negotiate with Fred (and inclined to do so), she would refuse to buy insurance, or name Fred as the beneficiary unless Fred agreed somehow to equalize the outcome.

Obviously, Fred and Wilma cannot dictate terms to an insurance company, but they might be able to deal with an insurance company that offers unisex rates. The problem is that no insurance company would likely do so voluntarily, because men would flock there to buy insurance while they would continue to buy annuities at companies offering gender-

13. Although there is certainly no requirement that one use insurance benefits to purchase an annuity, the purchase of an annuity maximizes income for the beneficiary and thus minimizes the premium payments (and maximizes remaining income) for whoever pays the premiums. Although it may go without saying, the assumption here is that Fred and Wilma have the same marginal utility for income.

based rates. And women would continue to buy insurance from companies offering gender-based rates while they would flock to the unisex company to buy annuities. In other words, any company that voluntarily offered unisex pricing would face a serious adverse selection problem.

Another possibility is that Fred would agree to increase his insurance coverage by enough to equalize the outcome for Wilma.[14] Or Wilma might agree to pay the difference. Or they might agree to split the expense so that both could maintain their current levels of income. Both would likely prefer, however, for the insurance industry to shift to unisex rates if only because it relieves them of the need to figure out the relative benefits and negotiate about them. In short, although Fred and Wilma can fix the problem (if they understand it), they probably have at least a mild preference for the convenience of unisex pricing. At the very worst (for purposes of this argument), they are indifferent between the pricing schemes.

In the real world, most married couples probably pool their income anyway, so that the expense of the man's additional insurance would effectively be borne by both partners. But it is also likely that many working couples who make similar incomes buy similar amounts of insurance. And they may do so even if the cost of the insurance differs because of gender-based pricing. It seems quite unlikely that many realize that the same lump sum benefit has a very different value in terms of the annuity income it will generate. The risk of bad planning is a risk like any other. And inasmuch as unisex pricing would reduce that risk, consumers would gain.[15]

Clearly, Fred and Wilma would do the deal. It follows that for them there must be some gain from unisex pricing.[16] Nevertheless, the fact that Fred and Wilma are married may distort the example.[17] Suppose that an

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14. The argument that a woman could adjust her benefits by buying more insurance was made and rejected. *See* Arizona Governing Comm. for Tax Deferred Annuity & Deferred Compensation Plans v. Norris, 463 U.S. 1073, 1098-99 (1983).

15. Insurance agents may attempt to explain these considerations, but there is no requirement that they do so. Moreover, much insurance is bought without the help of an agent. In those cases in which an agent is involved, any change that reduces the need to meet with the agent presumably constitutes a gain, as is well illustrated in the movie *Groundhog Day.*

16. Presumably, if there is something to gain from a trade, the trade will occur absent some barrier. *A fortiori,* if a trade does in fact occur, there must have been a perceived gain in excess of the cost of trading. This would seem to be a straightforward implication of the Coase Theorem, albeit stated in reverse.

17. For example, it may be that one of the underlying rationales for marriage is risk

utterly unrelated man and woman are afforded the opportunity to bargain with each other about the rates they will pay for insurance. That is, they may agree with each other to be governed by unisex rates or not. Will they make a deal? Or will they walk? Neither one knows whether he or she will die early or late. Thus, neither one knows whether he or she will leave behind dependents or rather become dependent on an annuity. Although the man knows that the odds are somewhat higher that he will die early, and the woman knows that the odds are somewhat higher that she will die late, both are presumably concerned about how their dependents will fare *and* about how they themselves will fare. The odds really do not matter much if in fact they matter at all.[18]

If the value of insurance lies in the income it will generate, and if that income differs depending on gender, then consumers stand to gain from unisex pricing because unisex pricing reduces risk. People buy insurance to reduce risk not because of the prospect of gain.[19]

Complications created by gender-based pricing result in unnecessary

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reduction through diversification, and that a married couple will therefore think about risk in a different way.

18. If anything, the odds militate in favor of unisex rates. The man is probably somewhat more worried about providing for dependents, and the woman is probably somewhat more worried about depending on an annuity. Both will therefore gain from making a deal. The deal is similar in many ways to a futures or options contract. In the futures market, potential buyers and sellers of a commodity agree with each other to pay a specified price on a specified date in the future in order to avoid the risk that the price of the commodity will rise (for the buyer) or fall (for the seller). Even though there is no aggregate gain or loss to the system (i.e. no *social* cost or benefit), the parties to the futures contract enjoy a gain because they reduce their risk. The proof is that they are actually willing to pay to enter into the contract. If they were not, there would be no futures or options markets. Incidentally, the existence of futures and options markets also proves that people are risk averse. So does insurance. Paradoxically, there is no social gain from hedging even though everyone involved is made better off individually. Insurance and hedging are arguably wasteful if the beneficiary is risk neutral. *See* Richard A. Booth, *Stockholders, Stakeholders, and Bagholders (or How Investor Diversification Affects Fiduciary Duty)*, 53 BUS. LAW. 429 (1998); Richard A. Booth, Editorial, *Reducing Risk Doesn't Pay Off*, WALL ST. J., Mar. 15, 1999, at A18.

19. Risk can be characterized as variability in income or cash flow. *See* HAMILTON & BOOTH, *supra* note 10, at 207. Merger of the groups thus reduces risk, which is what insurance is supposed to do. Although it may go without saying, it is assumed here that both consumers have the same need for money. In the real world, the need for money may differ and may lead different people to buy different amounts of insurance as opposed to their choosing to self insure. For example, a single mother may want more insurance and thus may be unwilling to forgo gender-based rates, whereas a married couple faces somewhat lower risk because if one dies the other will likely survive to care for the children.

complications (and thus risk) for consumers of insurance.[20] With gender-based pricing the buyer must consider the sex of the beneficiary in deciding how much insurance to buy.[21] For example, a husband must buy relatively more insurance for his wife than for a dependent son, brother, or father.[22] Irrespective of his or her own sex, a buyer must buy more insurance for a female beneficiary of a given age than for a male beneficiary of the same age.

B. WHAT WOMEN (AND MEN) WANT

Although Fred and Wilma should negotiate their way to the equivalent of unisex rates, Fred would not likely favor an unequal outcome. The idea that he would is based on the assumption that men and women would choose the rate structure that favors their own gender. That may be true with regard to most goods, but life insurance is an unusual product. People buy insurance *for* others or *on* others. In other words, Fred (if he is thinking clearly) is not thinking of himself when he buys a life insurance policy. He is thinking about Wilma and how well she will be able to live on the proceeds of that policy. Although one should ordinarily be skeptical of arguments based on altruistic motives, life insurance that is bought by the insured is, by definition, bought for the benefit of someone else.

Still, the argument may prove too much. Wilma, in thinking about Fred, may prefer gender based rates because they save Fred money. There is no reason to think that Wilma would be willing to sacrifice her own security in order to make Fred better off in the event that he survives her. Thus, there is no reason to think that consumers would choose a pricing system resulting in radically different standards of living for beneficiaries depending on their own sex. It seems clear that if consumers were able to bargain with each other, they would agree to unisex rates -- with equal contributions and benefits -- rather than to gender-based rates.

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20. *See, e.g.*, Fluid Components Int'l v. Corp. Benefit Consultants, 977 F. Supp. 1046, 1047 (S.D. Cal. 1997) (involving malpractice claim against consultants who advised use of gender-based mortality tables in connection with setting up pension plan).

21. The assumption here is that the beneficiary is an *adult* dependent (not one that will earn his or her own living in a few years) that will use the proceeds to purchase an annuity. The purchase of an annuity is not crucial to the argument. All that matters is that annuities be available. It is, however, realistic to assume the purchase of an annuity in that *a priori* there is no reason to think that there will be more demand for either insurance or annuities.

22. The amount will of course also depend on the age of the beneficiary.

C. WHO REALLY BUYS INSURANCE?

It is not unusual for one person to buy insurance on another person. For example, it is quite common for a business to buy insurance on a key employee to compensate for disruptions that may result from the employee's death. For similar reasons, it is quite common for working spouses to buy insurance on each other. Many employer-sponsored insurance plans permit an employee to purchase spousal insurance up to some specified percentage of the amount purchased by the employee for himself or herself. Indeed, the more "normal" pattern of an insured buying insurance on himself or herself is more accurately seen as akin to "key person" insurance in which the beneficiary buys the insurance.[23]

If insurance is more often bought by someone other than the insured (or should be so viewed), then the argument that individuals would prefer gender-based pricing -- because of how they themselves would fare -- breaks down. It is the *buyer's* preference that counts, and because there is no reason to presume that all men buy for women and all women buy for men, there is no reason to presume that men and women will favor their own gender. In other words, it is unclear that there is much of any incentive to form gender-based groups.

D. INSURANCE AND ANNUITIES AS A TYING ARRANGEMENT

Notwithstanding the argument that consumers would not focus on their own gender in choosing between unisex and gender-based pricing, self-interest also dictates a preference for unisex pricing. Gender-based rates effectively force a link between insurance and annuities: men must make up for their insurance losses by buying annuities (or less in insurance), and women must make up for their annuity losses by buying cheaper insurance (or less in annuities). In effect, both groups are forced into a package deal. Whatever one group gains from creating a separate pool for one product is lost as a result of being excluded from the cheaper pool for the other product. In other words, it is not unisex pricing that creates cross-class subsidies. Rather, it is gender-based pricing that creates *artificial* incentives. Unisex insurance thus affords consumers more choice, because

23. For example, it may be that in some cases people buy insurance because of a nagging spouse or out of a sense of guilt. In addition, there are significant tax incentives for insurance to be bought by the beneficiary. The proceeds of insurance are includable in the decedent's estate only if the decedent owned the policy at the time of death or the proceeds are paid into the decedent's estate. *See* I.R.C. § 2042 (West 2002).

they are not faced with a tie in.[24]

E. THE PROBLEM OF OPPORTUNISM

To be sure, the situation is different with annuities. Annuities are often -- perhaps usually -- purchased by the annuitant. Thus, an annuitant will clearly prefer the pricing scheme that affords the largest benefit. But if the buyer does not know in advance that he or she will survive to buy an annuity -- if a buyer does not know in advance that he or she will pay or will collect -- the buyer will prefer unisex pricing, at least upon entering the insurance system. Thus, it seems fairly clear that women would forgo the upfront benefits of cheaper insurance if they could be assured of cheaper annuities. But what is to keep men from forming their own annuity companies once they are retired or their spouse dies even though unisex rates look like a good idea in the beginning?

The fact that someone might renege on a deal does not mean that it was a bad deal in the first place; clearly some sort of enforcement mechanism is necessary. The answer is that if surviving men remain free to break away from the deal and form their own annuity companies, then women must also be free to form their own insurance companies. That would eliminate any upfront gains for men.[25] As a result, it should be possible to extract a

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24. By the same token, it may be that insurance companies prefer gender-based pricing precisely because it operates as a tying arrangement, which (incidentally) is usually illegal as a matter of antitrust law. In any event, there must be some gain for insurance companies from gender-based pricing or they would not oppose it so. For example, it may be that by offering cheaper insurance to women, more women are drawn into the insurance system at an earlier stage (after all, one almost invariably buys insurance much earlier in life than one would buy an annuity). Then again, the insurance industry may oppose unisex rates simply because the changeover would entail some expense, though given that unisex pricing is mandated where state action is involved, the actuarial models presumably already exist that would allow for its implementation. *See* note 4, *supra* and accompanying text.

25. This is a classic prisoner's dilemma. Men and women, as groups, are more or less compelled to engage in opportunistic behavior because of the danger that the other group will do so. Women may also be tempted to hold out because they can buy cheaper insurance if they do not agree to unisex rates. But they would presumably be less inclined to do so (and more inclined to strike a deal) because one typically buys insurance earlier in life (and annuities later). Assuming they understand the Fred and Wilma example, women who think they may need an annuity later would be inclined to deal so long as they can be assured that men will not renege. On the other hand, if women form a separate group in order to obtain cheaper insurance, then men must form a separate group to get cheaper annuities. If women exclude men from their insurance pool, men will be forced to pay more for insurance and thus to exclude women from their annuity pool in order to make up for the loss. And neither woman nor man may be allowed to obtain the cheaper product from the

promise from men to remain in a unisex pricing system as a condition of getting unisex insurance in the first place. It would be quite extreme to *require* men to buy unisex annuities as a condition of obtaining insurance.[26]

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other group because to do so would raise the cost for the other members of the group. The obvious solution is to impose some sort of external coordinating mechanism such as mandatory contract terms. But one need not always be so heavy-handed. Another way to avoid the problem is to put the matter up to a binding vote or to require a one-time irrevocable election to participate in the unisex pricing system (which is roughly the same thing as a vote conducted over time). In voting, one avoids the problem of knowing how the other side will behave (again assuming that the vote can be enforced). That is the central idea behind control share statutes adopted by many states to deal with the (perceived) problem that shareholders who are offered a modest premium in a front end loaded two tier tender offer may be inclined to tender their shares for less than they really think they are worth. *See* Richard A. Booth, *The Promise of State Takeover Statutes*, 86 MICH. L. REV. 1635, 1640 (1988). The solution was to suspend the vote of the shares acquired by the bidder and to allow the remaining shareholders to vote on whether they should be re-enfranchised. *Id.* at 1678-79. Thus, another way to see that consumers would likely choose unisex pricing if they had a choice, is to consider how they would likely vote if given the chance. The assumption in the foregoing is that the vote is *ex ante* (*i.e.,* that those who vote do not know their own fate under the system they will choose and that they must choose up front). That is a fair characterization of reality in the context of insurance, but it is not true for annuities.

26. On the other hand, it is not unusual to require the purchase of insurance. Most states require the purchase of insurance by all automobile owners. And it is quite common to require businesses to be insured as a condition of licensing. Moreover, at least one of the plans under discussion for universal health care would require all individuals to buy health insurance. *See* Geoff Colvin, *Check Your Pulse, and the Dow,* 156 Fortune, No 8 at 64, Oct. 15, 2007; Amity Shlaes, *Canada Creep,* New York Sun, April 19, 2006, at 9 (discussing requirement of health insurance in Massachusetts). The argument for unisex rates does not depend on the relative number of men and women in a unisex pool. If there are relatively few women in a unisex pool, their longer life expectancy will cause the price of insurance to fall slightly and will cause the price of annuities to rise slightly. With more women in the group, the changes in price become more dramatic, but they are still presumably offsetting. It is not necessary for insurance and annuities to be based on a common pool of risks and premiums. Indeed, state law generally requires segregation of reserves. *See, e.g.,* 11 NYCRR Part 98 (regulating life insurance reserves); Part 99 (regulating annuity reserves). *See also* 11 NYCRR Part 96 (regulating surplus reserves and permitting commingling of excess reserves). Moreover, there is no reason to assume that the amount of insurance and annuities will be equal or even roughly so over time. Insurance industry data indicates that in recent years the amount of payouts under annuities have been more than twice the amount of payouts of death benefits. *See* ACLI, Life Insurers Fact Book 2006, Table 5.1, *available at* http://www.acli.com/NR/rdonlyres/A6113777-77BE-4679-8A06-8B6FE5B9BC6F/4493/FB06_Ch5_Expenditures.pdf. Interestingly, until 1984 death benefits exceeded payments under annuities, and since 1984 the reverse has been the case by a slight but increasing margin. *See* ACLI, Life Insurers Fact Book 2006, Table 4.10, *available at* http://www.acli.com/NR/rdonlyres/A6113777-77BE-4679-8A06-8B6FE5B9BC6F/4492/FB06_Ch4_Income.pdf. Nevertheless, there is no *a priori* reason to assume that aggregate

That would be an even more objectionable form of bundling than the rather subtle form of bundling presently used under a gender-based pricing. Moreover, it would be quite a radical reform to prohibit private contracting.[27] Mercifully, neither step is necessary. In order for men to gain the benefits of gender-based annuities someone would need to form an insurance company to offer that product.[28] So it should suffice for insurance to prohibit the use of gender-based rates.

II. EXTENDING THE ARGUMENT

The foregoing examples are just that -- examples. Even though the most common pattern may be for one spouse in a heterosexual couple to buy life insurance for the other, there are many other situations in which people buy life insurance. Moreover, the examples assume the purchase of

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insurance benefits will even roughly equal aggregate annuity premiums or benefits or even that most insurance proceeds will be used to buy annuities. In other words, it is entirely possible under a system of unisex pricing that insurance may be more or less expensive than annuities in the sense that one product may be more susceptible to adverse selection than the other and that the insurance company may therefore need to exact a higher mortality fee from one than the other. Indeed, it would be quite surprising if insurance and annuities did not differ in price in this sense. That does not, however, undermine the argument that consumers gain from unisex pricing. All that matters to the argument is that men and women of equal ages be charged the same amount for the same product. *A fortiori,* the argument does not depend on setting up a rule that requires everyone who collects under an insurance policy to use the proceeds to buy an annuity. That would, of course, run contrary to the argument that consumers gain from the unbundling of insurance and annuities. It might be possible in theory to limit unisex pricing to interspousal insurance although presumably it would be necessary to restrict any change of beneficiary and to prohibit any use of benefits by men to buy gender-based annuities. Or it might be possible to limit unisex pricing to some sort of product that rolls together first-to-die insurance with an annuity, though (again) that ties insurance and annuities together more strongly than under the current system.

27. There are some areas in which private contracting is prohibited. For example, it is illegal to enter into an off exchange futures contract if there is a comparable exchange traded contract. 7 USC §6 (2005). Moreover, the recently created Medicare drug benefit plan prohibits subscribers from obtaining private insurance for co-pays and other gaps in coverage. *See* Paul Krugman, *The Deadly Doughnut*, N.Y. TIMES, Nov. 11, 2005, at A23:6.

28. Practically speaking, one cannot form an annuity pool with a handful of annuitants. But a large enough pool will invariably qualify as an insurance company subject to nondiscrimination rules. Thus, it is not necessary to enact a law forbidding men from joining together to provide such benefits. It is merely enough for states simply to amend their insurance law to include nondiscrimination provisions. However, such insurance-like benefits might be offered under the guise of clubs or lodges. Possibly many clubs and lodges exist in part to perform such functions.

an annuity with the proceeds. In the end, however, none of these assumptions undermines the conclusion that consumers would prefer unisex rates.

First, it is fair to assume that insurance is purchased for a dependent (broadly defined) and thus to focus on the welfare of the dependent. It is also fair to assume (for purposes of the foregoing example) that the couple is heterosexual. Same sex couples (as between themselves) are clearly indifferent between pricing schemes because the gain or loss with the insurance is offset by the gain or loss with the annuity.

Second, it is also realistic to assume that the beneficiary will use the proceeds to purchase an annuity even though that may not usually be the case in the real world. At least in theory, an annuity (because of the insurance component) results in the maximum income that the beneficiary can generate with the proceeds. That is, the insurance company can afford to pay a bit more to each annuitant because some will die before they have collected. Thus, the assumption that the beneficiary will buy an annuity is consistent with value maximization.[29] Moreover, annuities are what the insurance industry has to offer. And given that the business of insurance is the focus here, annuities are part of the problem and part of the solution.

There are many other situations (outside marriage) in which people buy insurance, and the arguments for unisex pricing tend to be even stronger outside this paradigm case. Sometimes people buy life insurance to provide for their children or other relatives or dependents. And sometimes people buy insurance on the lives of their business partners. In these other situations, there is no reason to assume that the insured will be of any particular gender and thus no reason to think that one class will systematically gain or lose from the pricing system no matter what it is. Thus, outside the context of a heterosexual pair, consumers are even more likely to prefer the predictability of unisex rates.[30]

To be sure, a buyer typically knows the gender of the person for whom insurance is being bought and may prefer a rate structure that maximizes the outcome. For example, a business whose CEO is a woman may prefer

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29. In the real world, of course, the insurance company may charge fees that are so high that one could do better with a substitute investment such as a mutual fund.

30. One situation in which this may not be true is a single mother who buys insurance for the benefit of a child who then buys an annuity running through a certain age. Presumably, the cost of such an annuity will differ little (if at all) depending on the gender of the child because differences in life expectancy are much more significant among older people. Thus, a woman who seeks to provide for a dependent child will be able to offer larger benefits to the child under gender-based pricing.

lower gender-based insurance rates for women. But a business is just as likely to set up a retirement plan for its key employees. Thus, whatever the business gains from gender-based pricing of one product it loses on the other, assuming that it spends similar amounts on both. It is more expensive to insure a male partner, but it is more expensive to provide a pension for a female partner.[31]

In the case of business partners, there is no reason to think that the buyer will prefer to pay different rates depending on the sex of the insured. Indeed, there is every reason to think that businesses will have a distinct preference for unisex rates. Unisex pricing avoids the risk of discrimination claims in connection with benefits, reduces the cost of calculating benefits, and eliminates a potential artificial incentive for hiring or retaining employees based on gender.

Finally, most individual consumers buy numerous insurance products over the course of a lifetime and may not know in advance whether they and their family and associates will gain or lose from gender-based pricing. Indeed, as previously noted, many employer-sponsored plans offer spousal insurance. Thus, many individual consumers buy insurance on themselves and their spouse simultaneously.

In summary, the case for unisex pricing is just as strong, if not stronger, outside the context of a heterosexual marriage. Indeed heterosexual marriage may be the most difficult case. Yet even here it is clear that the parties would negotiate for unisex pricing and that there must be some gain.

III. THE UNDERLYING ASSUMPTIONS OF GENDER-BASED PRICING

The problem with gender-based rates lies in two unstated premises. First, it assumes that the risk-adjusted, present value of insurance benefits accurately measures their value from the consumers' point of view. Second, it assumes (a) that unisex pricing will cause consumers to buy more or less insurance or annuities than under gender-based pricing and (b) that the allocation of these insurance products is optimal under gender-based pricing.

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31. Although the two considerations balance out at the outset, over time the incentives may change as insurance becomes less important and employees approach retirement age. Clearly, it would be illegal to discharge women employees in order to reduce pension expense. Thus, a business would have a distinct preference for unisex pricing because it would equalize the costs related to older employees (who presumably all are subject to the same retirement age if any).

A. PRESENT VALUE AND THE VALUE OF INSURANCE

As for the assumption that the consumer values the prospect of a death benefit primarily on the basis of the probability of his or her own death, how long one lives is not the consumer's main concern, even though it is central to the insurance company. Indeed, virtually all insureds can expect to live beyond the term of their insurance policies. Thus most people buy insurance against the possibility of untimely death.[32] In other words, the primary value of life insurance is the spreading of risk among insureds over time. In what sense is insurance less valuable to someone likely to live a long time than to someone who is not? For the individual buyer, the function of an insurance policy is to reduce the individual's risk by providing for survivors. Actuarial life expectancy has very little to do with the consumer's perceived value, because most people expect to live forever; they just worry that they might not. Life expectancy has mostly to do with how much it costs the insurance company to provide the policy.[33]

Gender-based pricing means that a man must set aside more from his pay during life in order to secure the same insurance benefits as a woman. And a woman who uses the proceeds to buy an annuity must suffer lower benefits for a longer time than a man. In short, if one looks at the periodic outlay by the insured or at the income available to the beneficiary under an

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32. *See* HAMILTON & BOOTH, *supra* note 10, at 94-99.

33. In other words, the adverse selection problem is over-estimated in connection with life insurance. The purchase of insurance by the terminally ill, suicidal, or others who have substantial expectation of early death is a non-actuarial concern that does not affect the present analysis. Such people generally cannot obtain insurance. If they do, either they experience pay rates based on their peculiar condition or cannot collect when they die. Similarly, someone who has relatively few years left to live is not likely to be able to buy insurance. In practice, insurance companies require a relatively long life expectancy before agreeing to provide insurance. For example, even though the average sixty-year-old can expect to live about 21 more years, it is very difficult for a sixty-year old to buy insurance. In part, the difficulty is that it is very expensive to insure someone of that age, both because the insurance company has relatively little time to invest the premiums and because life expectancy decreases risk (in the sense of predictability of mortality). Thus, one might say that life insurance is only readily available for those who are quite unlikely to die and therefore have little reason even to think about life expectancy. There is also the worry that a sixty-year-old who is approaching retirement has less to insure. Someone who is working may be seen as buying insurance to replace his or her earning capacity in the event of death. The motives of someone who is expected to retire are less clear. To be sure, the assumption here is that age discrimination is permissible in setting life insurance rates is permissible. But there is every reason to believe that people would buy more insurance as they got older (and wealthier) if the cost were subsidized by younger buyers who in effect paid too much.

annuity, gender-based pricing appears to be quite unfair, both in terms of price and benefits. To be sure, gender-based pricing assures that men and women bear their own costs. But it is far from clear that insureds care much about cost. Fred and Wilma would hardly see themselves as equally well off with lifetime incomes of $9963 and $7205, respectively.

Consider the position of a beneficiary under a gender-based regime. If the insured is male, the beneficiary stands to collect less for each premium dollar spent than under a unisex system because the man is likely to die earlier. But if the policy is intended to meet living expenses for the beneficiary, the smaller benefit means a smaller income for a longer time than if the insured is a woman. The insurance company would argue that such a result is fair because it reflects the cost of insurance. From the beneficiary's perspective, the cost is irrelevant. What matters is how well one can live on the benefits. The process of paying for the insurance appears doubly unfair. In order to provide an equal benefit, the male insured will have to pay more up front. The unfairness is compounded if a woman beneficiary uses the proceeds of a man's insurance policy to purchase an annuity, as is often the case. A male survivor of a female insured who follows the same strategy will fare much better, because he will receive a bigger death benefit in relation to premiums paid, and will be able to buy a cheaper annuity or one that pays out more during each period.

It is a fact that women live longer than men. But no fact itself tells us what it means. Moreover, the facts one finds are the facts one seeks.[34] That women live longer than men may be a fact, but to extrapolate that insurance rates for women should be lower is to say more. In short, the fallacy of gender-based rates is that cost is the best indication of value. When one takes a close look at the value of insurance, it is clear that the present value of the benefits is far less important to an insured than the income that can be generated with them.

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34. *See* Brilmayer, *Sex Discrimination*, *supra* note 1, at 511-14 (1980); Mayer G. Freed & Daniel D. Polsby, *Privacy, Efficiency, and the Equality of Men and Women: A Revisionist View of Sex Discrimination in Employment*, 1981 AM. B. FOUND. RES. J. 585 (2000) (criticizing statistics based on self-fulfilling prophecies). There is little doubt that it is inappropriate and illegal to consider race in setting insurance rates even though as a matter of statistics, life expectancies differ among the races. *See* Scot J. Paltrow, *Life Insurers' Race Bias in Decades Past Affects Policyholders Even Now*, WALL ST. J., Dec. 26, 2000, at A1; Scot J. Paltrow, *Georgia Regulator to Lead Investigation into Insurer's Rates for Black Customers*, WALL ST. J., Dec. 15, 2000, at C13. The next question seems to be whether genetic information may be considered. *See* Jill Gaulding, *Race, Sex, and Genetic Discrimination in Insurance: What's Fair?*, 80 CORNELL L. REV. 1646 (1995).

B. SUBSIDIES AND INSURANCE -- KNOW THE DIFFERENCE

As for the second assumption -- that unisex pricing will cause consumers to buy more or less insurance than they would under gender-based pricing -- although it is true that it costs an insurance company more to insure a man than a woman, it does not follow that a man will buy more insurance under a system of unisex pricing. People buy insurance for the beneficiary. What really matters to a beneficiary is income, that is, how well the beneficiary will be able to live on the proceeds. It is *value,* not cost, that motivates one to buy something.[35]

Moreover, it makes little sense to buy insurance if the *beneficiary* does not need protection in the event of the insured's death. After all, paying for insurance reduces the income that may be shared with (or saved for) the beneficiary in the meantime.

The most important factor that determines the amount of insurance one will buy is the amount one can spend, at least up to the point of adequate coverage. Thereafter, it is unlikely that cheaper insurance will induce people to buy more. It is important to remember why people buy insurance. Insurance is a hedge, not a bet. And it makes no sense to hedge more risk than you have.[36]

Cost may be a more important factor in connection with an annuity, because usually the person who purchases an annuity also collects under it. Unlike life insurance, one can buy an annuity late in life at a time when the

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35. Regarding the value-laden notion of subsidies and their proper definition, see Abraham, *supra* note 2. There has been significant pressure in several state legislatures to require unisex rates in other forms of insurance such as car insurance. *See* Jerry & Mansfield, *supra* note 5, at 18. The fact that unisex rates make sense in life insurance and retirement benefits, however, implies nothing about its wisdom in connection with other forms of protection. *See* Abraham, *supra* note 2, at 443-44. It is only because of the nature of the benefits of life insurance and retirement plans that value becomes disconnected from cost. Where the insured has some control over the likelihood of a claim, such as with car insurance, fire insurance, or even health insurance claims, it is important to create incentives for classes of insureds to take affirmative steps within their control. *See* Abraham, *supra* note 2, at 413-17. This is not to say, however, that control is the only factor to be considered or that it is easy to determine particular matters within one's control. *See* Deborah S. Hellman, *Is Actuarially Fair Insurance Pricing Actually Fair?: A Case Study in Insuring Battered Women*, 32 HARV. C.R.-C.L. L. REV. 355 (1997). Nevertheless, control is probably a sufficient condition for mandating disregard of a risk factor. Clearly, one cannot exercise control over one's sex. At the very least, it is safe to say that the transaction costs for exercising any control are quite high.

36. This is essentially the rationale behind the requirement that a buyer must have an insurable interest in the life the insured.

difference in life expectancy between men and women becomes more immediate. Thus, there is a more significant potential for women to take advantage of unisex pricing by buying more annuities and for men to shy away from such instruments.[37] But the idea that a woman might take advantage of unisex pricing in buying an annuity is largely at odds with the idea of an annuity.

First, annuities are a way to hedge against the possibility of outliving one's money.[38] In other words, an annuity is another kind of insurance policy. It protects against untimely death where the untimeliness is a matter of living too long. On the other hand, another function of an annuity is to trade a lump some of money for a higher regular income than one could generate by simply investing the money and living on the return.[39] Clearly, if one has enough money to live comfortably off the interest, there is no need for an annuity, although even in such cases an annuity may serve a spendthrift function.

Second, as with any bargain, one must give up something. In the case of an annuity, the annuitant must give up control over his or her money. Moreover, the insurance company subtracts a management fee and there are often upfront commissions to be paid.[40] It is also possible to lose with an annuity. If one dies sooner than expected, the insurance company keeps the money.[41] Thus, one must give up the prospect of leaving an estate. In short, it seems unlikely that one would be tempted to buy an annuity because of unisex pricing given the enormity of the other factors to be considered. In other words, adverse selection would not seem to be a worry if there are more important factors dictating a decision than the potential for opportunism.[42] Few women would buy an annuity simply

37. Presumably, there is less of an adverse selection problem with respect to annuities. Although one can sometimes know when one is likely to die, one cannot know that one will live longer than others. Moreover, many individuals are subject to mandatory retirement at some age, which is presumably the same for both male and female employees in any given company. Indeed, federal law generally requires that one begin taking retirement distributions under an IRA or similar plan at age 70 1/2, and many elect at that point to buy an annuity. At 70, a man can expect to live about 12.7 more years, while a woman can expect live about 15.5 more years. *See* Statistical Abstract of the United States (2000), Table No. 118 (1997 data), *available at* http://www.census.gov/prod/2001pubs/statab/sec02.pdf.

38. *See* ACLI, Life Insurers Fact Book 2006, at 71, *available at* http://www.acli.com/ACLI/Tools/Industry+Facts/Life+Insurers+Fact+Book/FB06.htm.

39. *See* HAMILTON & BOOTH, *supra* note 10 at 71-72.

40. *Id.*

41. *Id.*

42. In other words, incentives are not necessarily additive.

because it is a relatively good deal compared to an annuity with gender-based rates -- if there are administrative costs and commissions to be paid and if the company that writes the annuity gets to keep the remaining principal when the annuitant dies sooner than expected. Clearly, one buys an annuity in order to assure oneself of a steady income and not as a bet that one will live longer than average.

In the end, the very existence of annuities makes the argument that people buy insurance products for the income they will produce and not based on some guess as to longevity. Indeed, the primary selling point for an annuity is that it provides a guaranteed income to the annuitant.[43] In other words, the essential idea behind an annuity is that people care more about income than about lump sum values.

C. OPPORTUNISM AND INTERGENERATIONAL CONFLICTS

Although it should suffice simply to prohibit gender-based pricing, it is not beyond the pale to consider some sort of mandatory bundling of life insurance and annuity products as a way of dealing with the problem of opportunism in connection with annuities. Exit restrictions are often imposed in connection with pension plans and retirement accounts and indeed plain vanilla mutual funds.[44] In addition, one may be permitted to move funds into an annuity from a mutual fund but precluded from moving the money out of the annuity and back into the fund.[45]

Similar, though more severe, intergenerational problems affect health insurance. For example, younger and healthier individuals may be inclined not to buy health insurance until they get older and are more likely to get sick. The problem can be fixed by charging different rates depending on age, but that would require older consumers to pay much higher rates. Although, it would still make some sense to buy health insurance even on such terms as a way of spreading the cost of health care over many people, consumers stand to gain the most if all participate, but the only way to

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43. *See* HAMILTON & BOOTH, *supra* note 10, at 71-72.

44. *Id.* at 85-88, 517-26.

45. For example, TIAA-CREF permits participants to transfer funds *from* its various investment funds into an annuity account with a guaranteed return but prohibits any reverse transfer. Presumably, the reason for this restriction is to prevent participants from locking in attractive rates of return (augmented by an insurance component) without committing to remain in the actuarial pool for the duration. Likewise, corporations generally do not issue classes of preferred stock with permanent conversion rights unless the corporation also retains the right to redeem the stock.

achieve that result, however, is to require younger consumers to participate as a condition for getting health insurance under the same plan when they get older.

One might liken such a plan to a system of forced savings in which payments by the young grow through investment and pay for health care in older age. But the investment component is not critical. The real point of the system is spreading the cost, both over individuals of the same age and across age groups.[46] Indeed, arguably any *actual* set-aside of funds for investment purposes would be inefficient, just as it is inefficient to require a bank to keep the cash of individual depositors on hand and segregated.[47] One could perhaps argue, along the same lines, that life insurance should not be priced according to age at all and that to do so constitutes age discrimination. But that would clearly create strong incentives to buy more insurance later in life as a way of building an estate.

Yet another factor that may distinguish health insurance from life insurance is that not everyone collects under health insurance (or any other form of hazard insurance). But neither does everyone collect under life insurance if it is term insurance. With health insurance, the temptation is to wait until one is older and then to join the pool. With term life insurance, coverage is arguably more valuable (purely as a matter of insurance) when one is younger and has a relatively small estate with which to provide for dependents and when the implications of untimely death are presumably much more disruptive.[48] Thus, it is more likely that a young consumer would be willing to agree to unisex pricing up front than that a young consumer would be willing to pay higher health insurance rates as a way of subsidizing older consumers.

Finally, it should be noted that because life insurance is sometimes used precisely to plan for intergenerational transfers of wealth (even if it is term insurance), intergenerational conflicts are somewhat reduced. In other words, consumers enter the life insurance system planning to some extent

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46. *See* HAMILTON & BOOTH, *supra* note 10, at 71-72, 108-11.

47. Although it may go without saying, the system suggested here is essentially the same as the Social Security (FICA) system we have. And as with Social Security, it is crucial that younger participants be assured that the system will remain solvent and thus that future generations will choose to participate. But because the solvency of the system does not depend on investment returns -- and thus is effectively able to guarantee the required return -- it should not be difficult to attract new participants as long as the population is not declining or aging without a concomitant increase in the retirement age. This suggests, however, that it may be a mistake to allow individually directed investment of social security funds at least if the system is to remain actuarially driven.

to provide for other generations and thus will be less likely to resent what may be viewed as free-riding by other generations under the health insurance system.

IV. A COASEAN VIEW

At first blush, the argument for pricing insurance according to its cost might seem to be a simple application of the principles propounded by Professor Ronald Coase in his landmark 1960 article *The Problem of Social Cost.*[49] It is sometimes said that the Coase Theorem, as the thesis of that article has come to be known, stands for the proposition that people and firms should bear their own costs. Although that generally turns out to be true, it is an over-simplification. In truth, the Coase Theorem does not involve any determination of who generates a cost. Rather, it focuses on who is able to avoid or reduce the cost.[50] By placing liability on that party, the law assures that cost-saving measures that make economic sense will be taken. In other words, it assures that investments of resources that should be made -- those that are economically efficient -- will be made.

To be more precise, the Coase Theorem states that in the absence of transaction costs, the initial placement of an entitlement or liability will have no effect on who ends up with it.[51] If a good is more valuable to someone other than the party to whom it is allocated under the law, the parties will bargain with each other and the good will end up in the hands of the party that places the highest value on it.[52] The central implication of the Coase Theorem is that ordinarily the law should not seek to determine who deserves a good, but rather should seek out market failures, which is to say, instances in which the parties are unable to bargain with each other because transaction costs are too high or for some other reason. In such situations, failure to assign an entitlement or liability to the proper party may result in unnecessary costs being borne by one party when the other has some way of reducing those costs.

Is there any reason to believe that the market for insurance is beset with failure? If so, how would the parties to an insurance contract bargain with each other if they were able to do so? The existing literature invariably treats the issue of gender-based rates as if it were a matter for negotiation

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49. 3 J. L. & ECON. 1 (1960).
50. *See* RICHARD A. POSNER, ECONOMIC ANALYSIS OF LAW 42-48 (7th ed. 2007).
51. *Id.* at 7.
52. *Id.*

between insurance companies and consumers.[53] But given that the primary value of life insurance is risk spreading and risk reduction among consumers, the real question should be how would potential consumers bargain with *each other* in the absence of barriers to contracting? Would they focus on cost or value? The Coase Theorem itself is based on the assumption that parties to a negotiation focus on the gains they can enjoy if a beneficial trade is consummated. Who will bear the cost is not necessarily central to the bargain. What is crucial is whether the gain from the transaction is large enough to justify the cost.

If the relevant negotiation is one among consumers, it would appear that the market for insurance is beset with failure. A consumer cannot choose unisex pricing unless insurance companies offer it. Competition to please and attract consumers should lead to such products being offered. But no single insurance company can offer unisex pricing because of the danger of adverse selection (however remote). Moreover, individual insurance companies have an incentive to offer cheaper insurance to groups that are cheaper to insure.[54] Individuals may be able to roll their own unisex insurance, as when a married couple shares the expenses of premiums.[55] But it is unclear that many consumers know to do so and in any event such arrangements presumably entail costly negotiation. Thus, even the Coase Theorem counsels a legal solution.

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53. *See, e.g.*, Abraham, *supra* note 2.

54. In other words, unisex pricing would require insurance companies to form a cartel. And that would constitute illegal price fixing. Moreover, any individual participant in a cartel stands to profit by undercutting fellow cartel members while other members continues to adhere to the price fixing agreement. A similar dynamic (known as *cherrypicking*) occurs in connection with health insurance where providers seek to attract the healthiest insureds by offering them reduced rates, thereby increasing the rates that must be charged to less healthy groups. Presumably, it is costly for insurance companies to engage in such competition, and they should therefore prefer a system that prevents it. It is therefore curious that the insurance industry has been so opposed to unisex pricing. Even if there were nothing to be gained by unisex pricing, an insurance company should be indifferent as between the two pricing systems as long as all insurance companies are required to adhere to the same system. In short, it appears that unisex pricing can only be affected by law.

55. Interestingly enough, however, such derivative arrangements have arisen between the terminally ill and investors who are willing to buy the benefits of their life insurance policies at a discount. *See, e.g.*, SEC v. Life Partners, Inc., 87 F.3d 536 (D.C. Cir. 1996). In some cases, insurance companies themselves have offered early payout, presumably at least in part because the attraction of viatical settlements demonstrated that there was a market for such benefits. One would think, therefore, that insurance companies would voluntarily offer unisex pricing but for the adverse selection problem that apparently can only be fixed by legal mandate.

CONCLUSION

The central argument for gender-based pricing of insurance is that any other system will lead to misallocation of resources, because those who can buy insurance for less than its true cost will buy more than they would if they had to bear the full cost. But it is far from clear that unisex pricing constitutes a subsidy. Whether a subsidy exists depends on one's point of view. If one adopts the viewpoint of the insurance company, there is a subsidy without differential rates. If one looks at equal rates as an individual consumer of insurance, it seems clear that there is no subsidy. Moreover, the fact that one class subsidizes another is not dispositive. It is similar to arguing that those who live long subsidize those who die early. Clearly that is true, but it is also totally beside the point. Indeed that sort of subsidy is the very goal of insurance. In the end, it is sufficient to recognize that there is a conflict between valid competing views of how to value life insurance and annuities. If rational consumers do in fact value insurance on some basis other than what it costs the insurance company to provide it, then the worry over subsidies is misplaced and the argument that insurance should be priced according to its cost must fail.

WHAT IS IT WORTH? A CRITICAL ANALYSIS OF INSURANCE APPRAISAL

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INTRODUCTION

When the waters of hurricanes Katrina and Rita receded from Mississippi and Louisiana in 2005, insurance adjusters descended to take stock of the damage. Questions about the existence and extent of coverage for wind, rain, and flood have been well publicized.[1] Important decisions parsing the insurance policy language have been issued.[2]

Less well known are the individual struggles homeowners and corporations have faced in reaching agreement with their insurance companies about the value of damaged or destroyed property. Unlike the high-profile coverage questions that receive significant media and judicial attention, many of the disputes about the amount of loss will be relegated to an ill-defined process called "appraisal."[3]

Virtually every property insurance policy for both homeowners and corporations contains a provision specifying "appraisal" as a means of

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1. *See, e.g.*, Gregory V. Serio, *National Strategy Needed for Disaster Financing*, NAT'L UNDERWRITER PROP. & CAS., Oct. 3, 2005, at 34; *Insurance Coverage for Flood and Wind-Driven Rain*, STATES NEWS SERVICE, Oct. 22, 2005; Eileen Alt Powell, *Americans May Need More Flood Insurance*, LAS VEGAS SUN, Sept. 29, 2005; Purva Patel, *Recovery Resources, Business Assistance*, HOUSTON CHRON., Sept. 30, 2005, at Special 2.

2. *See* Humphreys v. Encompass Ins. Co. (*In re* Katrina Canal Breaches Consol. Litig.), No. 05-6323, 2006 WL 3421012 (E.D. La. Nov. 27, 2006); Leonard v. Nationwide Mut. Ins. Co., 438 F. Supp. 2d 684 (S.D. Miss. 2006); Buente v. Allstate Ins. Co., 422 F. Supp. 2d 690 (S.D. Miss. 2006).

3. *See* Gordon Russell, *Nearly a Year After the Storms, Homeowners Will Begin Collecting Road Home Grants of Up to $150,000*, TIMES-PICAYUNE, Aug. 4, 2006, at National 1.

resolving disputes about the "amount of loss" for a covered claim. Questions about the existence or extent of coverage are not appraisable.[4] Consistently, courts make a distinction between questions of liability (the scope or extent of coverage) and damages (the value of the property or the amount of other loss) in deciding whether appraisal is necessary.[5]

Insurance policies typically provide little instruction or guidance about how an appraisal is to be conducted, and state laws and precedent vary in their treatment of such provisions.[6] During the appraisal process many disagreements can arise between the parties. Some common disputes include: (1) the procedure for appointing an umpire when the appraisers cannot agree; (2) whether the appraisal process is governed by arbitration statutes and precedent; (3) the procedure, if any, for confirming an appraisal award in court; (4) the grounds for challenging an appraisal award; (5) what due process protections, if any, must be afforded the parties to an appraisal; (6) the scope of appraisal provisions (i.e., what disputes are subject to appraisal and what disputes must be resolved in court); (7) whether an appraisal to determine the amount of loss and a declaratory judgment action or a breach of contract action to determine legal rights and liability can exist concurrently, or whether one should or must precede the other; and (8) whether it is bad faith for the insurance company to manipulate, delay, or obstruct the appraisal process or refuse to pay an appraisal award.[7]

Fully answering each of those questions is beyond the scope of this Article. Rather, we will discuss the nature of appraisal, analyze the general benefits and pitfalls of the appraisal process, identify common areas of dispute over the scope and nature of the appraisal process, and suggest refinements that could enhance appraisal as a means of dispute resolution.

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4. Hanson v. Commercial Union Ins. Co., 723 P.2d 101, 104 (Ariz. Ct. App. 1986); Jefferson Ins. Co. v. Superior Court, 475 P.2d 880, 883 (Cal. 1970).

5. *See, e.g.*, Franco v. Slavonic Mut. Fire Ins. Ass'n v. Court of Appeals, 154 S.W.3d 777, 786 (Tex. App. 2004).

6. *See generally* JONATHAN J. WILKOFSKY, THE LAW AND PROCEDURE OF INSURANCE APPRAISAL (Ditmas Park Legal Publishing 2003) (discussing various state laws and precedents).

7. *Id.*

I. WHAT IS APPRAISAL?

A. DETERMINING THE AMOUNT OF LOSS

Generally speaking, an appraisal is the determination of what constitutes a fair price, valuation, or estimation of worth.[8] The majority of property insurance policies allow appraisal when the insurance company and policyholder are unable to agree about the amount of loss to a covered property. Under most appraisal provisions, the party demanding appraisal and the other party must each name an appraiser within a specified number of days. Those appraisers are required to value the loss and attempt to reach agreement. If there is a disparity between the figures found by the respective appraisers, those appraisers typically appoint a third appraiser, known as an umpire, to resolve the discrepancy.[9]

The timelines and provisions can vary, but most appraisal provisions follow the same general format:

> In case the insured and this Company shall fail to agree as to the actual cash value or the amount of loss, then, on the written demand of either, each shall select a competent and disinterested appraiser and notify the other of the appraiser selected within twenty days of such demand. The appraisers shall first select a competent and disinterested umpire; and failing for fifteen days to agree upon such umpire, then, on request of the insured or this Company, such umpire shall be selected by a judge of a court of record in the state in which the property covered is located. The appraisers shall then appraise the loss, stating separately actual cash value and loss to each item; and, failing to agree, shall submit their differences, only, to the umpire. An award in writing, so itemized, of any two when filed with this Company shall determine the amount of actual cash value and loss. Each appraiser shall be paid by the party selecting him and the expenses of appraisal and umpire shall be paid by the parties equally.[10]

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8. BLACK'S LAW DICTIONARY 110 (8th ed. 2004).

9. As discussed in Section III, *infra*, an umpire could also be chosen by the appraisers prior to any disagreement in amount of loss, or appointed by the court.

10. N.Y. INS. LAW § 3404(e) lines 123-140 (McKinney 2006).

The preceding appraisal language is only one form, and there are variations.[11] However, appraisal will apply consistently only if there is a dispute between the insurance company and the policyholder as to the "*amount of loss*" related to the covered property.[12] Depending on the insurance policy, the amount of loss could relate to the actual cash value of property, the cost to repair or replace property, the amount of business income lost as a result of property damage, or "extra expense" covered by the insurance policy.

A dispute over the amount of loss can often exist, side-by-side, with disputes about the extent of policy coverage and liability. In such instances, courts have reached varying conclusions about whether the parties may, or must, proceed to appraisal. For example, in *American Nat'l Fire Ins. Co. v. Unigraphic-Color Corp.*, a federal court in Pennsylvania held that an insurance company could revoke a demand for appraisal when a dispute arose over liability.[13] The court held that "[a]ppraisal is an alternative dispute resolution device which facilitates the determination of the amount of damage owed an injured party. . . . [A]ppraisal cannot be converted into a non-judicial process for determining liability in the first instance [where] there is a fundamental factual dispute as to [liability]."[14]

In contrast to *American National*, other courts have held that when there is a dispute about liability or the extent of coverage, appraisal should still take place. In *Masonic Temple Assoc. of Grand Rapids v. Michigan Fire & Marine Ins. Co.*, for example, Michigan's highest court affirmed a trial court's decision to permit an appraisal proceeding despite the insurance company's denial of liability.[15] The court was hopeful that the appraisal process would resolve the liability issue because the parties would have to consult and adjust their loss differences.[16]

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11. For example, the California standard form also specifies that "[a]ppraisal proceedings are informal unless the insured and this company mutually agree otherwise. For purposes of this section, 'informal' means that no formal discovery shall be conducted, including depositions, interrogatories, requests for admission, or other forms of formal civil discovery, no formal rules of evidence shall be applied, and no court reporter shall be used for the proceedings." CAL. INS. CODE § 2071(a) (West 2006).

12. RICHARD P. LEWIS & NICHOLAS M. INSUA, BUSINESS INCOME INSURANCE DISPUTES § 8.05[A], at 8-50 (Aspen 2006) (discussing how representatives of the insurance industry agree that appraisal provisions are limited in scope and limited to the amount of loss).

13. No. 84-1512, 1984 U.S. Dist. LEXIS 15646, at *8 (E.D. Pa. June 22, 1984).

14. *Id.* at *7-8.

15. 36 N.W.2d 317, 321 (Mich. 1949).

16. *Id.*

One recurring question is whether issues of causation are subject to appraisal. In the ensuing litigation after hurricanes Katrina and Rita, the issue of causation was at the forefront: whether the property damage was caused by naturally-occurring flood (often uncovered),[17] the collapse or compromise of a levee (covered),[18] by wind-driven rain (covered),[19] or other causes (generally covered).

In *Johnson v. Nationwide Mut. Ins. Co.*, the Florida Supreme Court decided that the issue of causation must be decided in court rather than in an appraisal.[20] The court was confronted with the question whether a dispute over what *caused* the loss was actually a dispute over the *amount* of loss, and therefore appropriate for appraisal.[21] After looking at two Florida Appellate court decisions that reached opposite conclusions, the *Johnson* court agreed with the interpretation that coverage issues, including issues of causation, are exclusively judicial questions.[22]

Questions regarding the reach of the appraisal provision also arise in the context of business income coverage. Property insurance policies normally entitle the policyholder to compensation for loss of business income during the period of restoration, or the period that the business is interrupted due to property loss.[23] In general, courts have not allowed the period of restoration to be determined in an appraisal.[24]

In our view, the scope of appraisable disputes should generally be limited to issues of valuation. Appraisal is designed to provide an

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17. *See, e.g.*, Leonard v. Nationwide Mut. Ins. Co., 438 F. Supp. 2d 692, 689 (S.D. Miss. 2006).

18. *See, e.g.*, Humphreys v. Encompass Ins. Co. (*In re* Katrina Canal Breaches Consol. Litig.), No. 05-6323, 2006 WL 3421012, at *1, *24 (E.D. La. Nov. 27, 2006).

19. *See, e.g.*, *Leonard*, 438 F. Supp. 2d at 693.

20. 828 So. 2d 1021, 1025 (Fla. 2002).

21. *Id.*

22. *Id.*

23. *See* FILING YOUR BUSINESS INSURANCE CLAIM AFTER A DISASTER, CENTRAL INSURANCE COMPANIES, http://www.central-insurance.com/docs/claimfil.htm (last visited Feb. 20, 2007); *see also* Alan R. Miller, *Business Interruption Insurance For Damage to Other Property*, 53 FICC QUARTERLY 3, 343 (2003), *available at* http://www.thefederation.org/documents/Miller-Sp03.htm

24. *See, e.g.*, Duane Reade, Inc. v. St. Paul Fire & Marine Ins. Co., 411 F.3d 384, 389 (2d Cir. 2005) (rejecting the insurer's claim that the appraisal proceeding will show that any business interruption losses in excess of the sums already paid were offset because the scope of coverage provided cannot be determined by appraisal); Zamplas Johnson, P.C. v. Cincinnati Ins. Co., 367 F. Supp. 2d 1101, 1105-06 (E.D. Mich. 2005) (denying defendant's request that the Statutory Appraisal procedure govern the determination of coverage issues, including business income loss).

inexpensive determination of the amount of loss where coverage is conceded. Allowing, or even requiring, parties to appraise a loss that involves other issues, such as liability or causation, can create multiple proceedings and inefficiencies.

B. A KISSING COUSIN TO ARBITRATION

In analyzing the nature of appraisal, courts often compare appraisal to arbitration. Appraisal can be considered a type of arbitration,[25] akin to arbitration,[26] or fundamentally different from arbitration.[27] The similarities and differences between the processes of appraisal and arbitration are not

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25. *See, e.g.*, Cmty. Assisting Recovery, Inc. v. Aegis Sec. Ins. Co., 112 Cal. Rptr. 2d 304, 309 (Cal. Ct. App. 2001) ("The appraisal term creates an arbitration agreement subject to the statutory contractual arbitration law."); Giulietti v. Conn. Ins. Placement Facility, 534 A.2d 213, 217 (Conn. 1987) (holding that the appraisal clause constitutes an agreement to arbitrate and falls within the ambit of arbitration statutes); Closser v. Penn Mut. Fire Ins. Co., 457 A.2d 1081, 1087 (Del. 1983) (construing the appraisal provisions within the policy, if invoked, to provide a mandatory form of arbitration, precluding recourse to the courts); Wailua Assocs. v. Aetna Cas. & Sur. Co., 904 F. Supp. 1142, 1148 (D. Hawaii 1995) (finding that the appraisal procedure set forth in insurance policy was an "agreement to arbitrate" within the scope of the Federal Arbitration Act); Friday v. Trinity Universal of Kan., 939 P.2d 869, 872 (Kan. 1997) (holding that the appraisal clause was an arbitration clause and therefore unenforceable under the statute making a written agreement requiring submission of controversy to arbitration inapplicable to insurance contracts).

26. *See, e.g.*, Meineke v. Twin City Fire Ins. Co., 892 P.2d 1365, 1369 (Ariz. Ct. App. 1994) ("Despite some differences between arbitration and appraisal, appraisal is analogous to arbitration."); Aetna Cas. & Sur. Co. v. Ins. Comm'r, 445 A.2d 14, 20 (Md. 1982) ("[N]otwithstanding the distinctions between an appraisal under an insurance policy appraisal clause and arbitration, appraisal is analogous to arbitration. Consequently, this Court has applied arbitration law to appraisal clauses in insurance policies."); Hozlock v. Donegal Cos./Donegal Mut. Ins. Co., 745 A.2d 1261, 1263 (Pa. Super. Ct. 2000) (holding that for purposes of judicial review, appraisal is analogous to common law arbitration, rather than statutory arbitration).

27. *See, e.g.*, Rastelli Bros. v. Neth. Ins. Co., 68 F. Supp. 2d 440 (D.N.J. 1999) (noting the distinctions between appraisal and arbitration are significant, and the Federal Arbitration Act does not apply to appraisals); Miller v. USAA Cas. Ins. Co., 44 P.3d 663 (Utah 2002) (holding that the Arbitration Act does not directly apply to appraisal); Allstate Ins. Co. v. Martinez, 790 So. 2d 1151 (Fla. Dist. Ct. 2001) (holding that the appraisal process did not have to conform to rules of arbitration requiring attorney participation, court reporter transcriptions, and quasi-judicial hearing); Merrimack Mut. Fire Ins. Co. v. Batts, 59 S.W.3d 142 (Tenn. Ct. App. 2001) (holding that an appraisal clause was not an agreement for binding arbitration); Atlas Constr. Co. v. Ind. Ins. Co., 309 N.E.2d 810, 813 (Ind. App. Ct. 1974) (finding that the procedure of appraisal for fire loss pursuant to a fire policy did not involve an issue of liability and was not subject to statutory provisions with respect to arbitration).

well defined, although it is generally conceded that appraisal is designed to be less formal than arbitration.[28] The debate about whether appraisal is a specialized type of arbitration, or is not arbitration at all, is more than mere academic theory. A court's decision about whether to treat appraisal as arbitration will impact the applicability of state and federal laws, as well as the procedural protections afforded the participants.[29]

Although both arbitration and appraisal proceedings are contractual methods for settling disputes outside litigation,[30] as far back as 1910, the U.S. Supreme Court noted two differences between appraisal and arbitration: scope and procedural formality.[31] First off, arbitration may be wide in its scope, whereas an appraisal is limited to the narrow issue of the amount of loss.[32] In arbitration, the parties are asking for a determination of whether liability exists and, if so, to what extent.

> An agreement for arbitration, as that term is now generally used, encompasses the disposition of the entire controversy between the parties upon which award a judgment may be entered, whereas an agreement for an appraisal extends merely to the resolution of the specific issues of cash value and the amount of loss, all other issues being reserved for settlement by negotiation, or litigated in an ordinary action upon the policy. For example, it has been said that a clause in a fire policy providing for simple appraisal of values, so as to determine the amount of loss, is distinct from an arbitration clause, whereby the parties seek to

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28. *See, e.g., Allstate Ins. Co.*, 790 So. 2d at 1152; Hirt v. Hervey, 578 P.2d 624, 626 (Ariz. Ct. App. 1978) ("While appraisals are generally less formal than arbitrations, both provide a contractual method for settling questions in a less complicated and expensive manner than through court adjudication."); *In re* Delmar Box Co., 127 N.E.2d 808, 810-13 (N.Y. 1955) (noting that appraisal should not be given the same recognition as arbitration because it is limited to specific issues, conducted in a less formal manner, is not bound by strict judicial investigation, and requires no hearing).

29. *See* G. Frank McKnight, Adam S. Levy & Darren L. Harrison, *The Treatment of Appraisal Provisions in Insurance Policies*, NELSON LEVINE DE LUCA & HORST, Mar. 2002, http://www.nldhlaw.com/CM/Articles/Articles47.asp.

30. *Hirt*, 578 P.2d at 626.

31. City of Omaha v. Omaha Water Co., 218 U.S. 180, 192-98 (1910) (holding that value was a matter to be determined by the appraisement procedure, and in appraisement the strict rules relating to arbitration awards do not apply).

32. *Rastelli Bros.*, 68 F. Supp. 2d at 446.

> substitute tribunals other than courts to determine an entire controversy.[33]

Second, appraisal proceedings do not require the procedural formality of arbitration proceedings.[34] Parties to arbitration are generally required to "meet together at all hearings, take evidence, adjudge matters based only on what is presented to them in the course of adversary proceedings, determine ultimate liability, and otherwise act quasi-judicially."[35] In arbitration, parties want to present witnesses and evidence, and to cross-examine opponents' witnesses.[36] Appraisal, on the other hand, has few clear rules. If the appraisers do not find it necessary, there may not be a formal hearing, presentation of witnesses, or taking of evidence.[37] Appraisers "act independently and apply their own skill and knowledge in reaching their conclusions."[38] Appraisers can generally make their own decisions concerning what they wish to see and how they see it.[39]

One example of how courts have distinguished appraisal from arbitration under state law is *Atlas Constr. Co. v. Indiana Ins. Co.*[40] In that case the plaintiff, Atlas Construction Company, sought to overturn an appraisal award in part because the defendant's appraiser and the umpire did not include Atlas's appraiser when signing the award.[41] The Indiana Court of Appeals found against Atlas, holding that the appraisal provision in a fire insurance policy does not constitute arbitration, and is therefore not subject to Indiana's statutory provisions governing the conduct of arbitrations.[42] The court, observing that appraisal deals only with the amount of loss and is conducted through informal procedures, held that Indiana's arbitration statutes did not govern the appraisal provision,

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33. Rastelli Bros. v. Neth. Ins. Co., 68 F. Supp. 2d 440, 446 (D.N.J. 1999) (citing GEORGE J. COUCH ET AL., COUCH ON INSURANCE § 50:5 (2d ed. 1982)).

34. *See, e.g.*, *City of Omaha*, 218 U.S. at 198; Allstate Ins. Co. v. Suarez, 786 So.2d 645, 647 (Fla. Dist. Ct. App. 2001) (affirming neutral umpire's decision to conduct appraisal in an informal manner).

35. Budget Rent-A-Car v. Todd Inv. Co., 603 P.2d 1199, 1201 (Or. Ct. App. 1979).

36. Andrew L. Pickens, *Appraisement: An Old But Effective Form of ADR for Contract Liabilities*, 60 TEX. J. BUS. L. 18, 18 (1997) (quoting *City of Omaha*, 218 U.S. at 194) (discussing differences between appraisal and arbitration).

37. *See* Richard C. Bennett, *Appraisal*, *in* 2 INSURING REAL PROPERTY § 30.03[6] (Matthew Bender 2005).

38. *Budget Rent-A-Car*, 603 P.2d at 1201.

39. Bennett, *supra* note 37, § 30.03[6].

40. 309 N.E.2d 810, 812-13 (Ind. Ct. App. 1974).

41. *Id.* at 812.

42. *Id.* at 812-13.

because those statutes specifically contemplate a wider range of issues in dispute.[43]

In contrast, some courts have held that appraisal provisions should be treated exactly like arbitration.[44] For example, in *Friday v. Trinity Universal of Kansas*, the Kansas Supreme Court relied on the law of arbitration when ruling that an appraisal was improper.[45] The court held that because Kansas forbids an insurance policy from compelling a party to arbitrate a dispute, an insurance policy cannot compel a party to conduct an appraisal.[46] While it was permissible for the policyholder and insurance company to enter into a present agreement to resolve an existing dispute through appraisal, the language in the insurance policy did not constitute a present agreement to appraise the loss because the policyholder did not consent.[47]

When appraisal provisions are treated as a separate method of dispute resolution from arbitration, typically state contract law applies.[48] When courts determine that appraisal provisions are a species of arbitration, a state's arbitration act usually applies,[49] and most of those state statutes are based on the Uniform Arbitration Act.[50] The model act provides some consistency among the states, although there are still unique aspects to the various state arbitration laws.

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43. *See id.* at 813 (citing IND. CODE § 34-4-1-1 (1971) (current version at IND. CODE ANN. § 34-57-1-1 (2006)) and IND. CODE § 34-4-2-1 (1971) (current version at IND. CODE ANN. § 34-57-2-1 (2006))).

44. *See* Wailua Assoc. v. Aetna Cas. & Sur. Co., 904 F. Supp. 1142, 1148 (D. Hawaii 1995); Cmty. Assisting Recovery, Inc. v. Aegis Sec. Ins. Co., 112 Cal. Rptr. 2d 304, 309 (Cal. Ct. App. 2001); Giulietti v. Connecticut Ins. Placement Facility, 534 A.2d 213, 217 (Conn. 1987); Closser v. Penn Mut. Fire Ins. Co., 457 A.2d 1081, 1087 (Del. 1983); Friday v. Trinity Universal of Kansas, 939 P.2d 869, 871 (Kan. 1997).

45. 939 P.2d at 872.

46. *Id.*

47. *Id.*

48. McKnight, Levy & Harrison, *supra* note 29.

49. *Id.*

50. *See, e.g.*, Wailua Assocs. v. Aetna Cas. & Sur. Co., 904 F. Supp. 1142, 1147-48 (D. Hawaii 1995) (under the scope of the Federal Arbitration Act); Giulietti v. Connecticut Ins. Placement Facility, 534 A.2d 213 (Conn. 1987); Friday v. Trinity Universal of Kansas, 924 P.2d 1284, 1287 (Kan. Ct. App. 1996) (holding appraisal clause was considered an arbitration clause and therefore unenforceable under the UAA, which makes a written agreement requiring the submission of a controversy to arbitration inapplicable to insurance contracts); Aetna Cas. & Sur. Co. v. Ins. Comm'r, 445 A.2d 14, 19-20 (Md. 1982); U.S. Department of State, Arbitration, http://usinfo.state.gov/dhr/democracy/rule_of_law/adr/arbitration.html (last visited Feb. 22, 2007) ("35 states have adopted the Uniform Arbitration Act as state law.").

In jurisdictions where appraisal is considered arbitration, the Federal Arbitration Act (FAA) will be the governing law for insurance policies that involve interstate commerce.[51] The FAA, enacted in 1925, ensures the validity and enforcement of arbitration agreements.[52] Valid arbitration agreements may only be set aside based on traditional contract defenses such as fraud and unconscionability.[53] Although state arbitration statutes are preempted where the FAA applies, state law plays a role in the interpretation of the arbitration provision.[54] Therefore, state law can determine whether an appraisal provision would fall within the authority of the FAA by deciding whether appraisal is or is not arbitration.

In *Hartford Lloyd's Ins. Co. v. Teachworth,* the United States Court of Appeals for the Fifth Circuit considered whether an insurance appraisal conducted pursuant to the terms of a Texas multi-peril insurance policy constituted "arbitration" within the meaning of the FAA.[55] In *Teachworth,* the insurance company attempted to set aside the award by arguing that the appraisal was invalid because the policyholder's appraiser failed to act impartially and the policyholder acted fraudulently by withholding "vital information and misrepresent[ing] important facts and figures."[56] Initially, the district court ruled that the appraisal constituted arbitration and looked

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51. 9 U.S.C. §§ 1-16 (2001). The United States Constitution grants the federal government the power to "regulate Commerce with foreign Nations, and among the several states, and with the Indian Tribes." U.S. CONST. art. I, § 8. *See also* Moses H. Cone Mem. Hosp. v. Mercury Constr. Corp., 460 U.S. 1, 26 (1983) (holding that enforcement of the Federal Arbitration Act is "left in large part to the state courts" because it creates no independent federal question jurisdiction).

52. JON O. SHIMABUKURO, CONG. RESEARCH SERV., THE FEDERAL ARBITRATION ACT: BACKGROUND AND RECENT DEVELOPMENTS 2, 5 (June 17, 2002), *available at* http://www.thememoryhole.org/crs/RL30934.pdf (explaining that Congress, through the FAA, put arbitration on the same footing as other contracts by requiring that a valid arbitration agreement have the same force and binding effect as a valid contract). *See also* Scherk v. Alberto-Culver Co., 417 U.S. 506, 510-11 (1974).

53. *See* Doctor's Assocs., Inc. v. Casarotto, 517 U.S. 681, 686-87 (1996).

54. *See* Southland Corp. v. Keating, 465 U.S. 1 (1984) (holding that the FAA preempts state law because Congress would not have wanted state and federal courts to reach different outcomes about the validity of arbitration in similar cases); First Options of Chicago, Inc. v. Kaplan, 514 U.S. 938, 955 (1995) ("When deciding whether parties agreed to arbitrate a certain matter (including arbitrability), courts generally should apply ordinary state-law principles governing formation of contracts.").

55. 898 F.2d 1058 (5th Cir. 1990). *See also* Johnny C. Parker, *Understanding the Insurance Policy Appraisal Clause: A Four-Step Program,* 37 U. TOL. L. REV. 931, 934 (2006) (containing a detailed discussion on *Teachworth*).

56. *Teachworth,* 898 F. 2d at 1060 n.1.

to the FAA for guidance.[57] After examining the grounds under the FAA in which a court may vacate or modify an arbitration award, the district court affirmed the appraisal award.[58]

The Fifth Circuit in *Teachworth* reversed, finding that because state law determines whether a procedure is arbitration subject to the FAA, the court must look to the relevant state law to determine whether appraisal constitutes arbitration.[59] After reviewing the law of Texas, the Fifth Circuit ruled that an appraisal only determines value and is not arbitration.[60] Accordingly, the *Teachworth* court followed Texas law in finding that appraisal is not a form of arbitration and, therefore, is not subject to the FAA.[61]

The general rule is that the FAA preempts state laws when a court determines that the appraisal provision in a policy dealing with interstate commerce constitutes arbitration.[62] Nonetheless, it is worth mentioning that in certain cases, it has been determined that the McCarran-Ferguson Act supersedes the FAA.[63] Courts have held that the McCarran-Ferguson Act precludes application of the FAA when the FAA would invalidate, impair, or supersede a law enacted by a state for the purpose of regulating the business of insurance.[64]

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57. *Id.* at 1060.

58. *Id.*

59. *Id.* at 1062.

60. *Id.* at 1062-63.

61. Hartford Lloyd's Ins. Co. v. Teachworth, 898 F.2d 1058, 1062-63 (5th Cir. 1990).

62. *See, e.g.*, Wailua Assocs. v. Aetna Cas. & Sur. Co., 904 F. Supp. 1142, 1147 (D. Hawaii 1995) ("FAA's applicability to a particular dispute is an agreement to arbitrate the dispute in a contract which evidences a transaction in interstate commerce."). The sale of an insurance policy from a Connecticut corporation to California Limited Partnership for property located in Hawaii and other states constituted interstate commerce. *Id.* at 1147 n.2.

63. 15 U.S.C. §§ 1011–15 (2001). The act was passed in 1945 to permit the states to continue regulating the insurance business after the Supreme Court, in *U.S. v. South-Eastern Underwriters Association*, overruled a decision, declaring insurance to be interstate commerce and therefore within Congress's constitutional authority to regulate. *See* Charles D. Weller, *The McCarran-Ferguson Act's Antitrust Exemption for Insurance: Language, History and Policy,* 1978 DUKE L.J. 587, 590 (1978) (providing a detailed discussion of the legislative history of the McCarran-Ferguson Act). The Act provides: "No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of Insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance." 15 U.S.C. § 1012(b) (2001).

64. *See* Davister Corp. v. United Republic Life Ins. Co., 152 F.3d 1277 (10th Cir. 1998) (holding that Utah's statutory stay of actions against insurance companies in liquidation regulated insurance, and would be invalidated, impaired or superseded by

In comparison, few states actively regulate the appraisal process. Accordingly, the McCarran-Ferguson Act rarely prevents the application of the FAA to appraisal. One of those rare cases is *Friday v. Trinity Universal of Kansas*.[65] Although appraisal is not specifically regulated in Kansas, the court reasoned that the McCarran-Ferguson Act precluded application of the FAA because Kansas law regulates the business of insurance by barring arbitration clauses in insurance contracts, and the court concluded that appraisal was a species of arbitration.[66]

In states that do categorize appraisal as a form of arbitration, the FAA would apply to appraisal disputes if the insurance policy touches upon interstate commerce. The McCarran-Ferguson Act would prevent the FAA's application, as stated above, only if it would invalidate, impair, or supersede a state law that regulates the business of insurance. In instances where the FAA is fully consistent with state laws that regulate the business of insurance, the McCarran-Ferguson Act would not prevent application of the FAA.[67] On the other hand, if appraisal is not arbitration, the FAA would not apply to appraisal disputes and the applicability of the McCarran-Ferguson Act to protect state insurance regulatory systems from the FAA would not come into play.

In our view, appraisal is not arbitration. However, regardless of whether appraisal is viewed as a form of arbitration, the application of certain arbitration procedures to appraisal may be beneficial from a public policy perspective to ensure procedural due process.[68]

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application of FAA); Munich Am. Reinsurance Co. v. Crawford, 141 F.3d 585 (5th Cir. 1998) (holding that because the Oklahoma Uniform Insurers Liquidation Act ("OUILA") regulated insurance and vested exclusive jurisdiction over an insolvent insurance company's assets in a single state forum, application of the FAA to compel resolution of a matter in arbitration, rather than in receivership would invalidate, impair or supersede OUILA).

65. 939 P.2d 869, 869 (Kan. 1997). *See also supra* text accompanying notes 44-47.

66. *Friday*, 939 P.2d at 872. *See also supra* text accompanying notes 44-47.

67. *See, e.g.*, Humana, Inc. v. Forsyth, 525 U.S. 299 (1999) (holding McCarran-Ferguson Act does not preclude application of federal law that does not directly conflict with state regulation, would not frustrate any declared state policy, and would not interfere with state's administrative regime).

68. *See* discussion *infra* Part II.

II. ADVANTAGES AND DISADVANTAGES OF THE APPRAISAL PROCESS

A. SPEED

Perhaps the most often cited advantage of the appraisal process is speed. Appraisals are frequently less time-consuming than a lawsuit.[69] Speed can be important not only to policyholders, but also to insurance companies.

On the other hand, insurance companies make a large portion of their profits from interest income, so delay has real economic benefits for insurance companies.[70] In 2005, the year that saw hurricanes Katrina and Rita, the property and casualty insurance industry in the United States made $51.7 billion in investment income while the industry lost $5.7 billion in underwriting income.[71] Indeed, the property and casualty insurance industry in the United States has had an underwriting loss every year since 1981, with the exception of 2004 and with the likely exception of 2006.[72] Thus, despite the recent trend toward underwriting profits, it is

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69. Herbert Dodell, *Using the Appraisal Process to Resolve Insurance Disputes*, L.A. LAWYER, July-Aug. 2002, at 15 ("The only real benefit of an informal appraisal is the reduced cost and a more speedy resolution of the dispute."); Stuart P. Schlem, *Appraisal – The Alternative to Insurance Litigation*, POLICYHOLDER ADVOCATE, Nov. 2005, at 27, *available at* https://www.policyholdersofamerica.org/newsletter/nov_2005/November_2005.pdf (stating that appraisal allows for a quick and easy resolution to a claim).

70. One commentator explained the economic incentives in claim denial and delay: With regard to claims for small amounts of money, the insurance company has some incentive to refuse payment because little likelihood exists that claimant will pursue the claim. As for large claims, the insurance company may find it profitable to delay payment as long as possible to keep for itself the time value of the amount due. Mark Pennington, *Punitive Damages for Breach of Contract: A Core Sample from the Decisions of the Last Ten Years*, 42 ARK. L. REV. 31, 53-54 (1989). *See also* Eugene R. Anderson & James J. Fournier, *Why Courts Enforce Insurance Policyholders' Objectively Reasonable Expectations of Insurance Coverage*, 5 CONN. INS. L.J. 335, 398 (1998) (discussing how insurance companies profit by prolonging a coverage dispute); MARY BUFFETT & DAVID CLARK, THE NEW BUFFETTOLOGY: THE PROVEN TECHNIQUES FOR INVESTING SUCCESSFULLY IN CHANGING MARKETS THAT HAVE MADE WARREN BUFFETT THE WORLD'S MOST FAMOUS INVESTOR 15-16 (2002) (discussing how Warren Buffet used insurance companies and their cash reserve from policyholders as investment vehicles to become one of the richest people in the world).

71. Greg Alff, *Outlook Good: Price Decreases and Stability Ahead for Commercial Insurance*, RISK MANAGEMENT MAGAZINE, Jan. 2007, at 7-8, *available at* http://www.rims.org/Magazine/PDF/PC%20Market.pdf.

72. *Id.* at 8-9 (figures 1 and 3).

fair to say that insurance companies make their money by holding premium dollars and investing those dollars before they are ultimately paid.

For policyholders, the speed of recovery can be just as important as the amount of recovery. Imagine, for instance, how important speedy recovery is to those who have been displaced from their homes due to a disaster. In such situations, the adage "justice delayed is justice denied" applies in a very real sense.[73] Unlike insurance companies, whose motivations and incentives may be mixed, policyholders always want their claims paid sooner rather than later.

Any reforms or refinements to the appraisal system should recognize speed of resolution and recovery as a primary public policy goal of appraisal. Appraisal can effectuate prompt recovery if utilized properly, but where it is used as a way to delay ultimate resolution and recovery, it has failed to achieve its essential purpose.

B. EXPENSE

Lawsuits are a notoriously expensive means of dispute resolution. Appraisal, on the other hand, is usually a less expensive means of resolving a dispute over the amount of loss. One policyholder watchdog, however, has argued that insurance companies have turned the appraisal process into "one of the most expensive, over-lawyered, dragged out sideshows in insurance claim resolution."[74]

Because appraisal cannot always avert the need to litigate, it is occasionally utilized in conjunction with litigation over coverage disputes. The appraisal process is limited to determining the "amount of loss," and does not supplant litigation for resolving coverage or liability disputes. If the parties need to resort to the courts for resolution of other issues, appraisal adds another layer of costs onto an expensive litigation process.[75]

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73. The phrase "Justice delayed is justice denied" is normally attributed to former British Statesman and Prime Minister, William E. Gladstone (1809-1898). JOHN BARTLETT, FAMILIAR QUOTATIONS 446 (16th ed. 1992). Prior to Gladstone, William Penn expressed the same sentiment in 1693: "Our law says well, '[t]o delay justice, is injustice.'" WILLIAM PENN, FRUITS OF SOLITUDE: REFLECTIONS AND MAXIMS RELATING TO THE CONDUCT OF HUMAN LIFE 69 (Lakeside Press 1906).

74. United Policyholders, Mold Damage Claims Tips, http://www.unitedpolicyholders.org/claimtips/tip_mold.html (last visited Feb. 19, 2007); *see also* Bennett, *supra* note 37, § 30.01 (noting "that a properly prepared and presented appraisal is not cheap").

75. *See* discussion *infra* Part IV.

This is especially true in jurisdictions where a party is required to proceed with appraisal despite a material dispute over policy coverage.[76]

Thus, just as speed of resolution is an important public policy goal of appraisal, so too is minimizing expense for all parties, but particularly for policyholders who may be unable to afford an expensive appraisal process at the time of loss. Appraisal should not be a sideshow in a coverage litigation, but an alternative dispute resolution process designed to quickly and inexpensively determine the amount of loss when that is the dispute among the parties.

C. BIAS

Originally appraisal provisions were thought to benefit policyholders, but now they are generally considered to benefit insurance companies.[77] The structure of appraisal is designed to be fair and balanced. Both parties select an appraiser, and those two appraisers select a disinterested umpire. The structure of balance is fundamental and must be honored in practice, as well as theory. Some critics believe that, as currently utilized, appraisal is designed to help insurance companies avoid lawsuits over disputed losses where juries may be inclined to find for the policyholder.[78] Given that lawsuits are often long and expensive ordeals, however, policyholders also have an incentive to avoid a lawsuit if a quicker and less expensive process is fair.

A boilerplate appraisal provision rarely, if ever, is the subject of negotiation or reflects a true meeting of the minds. A form insurance policy is an "adhesion contract."[79] This term, coined more than a century

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76. *See, e.g.*, Giulietti v. Connecticut Ins. Placement Facility, 534 A.2d 213 (1987) (holding that an insurance company, despite its denial of coverage, must nevertheless proceed to appraisal); DeGroot v. Farmers Mut. Hail Ins. Co. of Iowa, 643 N.E.2d 875 (Ill. App. Ct. 1994) (where court found that the appraisal award was not binding, the insurance company was required to pay the expenses of litigation after paying its share of the appraisal costs); Hueser v. Shelter Mut. Ins. Co., 901 S.W.2d 138, 139-40 (Mo. Ct. App. 1995) (holding that where the policyholder had the option to proceed to appraisal or elect to have the insurance company repair the damage, the policyholder's decision to proceed to appraisal was not irrevocable in all cases).

77. LEWIS & INSUA, *supra* note 12, at 8-50 (citing Int'l Serv. Ins. Co. v. Brodie, 337 S.W.2d 414, 415 (Tex. Civ. App. 1960)).

78. *Id.*; *see also* Policyholders of America, The Appraisal Process: It ain't justice but if it's kept honest, it can work, http://www.policyholdersofamerica.org/appraise.html (last visited Apr. 2, 2007).

79. *See, e.g.*, Clement v. Smith, 19 Cal. Rptr. 2d 676, 679 (Cal. Dist. Ct. App. 1993); Graham v. State Farm Mut. Auto Ins. Co., 565 A.2d 908, 912 (Del. 1989); First Newton

ago,[80] refers to a standardized contract offered on a "take it or leave it" basis, without the opportunity to bargain, and without the opportunity to obtain the product except through acquiescence to the terms of the form contract.[81] Because insurance policies are adhesionary contracts, it is important to recognize that most policyholders are unaware that they have "agreed" to appraisal of the amount of loss upon disagreement.[82]

Insurance companies, on the other hand, are well aware of their policy provisions and the appraisal process. In particular, insurance companies are often aware of the past rulings of umpires and appraisers, while policyholders do not have access to that information. The disparity of knowledge and familiarity with appraisal may create both a perception and a reality that appraisal favors the insurance company over policyholders. Minimizing any such bias in the appraisal process would serve public policy.

Nat'l Bank v. Gen. Cas. Co. of Wis., 426 N.W.2d 618, 628 (Iowa 1988); Jones v. Bituminous Cas. Corp., 821 S.W.2d 798, 801-02 (Ky. 1991); Meier v. N.J. Life Ins. Co., 503 A.2d 862, 869 (N.J. 1986). In order to protect the party with less bargaining power, (i.e., the adhering party), courts throughout the country scrutinize more strictly the terms of contracts of adhesion than those of ordinary contracts. *See* Ericksen, Arbuthnot, McCarthy, Kearney & Walsh, Inc. v. 100 Oak Street, 673 P.2d 251, 257 n.7 (Cal. 1983); Sparks v. St. Paul Ins. Co., 495 A.2d 406, 412 (N.J. 1985); Glaspell v. Ohio Edison Co., 505 N.E.2d 264, 266 (Ohio 1987); *see also* Stephen J. Ware, *A Critique of the Reasonable Expectations Doctrine*, 56 U. CHI. L. REV. 1461, 1464-66 (1989). For an extensive discussion on insurance policies as contracts of adhesion, see 1 EUGENE R. ANDERSON ET AL., INSURANCE COVERAGE LITIGATION § 2.01 (2d ed. 2000 & Supp. 2004).

80. *See* RAYMOND SALEILLES, DE LA DECLARATION DE VOLONTE 229-30 (1901), *translated in* Edwin W. Patterson, *The Interpretation and Construction of Contracts*, 64 COLUM. L. REV. 833, 856 (1964). It is interesting to note that in the United States, the term was first used in an insurance coverage case. *See* Bekken v. Equitable Life Assurance Soc'y of U.S., 293 N.W. 200, 212 (N.D. 1940).

81. BLACK'S LAW DICTIONARY 342 (8th ed. 2004). A contract of adhesion is defined as a "standardized contract, which, imposed and drafted by the party of superior bargaining strength, relegates to the subscribing party only the opportunity to adhere to the contract or reject it." Neal v. State Farm Ins. Cos., 10 Cal. Rptr. 781, 784 (Cal. Dist. Ct. App. 1961). The distinctive feature of a contract of adhesion is that the weaker party has no realistic choice as to its terms. *See* Wheeler v. St. Joseph Hosp., 133 Cal. Rptr. 775, 783 (Cal. Dist. Ct. App. 1976); Broemmer v. Abortion Servs. of Phoenix, Ltd. 840 P.2d 1013, 1016 (Ariz. 1992); Clinic Masters, Inc. v. County of El Paso, 556 P.2d 473, 475 (Colo. 1976); Wagner v. Farmers Ins. Exch., 786 P.2d 763, 766 (Utah Ct. App. 1990).

82. The classic model of freely negotiated agreements is "far removed from the reality of the business of insurance." 139 ROBERT H. JERRY, II, UNDERSTANDING INSURANCE LAW, § 25C (2d ed. 1996). Indeed, in many instances, the policyholder will not even have seen the insurance policy language when the policyholder buys the insurance policy. Delays of many months in the delivery of the insurance policy are not unusual, albeit unreasonable.

D. EXPERTISE

In comparison to litigation, the appraisal process can provide more opportunities for expert assessment of loss. Appraisal places resolution of the dispute in the hands of professionals who are likely to be far more expert and knowledgeable about the valuation of loss than any judge or jury.[83] Accordingly, ensuring the expertise and qualifications of the appraisers should also be included among the appropriate public policy goals underlying appraisal as a method of dispute resolution.

E. PROCEDURAL DUE PROCESS

The lack of clear-cut appraisal rules or uniformity among jurisdictions, and sometimes even within a jurisdiction, creates serious concerns that the appraisal process does not provide procedural due process in the assessment of loss. The appraisal process calls for sound protocol. If the rules affecting outcomes are unpredictable, appraisal could deprive parties of their most basic and essential protections of due process and fundamental fairness.[84] Ensuring procedural due process is especially important because appraisal provisions in form insurance policies, which are contracts of adhesion, essentially result in the forfeiture of a policyholder's right to have the amount of loss determined by a jury.

F. CONSIDERATIONS

Any refinements to the appraisal procedure should recognize and support the basic advantages and public policy goals of appraisal. Appraisals must be inexpensive, quick, and fair. Furthermore, any reforms to the appraisal process must take into consideration that appraisal places great reliance upon expert appraisers who may be best positioned to determine the amount of loss.

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83. Some policyholder watchdogs have compiled lists of recommended appraisers for their members. *See* Policyholders of America, *supra* note 78.

84. Bennett, *supra* note 37, § 30.03[6]. Some courts have found that appraisal proceedings should give both formal notice and an opportunity to present evidence in a way similar to that required by arbitration. Cas. Indem. Exch. v. Yother, 439 So. 2d 77 (Ala. 1983). *See supra* discussion on procedure and appraisal versus arbitration at Part I.B.

III. INTERACTION OF APPRAISAL AND LITIGATION

Questions as to the interaction and sequence of appraisal and litigation trouble the most conscientious courts and practitioners. The following section demonstrates just how inconsistently courts have construed the relationship between appraisal and litigation. In our view, there is substantial room for reform.

When a dispute is strictly over coverage, appraisal is unnecessary. Similarly, when the issue is simply that of valuation, litigation would not prevent an appraisal from proceeding upon request of either party.[85] In many cases, however, the line between valuation and coverage is not easily drawn, and the interaction between appraisal and litigation becomes uncertain. Common situations include those in which an insurance company pays only part of the policyholder's calculation of a loss but rejects others because of valuation and coverage disputes.[86]

Courts have an appropriate role to play in enforcing appraisal provisions, and determining how appraisal may be affected by litigation or vice versa. The relationship between appraisal and litigation becomes increasingly important in instances where litigation can result in a waiver or breach of appraisal provisions.[87] The judicial forum is appropriately utilized to compel appraisal, appoint umpires, confirm appraisal awards, and vacate appraisal awards, but the procedures for doing so are far from clear.

A. APPRAISAL AS A CONDITION PRECEDENT

In certain policies and jurisdictions, a lawsuit to recover the amount of loss is unsustainable until appraisal is initiated or until it is complete.[88]

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85. Bennett, *supra* note 37, § 30.03[6].

86. *Id.*

87. *See, e.g.*, Philips v. Gen. Acc. Ins. Co. of Am., 685 So. 2d 27 (Fla. Dist. Ct. App. 1996).

88. *See, e.g.*, Richardson v. Merrimack Mut. Fire Ins. Co., No. 98 Civ. 5967 (JFK), 2000 WL 297171 (S.D.N.Y. Mar. 21, 2000) (Policyholder refused settlement offer and sued insurance company, who raised appraisal as a defense. Court dismissed action because policyholder refused to submit to appraisal); Peck v. Planet Ins. Co., No. 93 Civ. 1961 (MBM), 1994 WL 381544 (S.D.N.Y. July, 21 1994) (requirement whereby party is contractually bound to exhaust the appraisal process before bringing suit on its claim in a demand for appraisal is valid); Piedmont Corp. v. Midwestern Indem. Co., No. WD-00-018, 2000 WL 1752765 (Ohio Ct. App. Nov. 30, 2000) (affirming trial court's decision regarding property and business interruption losses based on policyholder's failure to submit to

Appraisal is not always considered a condition precedent to filing suit, however.[89] Even when it is not considered a condition precedent, some courts have allowed an insurance company to demand appraisal after the policyholder filed a sustainable suit.[90] When appraisal and litigation are both initiated, the question becomes whether they should proceed concurrently or sequentially, and if sequentially, in what order. Generally, courts have left the sequence of appraisal and litigation to the discretion of the trial judge.[91]

In some instances, a policyholder may file suit even though the insurance company has invoked appraisal.[92] Litigation is often permitted to proceed because the disputed amount of loss is actually a disagreement over contract interpretation.[93] Courts can also be flexible by allowing the policyholder to revoke a demand for appraisal when a dispute arises over liability.[94]

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appraisal); Commercial Union Ins. Co. v. Swain, 694 So. 2d 39 (Fla. Dist. Ct. App. 1997) (compelling appraisal after policyholder initiated lawsuit rather than submit to appraisal).

89. *See, e.g.*, Rebel Tractor Parts, Inc. v. Auto-Owners Ins. Co., No. CV206-102, 2006 U.S. Dist. LEXIS 86502, at *6-7 (D. Ga. Nov. 28, 2006); Goldberg v. Provident Washington Ins. Co., 87 S.E. 1077, 1079 (Ga. 1916).

90. *See, e.g.*, Preferred Mut. Ins. Co. v. Martinez, 643 So. 2d 1101 (Fla. Dist. Ct. App. 1994).

91. There are at least two recent cases involving the destruction of the World Trade Center where the court has addressed whether appraisal should proceed before legal decision of the court. *See* SR Int'l Bus. Ins. Co. v. World Trade Ctr. Props. LLC, No. 01 Civ. 9291, 2006 WL 3073220, at *5 n.28 (S.D.N.Y. Oct. 31, 2006) ("Because appraisal panel cannot decide questions of law, such issues must be resolved by a court."); SR Int'l Bus. Ins. Co. v. World Trade Ctr. Props. LLC, 445 F. Supp. 2d 320 (S.D.N.Y. 2006). *See also* Paradise Plaza Condo. Ass'n, Inc. v. Reinsurance Corp. of N.Y., 685 So. 2d 937 (Fla. Dist. Ct. App. 1996) (In exercising discretion, the trial judge may consider the costs involved and relative importance and viability of the damages and coverage issues, as well as other factors).

92. *See* Hayes v. Allstate Ins. Co., 722 F.2d 1332 (7th Cir. 1983) (policyholder was not precluded from bringing action under fire policy, even though insurance company had demanded appraisal).

93. *See* Indian Cheff, Inc. v. Fire & Cas. Ins. Co. of Connecticut, No. 02 CIV. 3401, 2003 U.S. Dist. LEXIS 2199 (S.D.N.Y. Feb. 13, 2003) (rejecting partial motion for summary judgment to compel appraisal where the dispute was regarding coverage provisions in the policy); Hawkinson Tread Tire Serv. Co. v. Ind. Lumbermens Mut. Ins. Co., 245 S.W.2d 24 (Miss. 1951) (holding that a demand for appraisal did not preclude litigation where the parties' primary dispute involved the appropriate length of the period of restoration of a business interruption loss).

94. *See, e.g.*, Am. Nat'l Fire Ins. Co. v. Unigraphic-Color Corp., No. 84-1512, 1984 U.S. Dist. LEXIS 15646, at *8 (E.D. Pa. June 22, 1984).

B. WAIVER AND TIMING ISSUES

A contractual right to appraisal may be waived. Some courts have held that the provision is waived if suit is filed prior to an appraisal demand[95] or if an insurance company denies liability under the policy.[96]

Waiver may also take place because of timing. The right to appraisal is not indefinite as to time, but must be exercised within a reasonable period depending on the policy or the facts of a particular case.[97] Courts will find an insurance company has waived the right to appraisal when it is not timely invoked.[98] Some policies specify a time period in which a demand must be made, such as 60 days after proof of loss, while other policies are not as specific and questions of waiver turn on a finding of reasonableness and lack of prejudice.

Several issues relating to waiver and timing arose in *SR Int'l Bus. Ins. Co. v. World Trade Ctr. Prop. LLC,* a well-known case from the World Trade Center disaster. [99] The policyholder argued that the insurance companies moving to compel appraisal had "waived their right to an appraisal by failing to make a timely demand." [100] The issue was whether the policyholder's proof of loss started the time to demand appraisal.[101] Even though the demand came months after litigation began, the court applied a "reasonable insurance company" standard, finding it was reasonable to delay demanding an appraisal until after a final report on the amount of the loss was received.[102] Accordingly, the insurance company's delay did not result in waiver of its right to appraisal in that case.[103]

Courts are generally inclined to find a policyholder's demand for appraisal timely, so long as the insurance company has not lost some right

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95. *See, e.g.*, Mieneke v. Twin City Fire Ins. Co., 892 P.2d 1365 (Ariz. Ct. App. 1994) (Insurer waived right to appraisal by filing answer to insured's suit and not demanding appraisal until ten days later, though insurer stated in its answer that it reserved the right to demand arbitration or appraisal).

96. *See, e.g.*, Massey v. Farmers Ins. Group, 837 P.2d 880, 882 (Okla. 1992) (Denial of liability by an insurer waives the right of the insurer to invoke the appraisal provision).

97. 44a AM. JUR. 2D *Insurance* § 1656 (2006).

98. *See, e.g., Mieneke,* 892 P.2d at 1372.

99. SR Int'l Bus. Ins. Co. v. World Trade Ctr. Props. LLC, No. 01 Civ. 9291, 2003 WL 1344882 (S.D.N.Y Mar. 18, 2003). *See also* LEWIS & INSUA, *supra* note 12, § 8.05[C], at 8-66 (discussing other appraisal disputes surrounding *SR Int'l Bus. Ins. Co.*).

100. *SR Int'l Bus. Ins. Co.*, 2003 WL 1344882, at *1.

101. *Id.*

102. *Id.* at *2.

103. *Id.* at *4.

under the policy, and appraisal has not become impossible or impractical at the time demand is made.[104] Some argue that a more flexible approach to time limits is favorable.[105] They contend that any strict legally imposed deadline would defeat the purposes which appraisal serves in dispute resolution, and would result in a "race to the courthouse."[106]

If an insurance company fails to respond to a demand for appraisal, the potential consequences could involve more than simply a waiver of the appraisal process. A failure to appraise by the insurance company may entitle the policyholder to sue on the policy.[107] In some instances, courts have even held that it is permissible for the demanding party to proceed through appraisal without the other party's appraiser.[108] In one case, an umpire was appointed through the court of the jurisdiction where the loss occurred, and an appraisal award was obtained through the agreement of the demanding party's appraiser and the umpire.[109] In addition, at least one court has held that the failure to comply with an appraisal demand constitutes a breach of the terms of the insurance policy, which can result in a complete forfeiture of coverage.[110] Such results are highly disfavored in the law.[111] In any event, a demand for appraisal should not be ignored.[112]

C. COMPELLING APPRAISAL

Parties can generally compel appraisal in jurisdictions that apply arbitration law to appraisal provisions through the same procedural devices

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104. A.L. Frechette, Annotation, Time Within Which Demand For Appraisal of Property Loss Must Be Made, Under Insurance Policy Providing for Such Appraisal, 14 A.L.R. 3d 674, 678 (1967).

105. Bennett, *supra* note 37, §30.03[2][b].

106. *Id.*

107. *See, e.g.*, St. Paul Fire & Marine Ins. Co. v. Kirkpatrick, 164 S.W. 1186, 1188 (Tenn. 1914).

108. *See, e.g.*, Commercial Union Assurance Co. of London v. Schumaker, 119 N.E. 532, 537 (Ind. Ct. App. 1918).

109. *Id.*

110. *See, e.g.*, Caledonian Ins. Co. of Scotland v. Traub, 35 A. 13, 15 (Md. 1896); Bucholz v. U.S. Fire Ins. Co., 265 N.Y.S.2d 467, 468 (N.Y. App. Div. 1943).

111. *See* Eugene R. Anderson et al., *Draconian Forfeitures of Insurance: Commonplace, Indefensible, and Unnecessary*, 65 FORDAM L. REV. 825, 852 (1996).

112. *See* Schlem, *supra* note 69.

that are used to compel arbitration.[113] The rules, however, are not as predictable in jurisdictions that make a distinction between arbitration and appraisal. The case of *Aetna Cas. & Sur. Co. v. Ins. Comm'r* takes an in-depth look at how different jurisdictions have determined which parties have the ability to compel appraisal.[114]

The *Aetna* court observed that in some jurisdictions a policyholder may not compel an insurance company to submit to appraisal.[115] These jurisdictions focus on the comparison of appraisal to arbitration and reason that "because of the basic distinctions between appraisal under a standard fire insurance policy and statutory arbitration, the legislative policy favoring enforcement of executory agreements to arbitrate is inapplicable."[116] Some courts that do not allow a policyholder to compel appraisal recognize the mandatory language of the appraisal clause, yet view the clause as "wholly for the protection of the insurer."[117]

On the other hand, the *Aetna* court remarked that jurisdictions which allow policyholders to compel appraisal do so for three reasons.[118] First, the plain language of an appraisal clause established that submission to appraisal is mandatory when demanded by either party.[119] Second, the policyholder is entitled to receive the benefit of a bargain for which premiums were paid.[120] Third, such a result is consonant with a legislative policy in favor of enforcement of executory agreements to arbitrate.[121]

Ultimately, the *Aetna* court agreed with the arguments in favor of allowing policyholders to compel appraisal if a dispute arises over the amount of loss. The court held that Maryland law, despite distinctions between arbitration and appraisal, views appraisal as analogous to arbitration.[122] Hence, because Maryland also favors enforcement of

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113. *See infra* Part V. Similarly to compelling appraisal, if the appraisers cannot agree on an umpire, then either party may petition the court where the covered property is located to appoint an umpire. Allstate Ins. Co. v. Kleveno, 81 A.D.2d 648 (N.Y.S.2d 1981).

114. 445 A.2d 14, 16-19 (Md. 1982).

115. *Id.* at 18.

116. *Id.*

117. *Id.*

118. *Id.* at 17.

119. *Id.*

120. Aetna Cas. & Sur. Co. v. Ins. Comm'r, 445 A.2d 14, 17 (Md. 1982).

121. *Id.*

122. *Id.* at 20.

executory agreements to arbitrate, it therefore favors both parties having the right to compel an agreement to appraise loss.[123]

D. CONFIRMING OR VACATING AN APPRAISAL AWARD

Policy provisions that require appraisal of a loss are usually valid and binding on both parties,[124] so long as the terms and conditions do not violate an existing statute.[125] There are, however, exceptions in certain states. In Oklahoma, for example, the award is only binding on the party who invokes the appraisal process.[126]

Under the standard appraisal provision, the filing of the appraisal with the insurance company triggers payment deadlines.[127] In many states, especially those that utilize arbitration law to govern appraisals, the policyholder may petition a court to confirm and enter judgment upon the award.[128] If an insurance company refuses to pay the award, whether confirmed by judgment or not, a policyholder may initiate legal action against the insurance company.

Challenging an appraisal award is very difficult. Courts prefer not to second-guess the appraisers and seem inclined to treat them like jury verdicts, in which only questions of fact are involved.[129] The standards to confirm or vacate an award may depend upon whether the state treats an

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123. *Id.* Minnesota, Ohio, New Jersey, Pennsylvania, and Florida are among the jurisdictions that support the *Aetna* decision. Bennett, *supra* note 37, §30.03[2][a].

124. Appraisals are not binding in South Dakota under the South Dakota Division of Insurance Bulletin 98-5, available at http://www.state.sd.us/drr2/reg/insurance/Legal/Bulletin/98-5.htm, and Virginia under the Virginia Bureau of Insurance Administration Letter 1998-12, available at http://www.scc.Virginia.gov/division/boi/webpages/adminlets/al98-12.pdf.

125. *See, e.g.*, Friday v. Trinity Universal of Kansas, 939 P.2d 869, 872 (Kan. 1997) (Kansas court found that appraisal clauses are really arbitration clauses and unenforceable under a state statute making written agreements requiring submission of controversy to arbitration inapplicable to an insurance contract); Rawlings v. Amco Ins. Co., 438 N.W.2d 769, 771 (Neb. 1989) (where a Nebraska court found that the appraisal provision was an unenforceable arbitration clause, based on the common-law doctrine that arbitration agreements entered into before a dispute arises, which purport to deny the parties the right to resort to the courts, nonetheless oust the courts of their jurisdiction and are thus against public policy and therefore void and unenforceable).

126. *See, e.g.*, Massey v. Farmers Ins. Groups, 837 P.2d 880, 884 (Okla. 1992).

127. *See, e.g.*, Erickson v. Farmers Union Mut. Ins. Co., 311 N.W.2d 579, 581 (N.D. 1981).

128. *See, e.g.*, Candales v. Allstate Ins. Co., 421 So. 2d 42 (Fla. Dist. Ct. App. 1982).

129. Bennett, *supra* note 37, §30.05[1] (citing Brethen Mut. Ins. Co. v. Filsinger, 458 A.2d 880 (Md. Ct. Spec. App. 1983)).

appraisal award in the same manner that it treats an arbitration award. The standards for confirming and vacating arbitration awards are often well-settled in the state's jurisprudence.

Vacating an appraisal award has been achieved when fraud, or the misfeasance or malfeasance of the appraisers is proven.[130] On rare occasions, a mere mistake may be sufficient to vacate an award. For instance, one court held that when the appraiser failed to take into consideration repairs which were made to the structure after the loss occurred there was a mistake of fact.[131] Similarly, a mistake of law was found when an appraiser measured actual cash value as "cost to repair less depreciation" and failed to consider all of the facts which make up actual cash value.[132]

If the appraisers go beyond their scope of authority, the award may also be challenged. For instance, an award may be challenged on the basis of "indubitable proof from qualified witnesses that the award was made without authority."[133] Similarly, an appraisal was vacated when the appraisers exceeded their authority and interpreted coverage provisions, rather than limiting any inquiry to "the amount of loss" at issue.[134] One court held that appraisers exceeded their authority by recalculating actual cash value after initially determining that the actual cash value excluded the cost of code upgrades for the undamaged portion of the building.[135]

E. LITIGATION TO SUPPORT APPRAISAL

Another appropriate use of litigation would be to support and effectuate the appraisal. A legal proceeding, such as a preliminary injunction proceeding, is occasionally required to ensure the appropriate sequencing of appraisal and litigation. For example, if certain legal issues must be decided for the appraisers to properly perform the appraisal, parties will occasionally seek to enjoin the appraisal from moving forward until the legal issues are decided. Parties may also employ the court to compel the

130. *See, e.g.*, Bentley v. N.C. Ins. Guar. Ass'n., 418 S.E.2d 705, 708 (N.C. Ct. App. 1992); London v. Trinity Cos., 877 P.2d 620, 622 (Okla. Civ. App. 1994); Wells v. Am. States Preferred Ins. Co., 919 S.W.2d 679 (Tex. App. 1996).

131. Mitchell v. Aetna Cas. & Sur. Co., 579 F.2d 342, 350 (5th Cir. 1978).

132. *See, e.g.*, McAnarney v. Newark Fire Ins. Co., 159 N.E. 902, 904 (N.Y. 1928).

133. *See, e.g.*, Toonen v. United Servs. Auto. Ass'n, 935 S.W.2d 937 (Tex. App. 1996).

134. *See, e.g.*, *Mitchell*, 579 F.2d at 342.

135. *See, e.g.*, Steiner v. Middlesex Mut. Assurance Co., 689 A.2d 1154 (Conn. App. Ct. 1997).

appraisal to move forward in the event of delay. Furthermore, the parties to an appraisal will occasionally avail themselves of the legal process to ensure the discovery of relevant information necessary for the appraisal.

In some instances, an insurance company will demand substantial documentation of the loss from the policyholder, but then will be less forthcoming in disclosing the fruits of its own investigation, including opinions on valuation that may be contrary to the position it is taking in the appraisal. Ensuring the availability of the judicial process to support appraisal is important to achieving fundamental fairness.

F. ESTABLISHING BAD FAITH

An insurance company's abuse of the appraisal process can result in extra-contractual liability. In addition, acting in bad faith establishes grounds for an award to be overturned.[136] Unfair claims settlement practices acts govern the conduct of insurance companies in resolving claims and typically require the insurance company to have as its goal the prompt and fair resolution of covered claims presented to it.[137] Violations of standards of conduct regarding claims settlement can result in a finding of bad faith.

If an insurance company delays an appraisal or otherwise violates its duties under state law, a policyholder may bring a bad faith lawsuit. For instance, in *Green v. Int'l Ins. Co.*, the Illinois appellate court held that the insurance company's actions could reasonably be seen by a court as an unreasonable and vexatious delay in settling the plaintiff's claim.[138] The insurance company's appraiser in *Green* repeatedly insisted on naming umpire candidates who currently or formerly had dealings with the company, and cancelled a series of meetings at the last minute, usually without explanation, and these actions caused the appraisal process to take four years.[139]

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136. *See, e.g.*, Roehrig v. State Auto Mut. Ins. Co., 2005 Mich. App. LEXIS 1607, at *4 (Mich. Ct. App. 2005) (stating that "[j]udicial review of the appraisal award is limited to instances of bad faith, fraud, misconduct, or manifest mistake.").

137. *See* WILKOFSKY, *supra* note 6, at 66.

138. 605 N.E.2d 1125, 1129 (Ill. App. Ct. 1992).

139. *Id.* at 1129.

IV. PROCEDURAL PROTECTIONS FOR THE APPRAISAL PROCESS

The typical appraisal provision in a property policy is silent about many of the specific details that will govern the process. This silence may provide necessary flexibility, in that disputes over a $1,000 loss may require fewer procedural protections than a dispute over a $100,000 or a $100,000,000 loss. The expense of the procedures may outweigh their utility in smaller losses.

Parties sometimes enter into a separate appraisal agreement once it has been decided to conduct an appraisal.[140] An independent agreement allows the parties to set forth details such as the specific property and the exact loss to be appraised, as well as the form of the appraisal award.[141] An additional agreement may also help clarify the procedures to be employed. For instance, the agreement may provide for a hearing to be attended by both appraisers and the umpire, for evidence and testimony to be taken, and for the submission of preliminary memoranda by the parties. The agreement can also require the appraisers and the umpire to be required to execute affidavits declaring that they will act impartially and that they will make a true and just award based upon their best knowledge, skill and judgment.[142]

Given that such agreements are not mandatory, a question arises relating to exactly what process and procedures are necessary to create a fair method for resolving disputes about an amount of loss. At a minimum, the umpire must be fair and impartial. There must also be some minimal level of process to ensure that the parties are heard, and that the decision is fairly reached and communicated. In our view, if the appraisal process does not include these essential and basic procedural protections, the policy's appraisal requirement should be voided as unconscionable and against public policy.

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140. Bennett, *supra* note 37, § 30.02[1]. *See also* Brethen Mut. Ins. Co. v. Filsinger, 458 A.2d 880, 884 (Md. Ct. Spec. App. 1983) (noting that a separate agreement can only be entered with the consent of both parties, and insurance company could not compel the policyholder to sign a separate agreement that defines policy terms).

141. Bennett, *supra* note 37, § 30.02[1].

142. *Id.*

A. REQUIREMENT OF COMPETENT AND DISINTERESTED APPRAISERS

Most policy language requires that appraisers and umpires be "competent and disinterested."[143] Competency requires only that individuals have the knowledge and experience to make an intelligent judgment concerning the amount of loss.[144] While the parties or the policy could require particular expertise or experience, courts generally do not require expertise on the particular subject matter involved in the claim in order to find an appraiser competent.[145] Of course, given full information and ability to pay, both parties are likely to select appraisers who have the education and experience necessary to ascertain the amount of loss. Insurance companies may have financial and informational advantages, however, that could skew the process in their favor.

Courts have different interpretations of what constitutes a "disinterested" appraiser. Older cases define "disinterested" as someone who is impartial and not under the control of either party.[146] Nevertheless, parties often attempt to set aside or resist confirmation of an appraisal award on the grounds of bias, interest, or partiality.[147] Some arguments that an appraiser is not qualified based on interest have included the number of times the appraiser has worked for the company,[148] the percentage of income that comes from the insurance company,[149] reputation,[150] and payment based on a contingent fee.[151]

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143. *See, e.g.*, N.Y. INS. LAW § 3404(e) (McKinney 2006).

144. *See, e.g.*, Hozlock v. Donegal Cos., 745 A.2d 1261, 1264 (Pa. Super. Ct. 2000) ("competent" i.e. capable of rendering a fair judgment).

145. *See, e.g.*, Fireman's Fund Ins. Co. v. Flint Hosiery Mills, 74 F.2d 533, 536 (4th Cir. 1935).

146. *See, e.g.*, Norwich Union Fire Ins. Soc. v. Cohn, 68 F.2d 42, 44 (10th Cir. 1933); Phoenix Assurance Co. v. Singer, 221 F. Supp. 890, 894-95 (E.D. Mo. 1963).

147. For a more detailed discussion on the existing cases, see generally George L. Blum, Annotation, *Setting Aside Arbitration Award on Ground of Interest or Bias of Arbitrators - Insurance Appraisals or Arbitrations,* 63 A.L.R. 5th 675 (1998).

148. *See* Sterling Spinning & Stamping Works v. Knickerbocker Ins. Co. of N.Y., 242 N.Y.S. 201, 204 (N.Y. Mun. Ct. 1930) (A contractor employed over 1800 times by insurance company was judged ineligible to serve as an appraiser).

149. Holt v. State Farm Lloyds, No. CA 3:98-CV-1076-R, 1999 U.S. Dist LEXIS 6257, at *13 (N.D. Tex. Apr. 21, 1999) (holding that whether an appraiser who derived more than one-quarter of his income from work done from the insurance company was independent is a question for the jury).

150. Bunting v. State Farm Lloyds, No. 3-98-CV-2490-BD, 2000 U.S. Dist. LEXIS 1674, at *7 (N.D. Tex. Feb. 14, 2000) (holding that a reputation in roofing industry as being

The selection of an umpire is perhaps the most important aspect of the appraisal process.[152] The umpire's ruling only needs the concurrence of one of the appraisers, so there is enormous power in the position. Policyholder advocates argue that the selection of an umpire is a particular area where insurance companies don't play fair.[153]

First off, umpires often come directly from the insurance industry.[154] The insurance company may attempt to seek one of their own as an appointed umpire, or the umpire may favor the insurance company because it is a potential repeat client.[155] In one specific account, an employee of the same engineering firm that had been retained by the insurance company as an expert was recommended as the umpire. [156] The conflict of interest is apparent. At a minimum, insurance companies will likely have more insider information about potential umpires.[157]

Certain states have created rules that reflect the importance of appointing neutral umpires. For instance, in 2001 California amended the Insurance Code Section that contains the form and all the terms of the insurance agreement and appraisal process.[158] Under the new California law, there is no longer a requirement that the appraisers disagree on the amount of loss before selecting a neutral umpire. The appraisers select a competent umpire within the first 15 days, and the parties may seek court intervention solely on the basis of the parties' inability to agree on the selection of an umpire.[159] This may create significant additional cost, especially in smaller claims, which may not always be justified.

B. RIGHT TO A HEARING AND NOTICE OF HEARING

The appraisers themselves will determine much of the appraisal process, including what is seen and heard. Historically, courts have been

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rude and unfair to homeowners and biased in favor of insurance companies will not disqualify appraiser).

151. Galvis v. Allstate Ins. Co., 721 So. 2d 421, 421 (Fla. Dist. Ct. App. 1998) (holding that the fact that appraiser was paid on a contingent fee basis did not result in a finding that appraiser was not disinterested).

152. Schelm, *supra* note 69, at 27.

153. *Id.*

154. LEWIS & INSUA, *supra* note 12, at 8-50.

155. *Id. See also* Schelm, *supra* note 69, at 27.

156. Schelm, *supra* note 69, at 27.

157. LEWIS & INSUA, *supra* note 12, at 8-50.

158. Dodell, *supra* note 69, at 15.

159. *Id.*

flexible in allowing the appraisers themselves to take the lead over what evidence they wish to receive and what procedure to use.[160] Whatever procedure they choose, all interested parties are entitled to notice of the time and place of any appraisal hearing.[161]

The right to present evidence and examine witnesses is a fundamental due process protection which should only be waived explicitly, and not implicitly by the absence of language specifying that right in the appraisal language. Most appraisals do not involve a formal hearing, but when an examination of witnesses or the opportunity to fully examine the evidence of the other party is requested, each party should be permitted to introduce their own evidence and witnesses.

In *Casualty Indemnity Exchange v. Yother*, the Alabama Supreme Court refused to uphold an appraisal award when the policyholder was "denied the opportunity to offer testimony or other evidence of the condition and value of his tractor at the time of loss," and the umpire "entered the amount of the award without having consulted the appraisers."[162] The court held that although the appraisal clause did not mention notice to the policyholder, or the opportunity to produce evidence, the policyholder was fundamentally entitled to both. The lower court was correct in setting aside the appraisal award, even though the insurance contract did not provide for these procedures.[163]

In accordance with *Yother*, policyholders should be afforded fundamental protections of due process. These protections should include, if asserted, the right to a hearing, the opportunity to produce evidence, the opportunity to review and analyze the insurance company's evidence, a right of discovery, the right of cross-examination, and the right to an award being entered without substantive errors or procedural irregularities. While not all (or even most) appraisals will require a full hearing, the process must always be fair and open to the submission and examination of the evidence.

Those protections may, however, add delay and expense to an appraisal. Because speed and expense are generally more important to policyholders, it can be fairly assumed that policyholders will not demand

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160. *See* Doherty v. Phoenix Ins. Co., 112 N.E. 940 (Mass. 1916).

161. *See* St. Paul Fire & Marine Ins. Co. v. Tire Clearing House, Inc., 58 F.2d 610 (8th Cir. 1932); *see also* D. E. Ytreberg, Annotation, *Insurance: Necessity and Sufficiency of Notice of and Hearing in Proceedings Before Appraisers and Arbitrators Appointed to Determine Amount of Loss*, 25 A.L.R.3d 680 (1969).

162. 439 So. 2d 77, 80 (Ala. 1983).

163. *Id.* at 81.

any more process than necessary to achieve a fair result under the circumstances.

C. RIGHT TO A WRITTEN APPRAISAL AWARD

The standard appraisal provision provides that when the appraisers disagree, they shall submit their differences only to the umpire.[164] An award must then be agreed upon by one appraiser and the umpire.[165] Splitting the difference would not constitute a valid award unless one of the other two appraisers agrees.[166] As one court explained:

> The function of the [umpire] in resolving the difference between the two original appraisers quite properly, then, contemplates the exercise of independent judgment on his part. To hold otherwise under circumstances as here presented would be to encourage, if not require, "quotient" appraisal awards. Such "quotient" awards are as strongly suspect in the law as are "quotient" jury verdicts.[167]

Proper awards must be in writing and sufficiently clear so that a reasonable person could comprehend the conclusion. Most awards must also be sufficiently itemized so as to satisfy the requirements of the policy and any applicable statutes.[168] One court ruled that, "a reasonable interpretation of the policy language necessitates only an itemization of the damage to the basic component systems (e.g. electrical, plumbing, heating, structure, carpentry, painting, refinishing) so as to insure a modicum of accountability and reliability in the appraisal process."[169] If an itemization requirement is not agreed upon by the parties, then a general conclusion or lump sum may suffice.[170]

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164. *See* WILKOFSKY, *supra* note 6, at 259.

165. *See, e.g.*, N.Y. INS. LAW § 3404(e) (McKinney 2006) (standard fire policy).

166. Allstate Ins. Co. v. Kleveno, 81 A.D.2d 648 (N.Y. App. Div. 1981).

167. Atlas Constr. Co. v. Ind. Ins. Co., 309 N.E.2d 810, 816 (Ind. Ct. App. 1974).

168. The lack of detailed itemization has been held to invalidate an award. *See, e.g.*, Mound City Roofing Tile Co. v. Springfield Fire & Marine Ins. Co., 277 S.W. 349 (Mo. Ct. App. 1925).

169. De Crescenzo v. Capital Mut. Ins. Co., 187 A.D.2d 793 (N.Y. App. Div. 1992).

170. Mich. Fire Repair Contractors' Ass'n v. Pacific Nat'l Fire Ins. Co., 107 N.W.2d 811 (Mich. 1961).

V. RECOMMENDATIONS

A. ARBITRATION PROCEDURES

We recommend that courts recognize that while appraisal may not be synonymous with or a subset of arbitration, many of the processes and precedent surrounding arbitration can be appropriately applied to the appraisal process. Because appraisal is distinct from arbitration and is intended to be less formal than arbitration, it is our view that arbitration statutes and procedures should not be universally applied to appraisal. Nevertheless, the selective incorporation of certain procedural protections and processes would help ensure that the due process rights of policyholders, who are denied trial by jury due to the incorporation of form appraisal provisions into standardized insurance policies, are not unduly compromised. In particular, we recommend that arbitration procedures be applied to appraisal for (1) the appointment of an umpire; (2) the compelling of appraisal; and (3) the confirmation of appraisal awards. Under normal circumstances, the application of those procedures should not significantly undermine any of the recognized benefits of the appraisal process. Rather, these procedures would support the appraisal process.

With regard to the right to a hearing and to present evidence, it should be recognized that appraisal is designed to be less formal that arbitration, but not less just. If a party demands procedural safeguards, such as a formal hearing at which witnesses could be examined and cross-examined, appraisers should provide basic procedures that comply with fundamental notions of due process. Furthermore, an appraisal award should be in writing and sufficiently clear so that a reasonable person could comprehend its conclusion.

B. APPRAISAL IN LIEU OF LITIGATION AND LITIGATION IN SUPPORT OF APPRAISAL

Appraisal is most useful when there are no coverage disputes, but solely disputes about the amount of loss. If properly conducted, appraisal can be an appropriate mechanism for the quick and efficient resolution of a dispute about the amount of loss by experts in valuation. Where appraisal will not achieve that purpose, it should not be mandated. Accordingly, we further recommend that policyholders be permitted, but not required, to avoid appraisal and proceed directly to coverage and bad faith litigation if the insurance company has not conceded coverage. In other words, when an insurance company denies liability under the insurance policy for all or

a portion of the claimed loss, the insurance company should be deemed to have waived the right to call for appraisal.

When an insurance company has not conceded coverage, to nevertheless compel appraisal at the insistence of the insurance company, would give rise to unnecessary multiple proceedings. A rule allowing a policyholder to proceed directly to litigation in the absence of a concession of coverage by the insurance company would also avoid conflicts about whether a litigation or appraisal should proceed first. Where a policyholder elects solely to litigate, there would be no appraisal. If a policyholder agreed to allow appraisers to decide the amount of loss, rather than a jury, then appraisal and litigation could proceed in either order or on dual tracks, at the discretion of the trial judge. Appraisal should not be seen as a duty or condition precedent that must be satisfied before the initiation of litigation, especially if litigation over coverage is necessary.

Litigation should also be available to support the appraisal process, if necessary. A legal proceeding is appropriate to ensure the appropriate sequencing of appraisal and litigation, compelling the appraisal to move forward in the event of delay, and ensuring the disclosure of information relevant to the appraisal. Ensuring the availability of the judicial process to support appraisal is important to achieving fundamental fairness, yet litigation can be expensive and should therefore not be permitted to undermine the speed and expense benefits of appraisal.

C. COST OF APPRAISAL

Similar to many arbitration provisions, most appraisal provisions provide that each appraiser will be paid by the party selecting that appraiser, and that the expenses of the appraisal process and of the umpire be shared by the parties equally.[171] This allocation can result in injustice. It is important to consider that while an insurance company can most often afford the costs and expenses of the appraisal process, some policyholders cannot, especially at a time of loss.

Any allocation of appraisal costs should also recognize that the insurance company has a fundamental advantage over the policyholder with regard to any disagreement about the amount of loss.[172] Imagine, for

171. *See, e.g.*, N.Y. INS. LAW § 3404(e) (McKinney 2006) (providng a standard form fire policy).

172. JEFFERY W. STEMPEL, INTERPRETATION OF INSURANCE CONTRACTS: LAW AND STRATEGY FOR INSURERS AND POLICYHOLDERS § 19.3 (1994) ("Unlike most other commercial actors fighting for supremacy in a world where possession is nine-tenths of the

instance, that a policyholder believes $50,000 should be paid on a claim, and an insurance company believes that $30,000 is the amount of loss. When the policyholder receives a check for $30,000 (or an offer to pay that amount), the policyholder is placed in an untenable position. The policyholder may fear that if the check is accepted the court will view it as accord and satisfaction of the claim. Indeed, the check may be accompanied by a demand for release of the entire claim. Having suffered a loss, the policyholder may desperately need that $30,000. This creates a risk of opportunistic breach by the insurance company, and an incentive to underpay a property loss.[173] The temptation to accept the $30,000 payment and sign the release is heightened if participation in the appraisal process will be an expensive proposition. While there may be competitive disadvantages to underpaying a loss, such as the disenchantment of a customer, the informational deficiencies in the insurance market, and particularly the lack of knowledge and resources relating to the claim practices of particular insurance companies, seem to limit the disadvantages to underpayment, especially in larger claims.[174]

Insurance policies are aleatory, meaning that the policyholder performs first, by paying premiums, while the insurance company performs later, if it is called upon to perform at all. Given that the appraisal process is designed to ascertain the true amount of loss, which is necessary for the insurance company to meet its obligations under the insurance policy, a strong argument could be made that an insurance company should bear the full cost of the appraisal process. In essence, the policyholder's premiums would fund the appraisal. The countervailing argument is that policyholders will too often demand appraisal if there are no costs for them to do so, thereby increasing the expense of insurance for everyone.

There are several possibilities for the allocation of appraisal costs. First, the party demanding appraisal could be forced to pay for the cost of the umpire and the appraisal. Second, the non-prevailing party could be

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law, insurers always have the nine-tenths advantage: They hold the money. Consequently, insurers always get to 'play the float' in any dispute.").

173. One remedy for opportunistic breach is the imposition of punitive damages. *See* Pennington, *supra* note 70, at 54. To receive punitive damages, however, a policyholder must hire an attorney and will likely end-up in litigation. Furthermore, some states unwilling to recognize a bad faith breach have also declined to impose punitive damages. *See, e.g.*, Yuen v. Am. Republic Ins. Co., 786 F. Supp. 531, 533 (D. Md. 1992) (holding that "it is well-settled that there is no first party bad faith claim maintainable against an insurer under Maryland law").

174. *See generally* Anderson & Fournier, *supra* note 70, at 398 (discussing the general nature of the insurance business).

forced to pay for the umpire and appraisal process. Third, the insurance company could be required to pay for the cost of the umpire and appraisal costs.

We recommend that the costs of appraisal be reflective of the disparity in power between insurance companies and their policyholders in order to disincentivize opportunistic breach by insurance companies. We further recommend that, in order to avoid unnecessary demands for appraisal by policyholders, the process not be free to policyholders in all instances. It seems fair to require insurance companies to pay (1) all undisputed amounts of loss promptly; (2) the cost of the appraisal proceeding, including the umpire, but not the cost of the policyholder's appraiser; and (3) the cost of the policyholder's appraiser if the appraisal results in any additional payments to the policyholder.

D. PREJUDGMENT INTEREST

Prejudgment interest should be available for amounts awarded in appraisal. Property insurance policies,[175] unfair insurance practice statutes, and unfair claim settlement regulations,[176] usually require an insurance company to pay the loss within 30 days, 60 days, or a "reasonable time" after proof of loss statements have been provided. Prompt investigation and determination of the amount of loss are fundamental to any good faith property loss adjustment.[177] When a policyholder pays its premiums up

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175. *See, e.g.*, N.Y. INS. LAW § 3404(e) (McKinney 2004) (providing standard fire insurance policy for the State of New York specifically requiring that payment be made within sixty days).

176. *See, e.g.*, ALA. CODE § 27-12-24 (1998); CAL. INS. CODE § 790.03(h)(5) (West 2005); DEL. CODE ANN. tit. 18, § 2304(16)(f) (1999); HAW. REV. STAT. § 431:13-103(11) (2005); 215 ILL. COMP. STAT. ANN. 5/424(4) (West 2000); 215 ILL. COMP. STAT. ANN. 5/154.5(D) (West 2000); IOWA CODE ANN. § 507B.4(9) (West 2006); KAN. STAT. ANN. § 40-2404(9) (2005); MASS. GEN. LAWS ANN. ch. 176D, § 3(9) (West 1998); NEB. REV. STAT. § 44-1540 (2005); N.H. REV. STAT. ANN. § 417.4 (2006); N.J. STAT. ANN. § 17:29B-4 (West 2006); N.M. STAT. § 59A-16-20 (2006); N.Y. INS. LAW § 2601 (McKinney 2006); OR. REV. STAT. § 746.230 (2005); 40 PA. CONS. STAT. ANN.§ 1171.5(10) (West 1999); S.D. CODIFIED LAWS § 58-33-46.1 (2004); TEX. INS. CODE ANN. § 541.060 (Vernon 2006); W. VA. CODE § 33-11-4(9) (2006).

177. *See generally* JAMES J. MARKHAM, ET AL., THE CLAIMS ENVIRONMENT (1st ed. 1993). When a covered loss occurs, the insurance company's obligation under its promise to pay is triggered. *Id.* The claim function should ensure the prompt, fair, and efficient delivery of this promise. *Id.* at 6. Claim representatives must investigate the facts of each claim because policyholders do not know exactly what is covered, under exactly what circumstances it is covered, or exactly what amount should be paid. *Id.* at 9.

front it has a right to expect the benefits of coverage when a claim is made, "not a lot of vexatious, time consuming, expensive litigation with [the insurance company]."[178] Insurance companies should not be entitled to retain the time value of money for the period between the date of loss and the date of payment.

In addition to prejudgment interest, when an appraisal subsequently determines that additional amounts should have been paid, the policyholder should also be compensated for any consequential damages resulting from the delay in the form of additional damages. Those damages should be awardable either by a court upon confirmation of an award or a subsequent lawsuit, or by the appraisers.

CONCLUSION

Because appraisal is not currently a matter of detailed statutory or regulatory law in most states, courts are free to develop refinements to the appraisal process through the common law. The objective of any reforms to the appraisal process, whether they be statutory, regulatory, or precedential, should be to ensure a fair and just valuation of the loss and to avoid inequitable and unconscionable insurance practices. Every state in the nation has a public policy that deplores insurance company misconduct in the payment of claims. The special public nature of insurance invests insurance companies with a unique position of trust with respect to their policyholders.[179] Common law refinements have developed the law in third-party insurance regarding the duty to defend, the duty to investigate, and the duty to settle in furtherance of public policy. In first party insurance, the insurance company's duty to accurately value the loss is equally fundamental. Providing incentives for an insurance company to accurately value the loss without the necessity of appraisal or litigation is a worthwhile goal.

Appraisal should be utilized as an inexpensive and predictable method of determining the amount of loss when the parties are in reasonable disagreement. If property insurance is to play its vital role of providing prompt and accurate compensation to policyholders when they have

178. Hayseeds, Inc. v. State Farm Fire & Cas., 352 S.E.2d 73, 79 (W. Va. 1986).

179. The Supreme Court of California reasoned that obligations of insurance companies are "rooted in their status as purveyors of a vital service labeled quasi-public in nature. Suppliers of services affected with a public interest must take the public's interest seriously, where necessary placing it before their interest." Egan v. Mut. of Omaha Ins. Co., 620 P.2d 141, 146 (Cal. 1979).

suffered loss, indeed often catastrophic loss, to their homes or businesses, the insurance community can demand no less.

OVERWHELMED: THE FEDERAL FLOOD INSURANCE ACT OF 1956

Henry S. Cohn[*] *&*
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INTRODUCTION

Hurricane Katrina and the 2006 springtime New England floods, led New York Times reporters to observe that this is the moment to consider "the obscure federal flood insurance program."[1] The reporters dolefully concluded that the current program has been plagued by an "inability over decades to work out who pays the bill for flooding...[T]he flood program has struggled against a basic handicap: Most people, except those in the clearest path of danger, believe they do not need it."[2] Those reporters probably would have reached a similar conclusion if they had written fifty years ago about the first Congressional enactment of flood insurance, The Federal Flood Insurance Act of 1956 (FFIA).[3] History repeats itself, and although flood prediction is difficult, the human response to floods is predictable: "(1) flooding, (2) flood losses, (3) disaster relief (4) flood control projects..., (5) renewed encroachment and development onto the floodplain and upstream watershed, (6) flooding, (7) flood losses, (8) disaster relief, (9) more projects, (10) more encroachment and development, ad infinitum."[4]

The National Flood Insurance Program (NFIP) is intended to be a self-sustaining program.[5] While it has always struggled to meet this goal,[6] the program's weaknesses cannot be ignored after Hurricane Katrina and Rita. In March of 2006, Congress increased the program's borrowing authority from 1.5 billion dollars to about 20.8 billion dollars,[7] as a necessary

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1. Christopher Drew & Joseph B. Treaster, *Politics Stalls Plan to Bolster Flood Coverage*, N.Y. TIMES, May 15, 2006, at A1.

2. *Id.*

3. *See* Federal Flood Insurance Act, Pub. L. No. 1016, 70 Stat. 1078 (1956). NFIP statistics indicate that floods are the most common natural disaster in the United States; over 90% of all natural disasters involve flooding. RAWLE O. KING, CRS REPORT FOR CONGRESS FEDERAL FLOOD INSURANCE: REPETITIVE LOSS PROBLEM, ORDER CODE RL32972, Summary, 1 (2005). Additional NFIP statistics are available at http://www.floodsmart.gov/floodsmart/pages/nfip_statistics.jsp.

4. Oliver A. Houck, *Rising Water: The National Flood Insurance Program and Louisiana*, 60 TUL. L. REV. 61, 64 (1985).

5. *See* National Flood Insurance Program, Pub. L. No. 90-448, 82 Stat. 573 (1968).

6. *See* KING, *supra* note 3 (illustrating NFIP borrowing and repayment history). The main sources for the NFIP's struggle for fiscal soundness are that there are not enough policy holders and the pre-FIRM policy holders strain the program. A pre-FIRM policy holder often pays a premium at 30% of the actuarial rate. *See id.*

7. *See* National Flood Insurance Program Enhanced Borrowing Authority Act of 2006, Pub. L. No. 109-208, 120 Stat. 317 (2006).

measure to allow the NFIP to pay flood claims,[8] but the increased borrowing authority required an admission that the program cannot repay this loan with premium revenues.[9] The Federal Emergency Management Agency (FEMA) estimates claims for Hurricanes Katrina, Rita and Wilma will total $23 billion, surpassing the $15 billion combined total for all NFIP claims since its inception.[10] This estimate has prompted the Government Accountability Office (GAO) to designate the NFIP as a high risk program.[11]

These recent events invite us to revisit the concerns that plagued the ill-fated 1956 FFIA.[12] President Eisenhower signed the FFIA (a program of federal flood insurance, reinsurance, and a loan program) more than a decade before the NFIP was enacted.[13] This article will revisit the political, scientific, and insurance industry concerns, and why many of these concerns, raised over fifty years ago, were left unresolved and are still relevant to the NFIP's struggle today. This article concludes that: (1) we still lack the scientific knowledge necessary to accurately predict floods, without which structural flood control plans are woefully inadequate and flood insurance rate maps (FIRM) render inaccurate insurance rates; (2) the NFIP needs more policy holders, and preferably more low-risk policy holders; (3) the government needs to bolster its flood mitigation efforts; and (4) FEMA needs better record keeping to reduce the NFIP's relief burden.

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8. NFIP paid about 162,000 Katrina-related claims, 83% in Louisiana, and about 9,000 Rita-related claims by May 2006 with about 95% of all reported claims closed. U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-07-069, REPORT TO CONGRESSIONAL COMMITTEES: NATIONAL FLOOD INSURANCE PROGRAM, NEW PROCESSES AIDED HURRICANE KATRINA CLAIMS HANDLING BUT FEMA'S OVERSIGHT SHOULD BE IMPROVED 6 (2006) [hereinafter GAO KATRINA CLAIMS].

9. U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-6-497T, GAO'S HIGH–RISK PROGRAM: STATEMENT OF DAVID M. WALKER, COMPTROLLER GENERAL OF U.S. 5 (2006).

10. *Id.* at 6.

11. *Id.* The GAO's reasons included: the unlikelihood that the NFIP will be able to repay the $20 billion loan; on-going concerns about the program's resources; repetitive loss properties (RLP); billion dollar flood map modernization efforts; and NFIP management. *Id.* at 5-6.

12. *See* Federal Flood Insurance Act of 1956, Pub. L. No. 1016, 70 Stat. 1078 (1956).

13. *See id.* It is important to note that not a single policy was issued under the FFIA; although the legislation was signed into law no funds were ever appropriated to the program.

I. ACT I: THE FEDERAL FLOOD INSURANCE ACT OF 1956

Late 1955 and early 1956 was the perfect time to introduce legislation for a national flood solution. The recent flooding in several regions generated public outcry for national response at the same time the president and several congressmen were up for re-election and wanted to increase public approval ratings. This section will explore the solutions proposed and industry opposition during the federal flood insurance Senate and House debates, and FFIA enactment.

A. RIPE TIME FOR FEDERAL FLOOD INSURANCE

The push to enact a federal flood insurance program was renewed after New England's disastrous 1955 flood.[14] This flood and the floods in the West caused by steady rain and thaw in the High Sierras led to an increased congressional desire for federal protection.[15] The underfunded emergency loan programs were inadequate and it was time to consider something else, such as flood insurance modeled after the federal insurance programs for war and crop damage.[16] This initiative came during a time period when government involvement in insurance was viewed as socialism that infringed on private industry.[17]

The floods and upcoming presidential election created favorable timing for federal disaster aid expansion,[18] and President Eisenhower called for a comprehensive federal plan.[19] Draft bills for a government flood insurance program were introduced in Congress and referred to the House and Senate Banking Committees.[20] The approaches included: private policies; private insurance with government reinsurance; a combination of private and government insurance; an indemnity program payable out of taxes; and

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14. *See* William M. Blair, *Plans for Flood Relief Get New Momentum,* N.Y. TIMES, Jan. 1, 1956, at E4. In the early 1950's, after floods in Kansas and Missouri, President Truman proposed a federal flood insurance program, but the proposed legislation failed. *See* KING, *supra* note 3.

15. *See* Blair, *supra* note 14.

16. S. REP. No. 84-1864 (1956), *as reprinted in* 1956 U.S.C.C.A.N. 4472, 4475.

17. *See House Unit Seeks a New Flood Plan*, N.Y. TIMES, Feb. 5, 1956, at 51.

18. *See* Blair, *supra* note 14.

19. President's Annual Message to the Congress on the State of the Union, 1 PUB. PAPERS 17 (Jan. 5, 1956).

20. *See* Blair, *supra* note 14.

government insurance for an initial amount, followed by private polices for moderate losses and government insurance for the excess.[21]

The political pressure from state and federal officials to enact legislation was apparent. Connecticut Governor Abraham Ribicoff accused Congress of "dragging its feet" on flood insurance.[22] He sought political approval in his flood-damaged state and pushed Congress to pass an insurance program by year's end.[23] Val Peterson, the Federal Civil Defense Administrator, called upon Congress to challenge the insurance industry to create a feasible flood insurance plan; but he admitted that developing such a plan was not easy.[24]

B. THE SENATE AND HOUSE HEARINGS

Both houses debated bills that offered variations on flood insurance with strong opinions on both sides of the issue. Those who argued in favor of federal involvement contended that flood insurance: (1) was a valuable supplement to direct relief through loans and government payments; (2) could boost morale for flood victims; and (3) could solve the problems private insurance companies faced in amassing sufficient reserves to cover expected flood losses.[25] Those who argued against the proposed legislation contended that: (1) there would most likely be high premiums; (2) government-sponsored insurance was not truly insurance, but an indemnity; (3) private charitable programs were sufficient; (4) flood protection was the true solution; and (5) the program would reward poor location choices in real property purchases.[26]

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21. *Id.*

22. *Disaster Insurance Urged by Ribicoff*, N.Y. TIMES, Apr. 8, 1956, at 39.

23. *Id.* Ribicoff supported a plan for private insurance with a federal subsidy based on the federal government's investment in businesses and its interest in businesses being insured to protect the government's investment. Ribicoff also wanted Congress to enact insurance to include coverage for all types of natural disasters and damage caused by atomic attack. *Id.*

24. *Flood Insurance 'Challenge' Urged*, N.Y. TIMES, Jan. 24, 1956, at 10.

25. Victor Gerdes, *Insuring the Flood Peril*, 30 J. INS. 547, 549-50 n.3 (1963).

26. *Id.*

1. The Proposed Bills

The Bush-Wolcott Bill, or the National Flood Indemnity Act of 1956,[27] proposed the establishment of a $3 billion, five-year, experimental flood insurance and indemnification program.[28] The bill required the insured's premium to be at least sixty percent of the Administrator's estimated rate,[29] with equal state and federal government contributions for the remainder.[30]

The Housing and Home Finance Agency (HHFA) was to administer the program.[31] It provided coverage up to $250,000 per individual, subject to a deductible of $300 plus 10% of the claim remainder.[32] The bill authorized reinsurance for participating private insurers, to encourage wider coverage.[33]

The most controversial bill provision was the state participation in the government subsidy.[34] This provision made policy availability contingent

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27. National Flood Indemnity Act, S. 2862, 84th Cong. (as amended, Jan. 16, 1956); *Fed. Disaster Insurance: Hearing Before a Subcomm. of the Comm. on Banking and Currency United States S. on S. 2768, S. 2863, and S. 3137 Bs. to Provide Insurance and Reinsurance Against Flood Damage, and for Other Purposes*, 84th Cong. 913 (1956) [hereinafter *Senate Hearings Part II*]. Senator Bush, with Representative Jesse P. Wolcott of Michigan, co-sponsored the Eisenhower administration's bill. *Congress Pushes Flood Insurance*, N.Y. TIMES, Jan. 6, 1956, at 14.

28. National Flood Indemnity Act, S. 2862, 84th Cong. §§ 106, 205 (as amended, Jan. 16, 1956); *Senate Hearings Part II*, *supra* note 27, at 915 (providing $1,900,000,000 maximum outstanding indemnity obligation and $1,000,000,000 maximum outstanding reinsurance obligation). The purpose was to "promote the national welfare by (1) making available, in cooperation with the various States, a program of indemnities with respect to certain types of property damaged or lost as a result of floods and (2) making available a program of reinsurance by the Federal Government of private insurers who underwrite certain flood risk." National Flood Indemnity Act, S. 2862, 84th Cong. § 2 (as amended, Jan. 16, 1956); *Senate Hearings Part II*, *supra* note 27, at 913-14.

29. The estimated rate is not the insurance premium, but rather an actuarial estimate set by the HHFA Administrator, which in his judgment would cover all claims for probable losses over a reasonable period of time. The estimated rate is the basis for calculating the insured's premium. National Flood Indemnity Act, S. 2862, 84th Cong. § 102 (as amended, Jan. 16, 1956); *Senate Hearings Part II*, *supra* note 27, at 914.

30. *Id.*

31. National Flood Indemnity Act, S. 2862, 84th Cong. § 3 (as amended, Jan. 16, 1956); *Senate Hearings Part II*, *supra* note 27, at 914.

32. National Flood Indemnity Act, S. 2862, 84th Cong. § 105 (as amended, Jan. 16, 1956); *Senate Hearings Part II*, *supra* note 27, at 915.

33. National Flood Indemnity Act, S. 2862, 84th Cong. § 201 (as amended, Jan. 16, 1956); *Senate Hearings Part II*, *supra* note 27, at 915.

34. *See* Edwin S. Overman, *The Flood Peril and the Federal Flood Insurance Act of 1956*, 309 ANNALS AM. ACAD. POL. & SOC. SCI. 98, 101-02 (1957).

on the state's ability or willingness to contribute.[35] This meant that a property owner in a non-contributing state had to rely on the option to purchase a private insurance policy with government re-insurance, if available.[36]

Senator Herbert Lehman and Senator John F. Kennedy introduced an alternative less costly bill that provided lower coverage limits.[37] Under the Lehman-Kennedy bill,[38] the government would sell the policies and set coverage limits to $10,000 per dwelling and $100,000 per purchaser.[39] Additionally, the bill encouraged private insurance coverage above those amounts.[40]

2. Industry Testimony

The insurance industry was opposed to the proposed legislation.[41] Property and casualty underwriters concluded that fixed-location, self-

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35. *Id.*

36. *Id.* at 99-101.

37. Kennedy set forth his plan at the committee hearings in Boston on November 9, 1955. *See Federal Disaster Insurance: Hearings Before the Comm. on Banking and Currency United States S. on B. to Provide Insurance Against Natural and Manmade Disasters and for Other Purposes*, 84th Cong. 414-16 (1955) [hereinafter *Senate Hearings Part I*] (statement of Sen. John F. Kennedy). He previewed his plan nearly a month earlier in a speech to the National Association of Cost Accountants. To Kennedy, flood insurance was a clear federal responsibility; private industry offered to insure "everything from race horses to the legs of famous actresses," but did not offer flood insurance. He rallied his audience with this dramatic conclusion: "We know the story from the Seventh Book of Matthew of the 'foolish man who built his house upon the sand, and the rain descendeth, and the floods cameth, and the winds blew, and beat upon that house; and it fall, and great was the fall of it.' But we have also seen that the hurricane-driven floods of New England make little or no distinction between houses built on rock and those built on sand. They pose a menace and a challenge to wise men as well as fools. And if our State is not to fall–and great would be the fall of it–all of us must work together toward that common goal." Senator John F. Kennedy, Speech on Federal Flood Insurance at the Fall River Chapter of the National Association of Cost Accountants (Oct. 13, 1955), *available at* http://www.jfklibrary.org/Historical+Resources/Archives/Reference+Desk/Speeches/JFK/JFK+Pre-Pres/002PREPRES12SPEECHES_55OCT13.htm.

38. *See* Federal Flood Insurance Act, S. 3137, 84th Cong. (1956); *Senate Hearings Part II*, *supra* note 27, at 922. Then-senator John F. Kennedy of Massachusetts was seeking nomination for vice-president. *See* Douglas Dales, *Kefauver, Kennedy and Humphrey are Leaders for Vice Presidential Nomination*, N.Y. TIMES, Aug. 12, 1956, at 60.

39. *Senate Hearings Part II*, *supra* note 27, at 924.

40. *Id.*

41. AM. INS. ASS'N, STUDIES OF FLOODS AND FLOOD DAMAGE, 1952-1955 3 (American Insurance Association 1956) [hereinafter AIA FLOOD REPORTS].

sustaining flood insurance in flood prone areas could not be written because the loss's certainty and magnitude would make premiums prohibitive;[42] a stance strengthened by industry flood studies.[43] According to the American Insurance Association (AIA), "[t]he solution to the age-old problem of flood damage (the wrath of hurricanes and rainstorms could not be predicted and might be cyclically increasing) ...was not insurance, but a relief plan and long-range flood control program involving federal, state, and local governments to reduce the probability of flood damage."[44]

Government intervention could not offset the industry's reluctance to enter the flood insurance market because the industry believed prohibitive premiums would result in government subsidized relief under the guise of insurance.[45] The industry also feared that a federal flood insurance program would set a precedent for government competition.[46] Accordingly, the industry proposed that the better solution was to leave relief efforts to the Red Cross.[47]

J. Victor Herd provided testimony as an insurance industry spokesman,[48] espousing the industry's view that flood insurance was unfeasible and that a sound actuarial basis could not be determined.[49] He criticized the proposition that insurers could remedy the flood insurance problem with additional studies; adamant that, if it could be done, the industry would have done it.[50] His colorful testimony provided that, "[w]hen a man is floating down a stream on the roof of his house with his family, he is much more interested in seeing a helicopter than he is in having an indemnity policy in his hands."[51] H.W. Yount of the American

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42. *Id.*

43. *See* Parsons, BRINCKERHOFF, QUADE & DOUGLAS, REPORT ON FLOODS AND FLOOD DAMAGE OF 1955 IN THE NORTHEASTERN STATES (1955), *reprinted in* AIA FLOOD REPORTS, *supra* note 41, at 125.

44. *Id.* at 3.

45. *Senate Hearings Part II*, *supra* note 27, at 1054 (statement of J. Victor Herd, Chairman of the Comm. on Flood and Flood Damages, American Insurance Association).

46. *See* Gerdes, *supra* note 25.

47. *Senate Hearings Part II*, *supra* note 27, at 1054 (statement of J. Victor Herd, Chairman of the Comm. on Flood and Flood Damages, American Insurance Association).

48. Mr. Herd was the outgoing president of the National Board of Fire Underwriters and the Chairman of the Insurance Executives Association's Committee on Flood and Flood Damages. *See Flood Insurance Held Unfeasible: Underwriters' Spokesman Rules Out Any Prospect of Coverage by Industry*, N.Y. TIMES, May 25, 1956, at 31; *Senate Hearings Part I*, *supra* note 37, at 756.

49. *Senate Hearings Part I*, *supra* note 37, at 756-64.

50. *Flood Insurance Held Unfeasible*, *supra* note 48, at 31.

51. *Senate Hearings Part II*, *supra* note 27, at 1053.

Mutual Alliance testified on premium rates.[52] He suggested that premiums at half the lowest estimated rate would still prohibit broad participation; a one percent rate would price the product out of the market.[53]

Simon Yaffe, a West Hartford, CT insurance agent, countered his colleagues' government invervention fears by testifying that the fears were unfounded since the government had been in the insurance business a long time:

> Let us keep one point always in mind. The United States Government is in the insurance business now and has been for a long time. It is, no doubt, the largest insurance company of any business, writing multiple lines, yet I do not know of a single private insurance company that has suffered in any way because of competition with it.[54]

Senator Lehman echoed Mr. Yaffe's sentiments that the industry's competition fear was unwarranted,[55] and he dismissed the suggestion that private relief was the answer because it could not make a dent in the need for assistance.[56]

3. The Senate Hearings

Senator Lehman served as Acting Chairman for the first session's Banking and Currency Committee and Chairman for the second session's Subcommittee on Securities; the latter hearings focused on whether to adopt the Bush-Wolcott Bill or another plan.[57] The HHFA and other Bush-

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52. *Id.* at 1117 (statement of H.W. Yount, American Mutual Alliance) (stating that Bush Bill's forty-percent subsidy is inadequate and the cost would still be prohibitive).

53. *Id.* at 1118.

54. *Id.* at 1174-75 (statement of Simon Yaffe, insurance agent).

55. *See* Overman, *supra* note 34, at 102-04. Overman was an assistant dean of the American Institute for Property and Liability Underwriters, Inc. *Id.* at 98. He stated that the insurance industry spokesmen were in general agreement that private industry could not provide flood insurance for real property, but at the same time it objected to the government intrusion into the field. They objected on two grounds: (1) sound flood insurance was unfeasible; and (2) it was a government intrusion into what had been a private industry. *Id.* at 103.

56. *Senate Hearings Part II*, *supra* note 27, at 1054-55 (statement of Senator Herbert Lehman).

57. *Id.* at 905 (statement of Senator Herbert Lehman) (summarizing first session hearings and purpose of second session hearings).

Wolcott Bill proponents were in favor of federal flood insurance with state subsidies, Lehman-Kennedy Bill proponents were in favor of federal flood insurance but opposed state subsidies, and others believed flood insurance was unfeasible and opposed federal flood insurance altogether.[58]

Frank J. Meistrell, deputy administrator of the HHFA, urged the Bush-Wolcott Bill's adoption.[59] Meistrell, outspoken in favor of state participation, testified that as a matter of philosophy states with historic floods should pay a portion of the load.[60] Meistrell attacked Senator Lehman's proposal as ill-conceived, with impossible to administer rate-setting.[61] He objected to the bill's $100,000 cap on the amount any one entity could purchase, preferring the Bush-Wolcott Bill's $250,000 cap.[62]

The Bush-Wolcott Bill's state participation requirement was met with strong opposition because it held the program hostage to the states.[63] To implement the Bush-Wolcott Bill, each state needed to review its constitution and statutes to determine if participation in the required state subsidy was possible.[64] If the legislature was out of session, it would be expected to schedule a special session for approval.[65] The Committee's counsel, William F. McKenna, in his Bush-Wolcott Bill critique, strongly advised rejecting the state participation component.[66] Mitchell Wendell, a representative of the New York Commission on Interstate Cooperation, presented the legal challenges to gaining approval under New York law.[67]

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58. For detailed debate see *Id.*

59. *Id.* at 947 (statement of Frank J. Meistrell, Deputy Administrator, Housing and Home Financing Organization).

60. *Id.* at 977-78 (statement of Frank J. Meistrell, Deputy Administrator, Housing and Home Finance Organization).

61. *Id.* at 963-64 (statements of Frank J, Meistrell, Deputy Administrator, Housing and Home Finance Organization).

62. *Senate Hearings Part II, supra* note 27, at 967-68.

63. *See id.* at 947-51 (statements of Frank J. Meistrell, Deputy Administrator, Housing and Home Finance Organization and Chairman Herbert Lehman) (discussing state participation and potential state constitution barriers to implementation). Even though the insurance companies opposed the legislation, the General Counsel of the National Board of Fire Underwriters was non-committal as to whether a subsidy should be solely a federal or partially a state responsibility. *Id.* at 1147-56 (statement of J. Raymond Berry, General Counsel, National Board of Fire Underwriters).

64. *See id.* at 1106-08 (statement of Mitchell Wendell, New York State Joint Legislative Committee on Interstate Cooperation).

65. *See id.* at 947-51 (discussing states' option to hold special sessions).

66. *Id.* at 933-34 (critique of S. 2862 by William F. McKenna, Committee Counsel).

67. *Id.* at 1107 (statement of Mitchell Wendell, New York State Joint Legislative Committee on Interstate Cooperation) (describing legal challenges in passing such legislation).

Rhode Island Governor Dennis J. Roberts declared flood disasters a federal problem, and he believed the risk should be spread nationally, not just to the hardest hit states.[68]

Senator Lehman stated: "I have felt right from the start that this bill was impracticable, insofar as it calls for financial participation by the States."[69] He accused Mr. Meistrell of "shooting in the dark" for not researching the mandatory state subsidy's legality before supporting the Bush-Wolcott Bill.[70] Senator Bush favored the federal and state contribution because it would provide states the needed incentive to enact flood control measures.[71]

In late April, after an executive session, the bill sponsors reached agreement on a final bill to report to the Senate floor.[72] The revised bill specified a federal government premium subsidy and set: (1) a $5 billion program cap; (2) a $250,000 policy limit per policy holder; and (3) a $10,000 limit per dwelling unit.[73] The program was to be administered by a flood insurance administrator under the HHFA who would set rates sufficient to pay claims in full, thereby allowing for a self-sustaining program.[74]

Senators from New England, New York, and other recently flooded areas termed the bill's passage as urgent because there was no private insurance alternative.[75] The bill's experimental nature was stressed and the program was termed a "pilot program designed to gain experience in this field" to appease the insurance industry.[76] The Senate debated the revised bill:

> The Senate was more casual than it usually is in its consideration of the bill which was technically under debate from noon until a few minutes after 7 p.m. Discussion of the Insurance Bill was

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68. *Senate Hearings Part II*, *supra* note 27, at 1203 (statement of Dennis J. Roberts, Governor of Rhode Island, delivered by H. Clinton Owen Jr., director of state administration).

69. *Id.* at 1109.

70. *Id.* at 950 (statement of Sen. Herbert Lehman).

71. *Id.* at 977 (statement of Prescott Bush).

72. *Senate Group Approves Bill on Flood Insurance*, HARTFORD COURANT, Apr. 13, 1956, at 10c.

73. *5 Billion Flood Insurance Is Voted by Senate, 61 to 7*, N.Y. TIMES, May 11, 1956, at 1 [hereinafter *Flood Insurance Vote*].

74. *Id.*

75. *Id.*

76. *Id.*

> interspersed, however, by many long speeches on such subjects as foreign policy, Communists in the United States, the injustice of the Amateur Athletic Union action against Wes Santee, and the course of action to be taken by the special Senate lobby investigating committee.[77]

The Senate majority leader, William Knowland, proposed an amendment to bring the bill closer to the Eisenhower administration's original concept.[78] The Knowland Amendment would exclude states, after June 30, 1959, that refused to pay half the government subsidy.[79] Senator Lehman, who had objected to state subsidy under the Bush-Wolcott bill, opposed the Knowland Amendment[80] and had an unexpected ally in Senator Bush.[81] Bush's view now mirrored his state's position on state contributions:

> Connecticut was among states that would not be able to continue in the program under the amendment. [Senator Bush] said he had been advised that under Connecticut decisions, even an amendment to the State Constitution would not permit state participation because the courts there had held the United States Constitution had been construed to bar changing the State Constitution in contravention to the federal guarantees. A basic argument against the state contribution to premiums on insurance for the benefit of a flood risk is that it diverts public funds to private benefit.[82]

But, despite opposition, the amendment was adopted thirty-nine to thirty-one, with most Republicans supporting it.[83]

A second amendment was introduced by Senator Robert Kerr of Oklahoma, by which he proposed to expand the bill to include catastrophes

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77. Robert D. Byrnes, *Senate Passes Flood Insurance Bill; Amendment Poses Problem for State*, HARTFORD COURANT, May 11, 1956, at 1A.

78. *See Flood Insurance Vote*, *supra* note 73.

79. *See* Byrnes, *supra* note 77.

80. 102 CONG. REC. 7924–27 (1956).

81. *See* Byrnes, *supra* note 77.

82. *Id.* Governor Ribicoff issued a statement a few days later that the amendment would make the Bill inoperable in Connecticut, and urged its elimination from the legislation. Keith Schonrock, *Ribicoff Urges Opposition to Flood Insurance Levy*, HARTFORD COURANT, May 23, 1956, at 1A.

83. 102 CONG. REC. 7929 (1956).

such as tornadoes and cyclones, to provide equal justice to all natural disaster victims.[84] The Kerr Amendment failed and the bill with the Knowland Amendment passed, sixty-one to seven.[85]

Senator Bush was pleased with the bill's passage; while the Knowland Amendment would cause difficulty in three years, it was not an immediate impediment to the program's initiation.[86] Bush acknowledged that the program was experimental, but if it was successful, the private industry would take over and sell unlimited amounts of insurance.[87] He regretted the $5 billion cap but emphasized it was necessary to cap the government's liability for the bill to pass.[88]

4. The House Hearings

The House Banking Committee was arguably less enthusiastic about the Bush-Wolcott Bill; its chairman, Representative Brent Spence, considered the bill unworkable and urged the committee to study at least thirty-two other proposals.[89] The committee's main criticisms were industry participation and unaffordable premiums. The bill depended on the insurance industry's participation, despite industry representatives' testimony to the contrary;[90] without industry participation the program would be more akin to federal grants than insurance and would be labeled, "socialistic - just as they labeled Social Security and the farm program socialistic."[91] The bill's premium rates were not affordable for the average person and this would prohibit broad program participation.[92]

The House report urged four modifications to the Senate-passed bill: (1) the program should be administered under an existing HHFA

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84. *Id.* at 7934-36.

85. *Id.* The seven opponents included Senator Kerr and Senator Richard Russell of Georgia. *Id.*

86. *See* Byrnes, *supra* note 77.

87. Letter from Sen. Prescott Bush to Simon M. Yaffe (May 7, 1956) (on file with author).

88. *Id.*

89. *House Unit Seeks a New Flood Plan*, N.Y. TIMES, Feb. 5, 1956, at 51.

90. *Id.*

91. *Id.*

92. *Id.* The skeptical Chairman told the International News Service, a month before the Senate passed the bill, that "a three-month search for a sound flood disaster insurance program had apparently ended in failure," and issued a public appeal to "anyone who thinks he can provide a solution to do so." Raymond Wilcove, *Flood Insurance Effort Failing, Congressman Says*, HARTFORD TIMES, Apr. 4, 1956, at 1.

department rather than under a new flood insurance commissioner; (2) the Administrator should be afforded discretion to offer specially reduced rates to homeowners who could not afford the chargeable rate; (3) a supplemental loan program should be established to provide potential flood victims an assured line of credit;[93] and (4) no state contribution to the program's government fund.[94]

The House Committee was concerned that the state contribution required under the Senate's Knowland Amendment would: (1) exclude some states from participation unless they amended their constitutions; (2) complicate the program's administration by requiring consideration of both state and federal jurisdictions; and (3) cause states to resist participation due to the financial burden. The House report recommended that the program proceed for three years on an experimental basis and then Congress would reevaluate state participation based on experience.[95] The House version's only restriction on state participation was its local flood-zoning provision, which made program availability contingent on state adoption of flood control measures after June 1958.[96]

Senator Lehman's office captured the pessimism surrounding the bill's fate in the House; predicting that if the legislation passed in the Senate, "some real tall pushing [would] be required, since Congressman Brent Spence . . . is reported to be unfavorable to any program of federal insurance."[97] Pressure succeeded, and in early July Representative Spence issued a statement urging action on the bill in a report which stated that "damage caused by flood is a national problem calling for a national solution."[98]

The House subcommittee drafted its own plan that sought low rates and industry participation.[99] The report concluded that government intervention was necessary to protect homeowners struggling to pay mortgages after losing homes and to allow business owners to re-start companies after flood damage;[100] absent industry flood policies, it was the

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93. This revision was suggested by Connecticut Representative Thomas J. Dodd. *See* 102 CONG. REC. 14548 (1956).

94. *See* H.R. REP. No. 84-2746 (1956), *as reprinted in* 1956 U.S.C.C.A.N. 4472, 4472.

95. *Id.* at 4479.

96. *Id.* at 4479, 4481.

97. Letter from Julius C.C. Edelstein to Simon M. Yaffe (May 5, 1956) (on file with author).

98. H.R. REP. No. 84-2746 (1956), *as reprinted in* 1956 U.S.C.C.A.N. 4472, 4473.

99. *See id.*

100. *Id.*

only option.[101] Without a federal flood insurance program, the country's only solutions were flood control and Red Cross disaster relief, but the Army Corps of Engineers estimated that current flood control projects would take about twenty-two years to complete.[102] Precedent for federal flood insurance included war damage insurance, bank-deposit insurance, and mortgage insurance.[103]

The Committee's major problem with the proposals was premium rates because policy holders in high risk areas would be subject to prohibitive rates. Its solution was government subsidies to absorb some of the losses.[104] The report's draft legislation included a requirement that the program's administrator appoint an advisory committee composed of individuals familiar with insurance issues. The proposed bill required feasibility studies: one for extending coverage to other natural disasters for which no affordable public or private insurance was available, and one to gauge the feasibility of transferring the program to private industry with or without federal aid.[105]

The bill passed the House on a voice vote;[106] it closely followed the House committee report but included an amendment similar to the Knowland Amendment, concurring with the Senate that states should share in the costs after 1959.[107] The sponsor of the bill in the House, Representative Jesse Wolcott, attempted to have the bill recommitted, but, "the House shouted down his efforts."[108]

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101. *Id.* The industry's reluctance was because it faced a high likelihood of bankruptcy from claims payouts before it could collect enough premiums to cover them.

102. *Id.* at 4474-75.

103. H.R. REP. No. 84-2746 (1956), *as reprinted in* 1956 U.S.C.C.A.N. 4472, 4474-75. The House report further stated:

The Federal flood-insurance program recommended by this committee is intended to blaze the trail and establish the actuarial and other experience needed to show, if it can be shown, that flood-risk insurance can be offered by private companies on a commercially feasible basis.

At the same time the committee has recognized the need to control within reasonable limits the financial risk to which the Government will be exposed. This has been done by making this program an experimental one, with strict limits on the amount of insurance that can be written and the amount of coverage any individual, corporation, or Government entity can acquire from the Federal Government.

Id.

104. *Id.* at 4475.

105. *Id.* at 4490.

106. The bill was passed on July 25, 1956. 102 CONG. REC. H14538 (1956).

107. *Id.* at H14548.

108. *Flood Insurance Is Voted By House*, N.Y. TIMES, July 26, 1956, at 12.

C. THE FEDERAL FLOOD INSURANCE ACT IS BORN

A conference committee met in July 1956 to reconcile the Senate and House bills.[109] The House version was agreed upon with two exceptions: (1) the provision for administrator discretion to offer reduced premiums based on financial need for owner-occupied homes was removed; and (2) the Senate language in the Knowland Amendment was incorporated because it was a more complete description of the state subsidy.[110] The bill passed bicameral presentment on the legislative session's last day.[111] The House passed the bill before it was rushed to the Senate, where it passed shortly after ten p.m.[112]

On August 7, President Eisenhower signed the FFIA.[113] The FFIA set up a system to indemnify flood losses, including tidal disasters; provide the insurance industry with federal reinsurance for private flood insurance policies; and assure a line of credit for reconstruction after flood damage.[114] Federal participation was not to exceed $5 billion,[115] and policy holders would pay at least sixty percent of the estimated rate with the federal government paying the balance.[116] But after June 30, 1959, mandatory state participation would reduce the federal contribution by half.[117] The maximum coverage for a home was $10,000 with a $100 deductible[118] and no person[119] could obtain more than $250,000 in combined policies.[120] The

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109. H.R. REP NO. 84-2746, at 4491 (1956) (Conf. Rep.), *as reprinted in* 1956 U.S.C.C.A.N. 4472, 4491.

110. *Id.* Both the Senate and House had provided for sharing of expenses by the states after June 30, 1959, but the provisions of the Senate bill "were more complete, providing for such matters, as consultation between the State and Federal Governments and a statement in the Administrator's 1958 report of the number of States which could be expected to participate in the program after this requirement takes effect." *Id.* at 4492.

111. *Congress Leaves Eisenhower Busy*, N.Y. TIMES, July 29, 1956, at 50.

112. *Id.*

113. Statement by the President Upon Signing the Federal Flood Insurance Act of 1956, 654 PUB. PAPERS 654-55 (Aug. 7, 1956) [hereinafter FFIA Signing Statement].

114. *Id.*

115. Federal Flood Insurance Act, Pub. L. No. 1016, §10(d), 70 Stat. 1078, 1081-82 (1956).

116. *Id.* § 7, 1081.

117. *Id.*

118. *Id.* § 10, 1081.

119. The FFIA defined a person as, "an individual or group of individuals, corporation, partnership, association, or any other organized group of persons, including State and local governments and agencies thereof." *Id.* § 22, 1086.

120. *Id.* § 22, 1086.

loan component offered flood damage loans up to $350,000 per person[121] at four percent interest with a program total of $2.5 billion.[122]

1. Political Fanfare Downplayed Weaknesses

The FFIA was left with unresolved weaknesses and contradictions after its politically urgent enactment. President Eisenhower's statements about the FFIA were contradictory; he declared that the federal government had a responsibility for the flood problem but he also endorsed state contributions. Is flood damage a national problem or a problem for flood-prone communities? This question was compounded by whether any program was viable when flood risk remained high and uncertain. But, ultimately, it was the flood loan component that served as the program's Achilles's heal and triggered its demise.[123]

President Eisenhower described the experimental FFIA as a venture "into an untested field of risk protection," using public resources for the first time.[124] The president wanted the government to take the lead on flood protection, as it was the most common natural disaster.[125] The FFIA was the way to help a citizen protect his or her property and assets against flood loss.

Eisenhower endorsed the government's premium subsidy.[126] He initially recommended that all states pay half the subsidy, but agreed to the compromise that covered states start contributing in 1959.[127] The state subsidy rationale was that floods do not occur throughout the country, but in specific localities, and therefore it is, "proper and just that each state should help share the costs of such protection in proportion to the benefits that its citizens receive."[128] But this justification contradicted Eisenhower's stance that it was the federal government's proper function to protect the public from "the crippling losses of floods and tidal disaster."[129]

Eisenhower made efforts to sooth relations with the private insurance industry by explaining that, "[the FFIA] does not propose putting the

121. Federal Flood Insurance Act, Pub. L. No. 1016, § 5, 70 Stat. 1078, 1079 (1956).
122. *Id.* § 7, 1080.
123. *See* 103 CONG. REC. 6419-47 (1957) (deciding not to provide additional appropriations because of liability).
124. FFIA Signing Statement, *supra* note 113, at 654-55.
125. *Id.*
126. *Id.* at 655.
127. *Id.*
128. *Id.*
129. *Id.*

Federal Government permanently into the flood insurance business. On the contrary, it provides for the Government to lead the way on a basis that will enable this field of responsibility to be absorbed into our private system in the shortest possible time."[130] During the transition period, he urged "full cooperation and active support of the private insurance carriers."[131] These statements reflected the tension between the legislative need and the industry's fears.

The FFIA was recognized as a congressional achievement by the American Municipal Association,[132] as it allowed a municipality to purchase flood insurance protection for its properties.[133] The Republican Party Platform included it as one of the party's achievements, stating: "We initiated the first flood insurance program in history under Government sponsorship in cooperation with private enterprise."[134]

2. HHFA and States Struggle With FFIA Implementation

After the high-profile signing ceremony, it became clear that the FFIA's implementation would not be smooth.[135] Northeastern states contacted Mr. Meistrell to assist in the program's regulation development.[136] States had to contend with the mandatory subsidy that would take effect in 1959, and they needed to establish a flood zoning regulation agency to limit flood damage and prepare for the state subsidy requirement.[137] New Jersey Governor Robert B. Meyner brought this issue to the New Jersey legislature, suggesting immediate attention.[138] He

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130. FFIA Signing Statement, *supra* note 113, at 655-56.

131. *Id.*

132. Robert F. Wagner, *1956 Legislative Roundup*, 35 ILL. MUN. REV. 152, 162 (1956). The president of the American Municipal Association, New York Mayor, Robert F. Wagner, in his August 1956 legislative roundup declared that the 84th Congress had done more for cities than any other Congress. *Id.* at 152.

133. *Id.* at 162.

134. Kirk H. Porter & Donald Bruce Johnson, National Party Platforms: 1840 - 1960, 550 (2d ed. 1961).

135. Letter from Julius Edelstein to Simon Yaffe (Sept. 7, 1956) (on file with author) ("I do not know how well the program is going to operate, if at all. It depends upon the intelligence with which it is administered and on the desire of the administrators to make it work. I have no doubt that the law will need a great deal of strengthening and tinkering with in order to make it a really good one.").

136. *States Seek Voice in Flood Insurance Policies*, N.Y. TIMES, Dec. 19, 1956, at 49.

137. *See* Federal Flood Insurance Act, Pub. L. No. 1016, 70 Stat. 1078 (1956).

138. *Excerpts from Gov. Meyner's Message*, N.Y. TIMES, Sept. 18, 1956, at 24.

recommended a study commission to research program participation's impact on the state and recommend state flood insurance regulation.[139]

At the federal level, issues regarding implementation remained.[140] Frank J. Meistrell, the FFIA's first commissioner,[141] reached out to private insurance companies who opposed the legislation and received their promise of cooperation.[142] Despite the insurance industry's promise to help sell policies, it was convinced policies could not be sold on a break-even basis.[143] HHFA officials, in collaboration with industry, developed a plan to allow customers to purchase flood insurance from the same companies and agents from whom they buy fire and auto insurance.[144] But few other details had been worked out and the program had the potential to create up to $7.5 billion in liability for the government.[145]

HHFA administrator Albert M. Cole was tasked with administering a "do-it-yourself package" without clear Congressional guidelines.[146] He was expected to develop regulations to resolve outstanding questions including: (1) how soon the policies would become available; (2) policy holders' premiums, taking into account the forty percent government subsidy; (3) whether the premiums would encourage broad participation; and (4) what was covered under the FFIA's broad flood definition.[147] Most attention focused on the rates to be charged, as the risk had to be spread widely since insurance companies could not afford to insure only bad risks.[148] A study was launched to determine whether more insurance companies selling policies would achieve the desired broad participation.[149]

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139. *Id.*

140. *Insurers to Help U.S. on Flood Plan*, N.Y. TIMES, Aug. 27, 1956, at 21.

141. *Flood Law Chief Sworn in by U.S.*, N.Y. TIMES, Sept. 29, 1956, at 10.

142. *Industry Aids Plans for Flood Insurance*, N.Y. TIMES, Aug. 22, 1956, at 27.

143. *See Insurers to Help U.S. on Flood Plan*, *supra* note 140.

144. *See id.*

145. *See id.*

146. *See id.*

147. *See id.* The FFIA defined flood as, "any flood, tidal wave, wave wash, or other abnormally high tidal water, deluge, or the water component of any hurricane or other severe storm, surface landslide due to excess moisture, and shall have such other meaning as may be prescribed by regulation of the Administrator." Federal Flood Insurance Act of 1956, Pub. L. No. 1016, 70 Stat. 1078, 1086 (1956).

148. *See Insurers to Help U.S. on Flood Plan*, *supra* note 140. Chairman Frank Meistrell had commented on the rate issue during Congressional hearings: "I do not know whether the actual cost, if you could make an actuarial survey would be $5 or $8 or $10 a hundred, or $3 a hundred." *Id.*

149. *Id.*

D. THE DEATH OF THE FFIA

Despite these issues, the HHFA continued its positive message, predicting that policies would be sold in early 1957,[150] but the FFIA never became a reality. The House Banking Committee criticized the loan program as unworkable and the Eisenhower administration asked Congress to repeal it.[151] No banks were willing to make loans at the government guaranteed rate, making the loan component inoperable, though in theory a homeowner or businessman had the opportunity to buy a policy entitling him or her to borrow money for flood damage.[152]

Almost six months after the 1956 elections, it was forecasted that the FFIA would likely collapse before it sold a policy; a victim of Congress's budget-cutting fever.[153] Meistrell sought $50 million from the House Appropriations Committee to initiate the program during the fiscal year 1958,[154] but the committee was concerned with the FFIA's extraordinarily high costs.[155] The request came at a time when congress was especially economy conscious, and the appropriations committee could see a multi-million dollar savings by scrapping the FFIA.[156] The House Appropriations Committee refused to authorize any additional funds, by a vote of nineteen to fourteen.[157] It also refused to endorse the $14 million Boland Amendment that would allow Meistrell to sign insurance company contracts and allow agents to market policies.[158] After lengthy debate, the House upheld the Appropriations Committee's recommendation, and rejected the Boland Amendment.[159] The Senate was still in favor of the FFIA and voted for start-up.[160]

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150. *See Time Clock*, TIME, Nov. 5, 1956, *available at* http://www.time.com/time/magazine/article/0,9171,865618,00.html (last visited Mar. 18, 2007).

151. Robert D. Byrnes, *Washington Report*, HARTFORD COURANT, Apr. 5, 1957, at 2.

152. *Loans as Flood Aid Face Repeal Move*, N.Y. TIMES, Feb. 26, 1957, at 18.

153. *Flood Insurance Faces Fund Peril*, N.Y. TIMES, Apr. 21, 1957, at 92.

154. 103 CONG. REC. 6421 (1957).

155. *Id.* at 6440 (statement of R. Taber discussing $5 billion program risk).

156. *Id.* at 6421 (discussing projected deficit and need to balance budget).

157. Robert D. Byrnes, *Washington Report*, HARTFORD COURANT, May 4, 1957, at 2.

158. 103 CONG. REC. 6421 (1957).

159. Robert D. Byrnes, *Washington Report*, HARTFORD COURANT, May 8, 1957, at 2. Mr. Boland, from Springfield, MA, served as a representative from 1952-1988.

160. Robert D. Byrnes, *Washington Report*, HARTFORD COURANT, May 21, 1957, at 2.

The FFIA was officially repealed in 1968, but it died in 1957 due to insufficient funding, only nine months after its enactment.[161] About two-fifths of the half million dollar initial appropriation lapsed upon the death of the program, although several studies and recommendations were made. The Flood Administrator felt little could be gained from further study since the program could be started at any time.

The House Boland Amendment debate revisited federal flood insurance issues; it addressed the certainty of flood loss, subsidized premiums, and government involvement in the insurance business.[162] The Boland Amendment allocated $14 million to provide operating expenses to the private insurance companies so the FFIA could write contracts to sell the insurance and adjust the losses. Flood policies were ready to be sold, but awaited necessary appropriation. The FFIA had been signed, and this was not a time to reargue its passage.[163]

Representatives Canfield, Lennon, Thompson, Fogarty and Barden favored the Boland Amendment and urged others to separate the FFIA enactment from the request for funding. Canfield argued that the House had previously voted for the FFIA with a two-thirds majority only one year before, and the appropriations committee was in effect vetoing the FFIA's enactment, and such an action was not the committee's function.[164] Lennon urged people to remember that the FFIA was a promise to homeowners and small business owners, and that Congress was committed to help them with flood damage.[165] Thompson recalled Senator Lehman's message that the

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161. Federal Flood Insurance Act, Pub. L. No. 1016, 70 Stat. 1078 (1956) (codified at 42 U.S.C.S. §§ 2401-13; repealed 1968); Gerdes, *supra* note 25, at 550.

162. *See* 103 CONG. REC. 6421-22 (1957). Recently, scholars have focused on the fate of legislation after executive approval; Professor Phillip J. Cooper explores the technique of defeating an act of Congress through post-passage activity. *See* PHILLIP J. COOPER, BY ORDER OF THE PRESIDENT: THE USE AND ABUSE OF EXECUTIVE DIRECT ACTION 55-65, 100-02 (2002). The American Bar Association has dubbed this activity as a back-door veto and established a task force to examine the constitutionality of presidential signing statements. *See* American Bar Association, *ABA to Examine Constitutional, Legal Issues of Presidential Signing Statements*, http://www.abanet.org/media/releases/news060506.html (last visited Apr. 4, 2007). The U.S. Supreme Court held that the Line Item Veto Act violated the Presentment Clause. *See* Clinton v. City of New York, 524 U.S. 417 (1998).

163. 103 CONG. REC. 6421 (1957) (statement of Rep. Boland).

164. *Id.* at 6422 (statement of Rep. Canfield) ("It is not the function of the House Committee on Appropriations to say that a bill enacted into law last year, approved by this body by a two-thirds vote, shall be null and void because we will not give this agency any money.").

165. *Id.* at 6428 (statement of Rep. Lennon).

mortgage is always left standing after a flood.[166] He stressed that the FFIA was ready to enter into fiduciary agreements with insurance companies and that the program's premiums were good and administrative costs were under control.[167] Fogarty accused opponents of quickly forgetting the devastation of flood loss; he stressed that Congress owed a duty to all citizens and criticized the unwillingness to fund the FFIA while providing foreign aid.[168] Barden stated that people were willing to pay the premium and the government should give them the opportunity to do so; he recalled that President Eisenhower, during a visit to Connecticut, instructed the chief of engineers to spend what it took to take care of the people.[169]

The Appropriations Committee Chairman, Clarence Cannon, opened the debate by reading a letter from a Missouri constituent that expressed the sentiment back home. His constituent accused Congress of giving up control of the purse strings, "What in the hell is the matter with you fellows? Are you afraid of the lobbyists, of the bureacrats [sic]? Are you afraid of the pentagon and pressure groups? You have an exceptionally clear mandate from the people. Token cuts do not mean a damned thing."[170] Cannon harshly criticized the Boland Amendment and questioned the FFIA's soundness.[171] He did not approve of burdening the taxpayers with flood losses and urged rejecting the appropriations request and lowering taxes.[172]

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166. *Id.* at 6429 (statement of Rep. Thompson).

167. *Id.*

168. *Id.* at 6437.

169. 103 CONG. REC. 6435-36 (1957).

170. *Id.* at 6420.

171. *Id.* at 6443 ("[O]f all the unjustifiable amendments that could be offered this is most unjustifiable. The United States is loaded with insurance people. There are insurance companies everywhere. There are insurance underwriters and insurance agents all over the country. Their advertisements are in every newspaper and magazine. Their dodgers are in every doorway and every mail that comes in brings their circulars. They will insure you or anything you have–your house, your dog, your car, your wife, or your glass eye. They will insure you against anything you might suggest - fire, hail, tornado, or twins. They will insure you against anything in the world, except one thing. They positively will not insure you against floods . . . . There is in it the absolute certainty of loss . . . . So the insurance companies will generously turn over to Uncle Sam all the losses. Uncle Sam is the goat. He holds the bag. But who is Uncle Sam? Why, Uncle Sam is the taxpayer. That is what this amendment means. [In addition] suddenly, and inconsistently, [the proponents] have reversed themselves and they are now hot to put the Government in business - the insurance business . . . . Let us stop these crazy appropriations and lower taxes.").

172. *Id.* at 6443.

Representative Thomas attacked the Boland Amendment and the FFIA, noting that the FFIA placed a $5 billion cap on the federal government's liability, but the commissioner's borrowing power was potentially unlimited. He explained that the subsidized premiums were likely to result in government liability; a flood with a $1 billion liability might only capture $150 million in premiums and charged at a rate of $3 per one hundred this would result in a $900 million treasury burden.[173] He proposed that the remaining funds be allocated for further studies and the Boland Amendment be voted down.[174]

Charles Wesley Vursell reminded the House that the bill became law because of the 1955 floods hysteria. He was opposed to the government being placed into the insurance business and argued that the FFIA should never have been enacted. He urged Congress to listen to the public's demand to reduce the budget.[175] The Boland Amendment was defeated by a vote of 127 to 97.[176]

1. Political Responses to the FFIA's Death

President Eisenhower expressed disappointment that the FFIA had been killed, but he was pleased that Congress had cut the budget by nearly $1 billion.[177] This reaction may be attributable to his re-election in 1956 and the time-lapse since the devastating 1955 floods since he had less political pressure after securing his second term, and flood damage was no longer on the forefront of the public's concern.

Senator Kennedy was disappointed because he considered the FFIA an important program and his continued commitment to a workable FFIA was evident.[178] He introduced a bill to amend the FFIA just before the House

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173. *Id.* at 6443-44 (statement of Rep. Thomas).

174. *Id.* at 6444.

175. 103 CONG. REC. 6419, 6423 (1957) (statement of Rep. Vursell) ("So today I think we should take another look at this matter, in a calmer mood than when the bill was passed . . .").

176. *Id.* at 6444.

177. The President's News Conference, 7 PUB. PAPERS 641, 649 (Sept. 3, 1957).

178. *See* Press Release, Office of Senator John F. Kennedy, Amendment to Flood Insurance Act of 1956 (Mar. 21, 1957) [hereinafter Kennedy Press Release] (on file with author) ("The nation's first flood insurance program, in the shaping of which I was privileged to participate, was one of our proudest accomplishments in the last session of Congress. It was intended to fulfill a dire need on the part of homeowners and businessmen in all parts of the country, including New England. It was promptly considered and passed

voted down the Boland Amendment.[179] His bill proposed three modifications: (1) remove the state participation component; (2) give preference to each person's first application to increase a homeowner's or small business owner's chance of coverage; (3) pay the federal contribution in the disaster insurance only when needed to pay claims.[180] The latter modification was intended to decrease the treasury's burden.[181]

Kennedy reinforced his commitment to the FFIA in 1957.[182] Kennedy believed that the FFIA's death was an administrative failure and largely due to the Knowland Amendment urged by the Eisenhower Administration.[183] He blamed Congress's unnecessary slow down and delay of the FFIA's implementation for forcing citizens to contend with pending flood damage on their own.[184] Flood insurance became one of Kennedy's presidential goals, along with income tax cuts, civil rights legislation, and Medicaid.[185]

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by both Houses of Congress, and swiftly approved by the President, because of the urgent need for such legislation before disaster struck again.").

179. *Flood Plan Change Offered by Kennedy*, N.Y. TIMES, Mar. 22, 1957, at 47.

180. *See* Kennedy Press Release, *supra* note 178.

181. *Id.*

182. *See id.*; Letter from John F. Kennedy to Simon Yaffe (Mar. 28, 2007) (on file with author) ("You may be sure that I shall continue my efforts in behalf of a genuine flood insurance program which will be of assistance to those who need it.").

183. *See* Kennedy Press Release, *supra* note 178 ("[Section 7(a)] mistakenly insisted upon by the Administration last year, did more than any other change to discourage the hopes of those anticipating effective protection. Many states, including some in New England, are required by this provision to undergo the long and expensive process of amending their state constitutions or statutes in order to participate in what should automatically be a nation-wide program. I can think of no more gross violation of 'states' rights.' No state, to my knowledge, has as yet begun the action required by this provision; and it is apparent that few, if any, will do so. This provision should be stricken now, so that both state and Federal officials will know exactly where they stand in planning for the future.").

184. *Id.*

185. As the following excerpt from a March 14, 1962 press conference demonstrates, President Kennedy had long considered the enactment of flood insurance an important issue. President Kennedy was asked the following:

> Q. Mr. President, I believe as a Senator about 6 years ago you were a cosponsor of legislation passed by Congress entitled The Federal Flood Insurance Act of 1956, setting up a program of Federal insurance and coinsurance against property loss by floods and other damage, water damages. That program never got off the ground because of lack of appropriations. In view of the devastating northeaster on the East Coast last week, and the importance of some kind of insurance against water damage, which is not provided by the insurance companies in the

Several unsuccessful attempts were made in the late 1950's to resurrect the FFIA. The issue arose in July 1957 after Hurricane Audrey devastated parts of Louisiana and Texas,[186] but Audrey's death toll and property damage were not enough to sustain flood insurance discussions in Congress.[187] In 1959 a bill to establish a federal-state board to consider flood insurance and insurance regulation died without any action taken. In 1962, a feasibility study bill was debated that proposed studying methods to provide financial assistance to flood victims.[188] After Kennedy's assassination, flood insurance followed civil rights and Medicaid legislation in becoming a reality.[189]

II. 1956-2006: LESSONS LEARNED?

A. FLOOD INSURANCE BECOMES A REALITY: THE NFIP

Twelve years after the FFIA, the National Flood Insurance Program (NFIP) was enacted. The NFIP took a different approach, by providing flood insurance policies for residential and non-residential property owners,[190] and requiring local floodplain management.[191] Over the last forty years the NFIP has been modified, mostly by post-flood legislation

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> rebuilding of these areas, would you consider requesting appropriations to get this flooded Federal insurance program under way again?
>
> THE PRESIDENT. Yes. Well, I know that your—why this has become a matter of—living—[*laughter*]—and I must say that I think your experience indicates the desirability of legislation. The legislation is still on the books—the authorization—the Senate passed the appropriation, but the House did not. So I would support it if—in fact, I will take another look at it and see whether we should recommend a supplemental appropriation in regard to the matter. But I do think the bill was useful and I think the experiences in the recent storm generally along the coast would indicate the desirability of the bill and the appropriation.

The President's News Conference of March 14, 1962, 1962 PUB. PAPERS 227, 229 (Mar. 14, 1962).

186. Allen Drury, *Disasters Come, Insurance Lags*, N.Y. TIMES, July 7, 1957, at 120.

187. *See* Richard E. Mooney, *President Rules Storm Area Eligible for Emergency Aid*, N.Y. TIMES, June 30, 1957, at 1.

188. *See* Gerdes, *supra* note 25, at 550.

189. President Kennedy was assassinated on November 22, 1963. The National Flood Insurance Program was enacted in August 1968. *See* National Flood Insurance Act of 1968, Pub. L. No. 90-448, 82 Stat. 572 (1968).

190. 42 U.S.C. § 4012 (2000).

191. *See id.* § 4001.

intended to bolster the program's viability and achieve its goal of self-sustainability.

The 1969 amendment introduced an emergency component to the program, allowing a property owner to purchase a policy before his or her community's completion of the mandatory floodplain management plan.[192] The 1973 amendment, adopted after Hurricane Agnes, made flood insurance mandatory to obtain federally-backed mortgages in high risk flood zones.[193] The 1994 amendment added a flood mitigation assistance program, and strengthened the mandatory policy purchase provision by imposing penalties on lending institutions that failed to require flood insurance.[194] The Flood Insurance Reform Act of 2004 (FIRA), that followed Hurricane Isabel, was intended to target the repetitive loss properties (RLPs) problem. It authorized the reallocation of up to $90 million from the National Flood Insurance Fund (NFIF) to the National Flood Mitigation Fund (NFMF).[195]

B. KATRINA BRINGS NFIP WEAKNESSES TO THE FOREFRONT

The NFIP's claim of being a self-sustaining government insurance program is gone post-Katrina. The NFIP was forced to borrow $20.8 billion from the U.S. Treasury to pay Katrina, Rita, and Wilma claims, with an estimated additional $3 billion needed in 2007 to cover all claims.[196] The NFIP cannot repay these loans and continue to payout future losses with an estimated debt burden approaching one trillion dollars.[197] Heavily-subsidized premiums, RLPs, out-dated Flood Insurance Rate Maps

192. Housing and Urban Development Act of 1969, Pub. L. No. 91-152, § 408, 83 Stat. 379, 396-97 (1969); *see also* KING, *supra* note 3, at 9.

193. Flood Disaster Protection Act of 1973, Pub. L. No. 93-234, § 102, 87 Stat. 975, 978 (1973).

194. National Flood Insurance Reform Act of 1994, Pub. L. No. 103-325, §§ 525, 553, 108 Stat. 2255, 2260-61, 2270 (1994).

195. Bunning-Bereuter-Blumenauer Flood Insurance Reform Act of 2004, Pub. L. No. 108-264, §§ 102(k)(1), 103(d)(1), 104(b), 118 Stat. 712, 720-23 (2004); *see also* KING, *supra* note 3, at 30 (discussing how repetitive loss properties impact the National Flood Insurance Program).

196. RAWLE O. KING, CRS REPORT FOR CONGRESS, NATIONAL FLOOD INSURANCE PROGRAM: TREASURY BORROWING IN THE AFTERMATH OF HURRICANE KATRINA 4 (2006), *available at* http://www.ncseonline.org/NLE/CRSreports/06Jul/RS22394.pdf (last visited Mar. 31, 2007) [hereinafter CRS TREASURY BORROWING].

197. GAO KATRINA CLAIMS, *supra* note 8, at 5.

(FIRMs), and no statutory control over local floodplain management are all NFIP program weaknesses.[198]

1. Subsidized Rates and Repetitive Loss Properties

Subsidized rates are provided for pre-FIRM construction and several post-FIRM classes. The pre-FIRM properties are afforded a lower premium rate under the rationale that the owner could not ascertain the property's flood risk absent a FIRM.[199] Pre-FIRM structures are either structures under the NFIP's emergency program,[200] or a structure built or substantially improved on or before December 31, 1974, or the effective date of the community's initial FIRM.[201]

There are three post-FIRM exceptions that are subsidized: (1) Zone A99 areas that are classified with a 1 percent annual flood risk but for which structural protections are at least 50 percent complete; (2) Zone AR areas for which the structural measures no longer meet the 1 percent annual flood standard; and (3) Zone V structures built between 1975 and 1981 in accordance with NFIP's standards for stillwater flood elevations because the standards set in 1981, using more state-of-the-art engineering required stricter building standards.[202]

Approximately 28 percent of NFIP policy holders pay a subsidized rate between 30 and 40 percent of the actuarial rate.[203] It was predicted that the

198. *See* KING, *supra* note 3, at 8, 19-20. Consumer reporter, John Stossel, made the same argument in 2004 that congressmen made 46 years before:

> But the outrage is that federal flood insurance exists at all. There is a quarter-million-dollar limit on each payment, and as long as I build my house in accordance with zoning laws and ordinances, there is no limit on how many times the government will pay if a house keeps washing away.

ABC News: Taxpayers Get Soaked by Government's Flood Insurance (ABC Television Broadcast Sept. 20, 2004), *available at* http://abcnews.go.com/Business/Insurance/story?id=94181.

199. KING, *supra* note 3, at 20.

200. The emergency program, established in 1969, allows a property owner to purchase a policy prior to his or her community's enrollment in the regular program; it offers timely, but limited coverage. 42 U.S.C. § 4056 (2000 & Supp. 2005).

201. THOMAS L. HAYES & SHAMA S. SABADE, FEDERAL EMERGENCY MANAGEMENT ASSOCIATION, NATIONAL FLOOD INSURANCE PROGRAM: ACTUARIAL RATE REVIEW 7-8 (2004).

202. Subsidized levels are offered for existing and new buildings if there are scheduled restoration projects. *Id.* at 8.

203. KING, *supra* note 3, at 15; HAYES & SABADE, *supra* note 201, at 11-12.

number of pre-FIRM subsidized policies would naturally decline soon after the NFIP's enactment, but while the rate has shifted from 75 percent in 1978 to 28 percent in 2004, it has not declined as anticipated.[204] This dilemma is further compounded by the repetitive loss properties (RLP) problem: 1 percent of the policies account for 30 percent of the claims paid.[205] Most RLP owners pay a pre-FIRM subsidized premium, and some have recouped the value of their homes many times over.[206]

The National Wildlife Federation (NWF) has criticized the NFIP for not going far enough to mitigate flood losses, pointing out that structural flood protections are often inadequate and have contributed to the perception that building in flood-prone areas is safe.[207] The NWF stresses that the best way to manage floodplains is to return them to open lands that provide much needed drainage.[208]

2. Participation

An insurance goal is to maximize the risk pool over which the risk can be distributed because if the risk is distributed over a large enough population, then the program is able to cover its losses with the policy premiums. The NFIP has two major participation issues: (1) policy holders in high risk flood areas fail to renew policies; and (2) there are insufficient low and moderate-risk policy holders.

The first issue is one that continues to persist despite statutory provisions intended to prohibit it. The NFIP requires a property owner in a high risk flood area to maintain flood insurance if he or she has a federally subsidized mortgage. Many are uninsured, however, and of those that are, it is estimated that ten to fifteen percent of those policies lapse annually.[209] This is attributable, in part, to poor record keeping by FEMA, which has

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204. KING, *supra* note 3, at 15.

205. *Id.* at 20.

206. *Id.* In fact, twenty percent of RLP's are located outside designated high-risk flood zones. NAT'L WILDLIFE FED'N, HIGHER GROUND: A REPORT ON VOLUNTARY PROPERTY BUYOUTS IN THE NATION'S FLOODPLAINS xi (1998), *available at* www.nwf.org/nwfwebadmin/binaryvault/Higher%20Ground.pdf.

207. HIGHER GROUND, *supra* note 206, at xi.

208. *See id.* at 130.

209. ROBERT P. HARTWIG, THE FUTURE OF THE NATIONAL FLOOD INSURANCE PROGRAM: WRITTEN TESTIMONY AS DELIVERED TO THE UNITED STATES SENATE COMMITTEE ON BANKING HOUSING AND URBAN AFFAIRS 4-6 (2005), *available at* http://server.iii.org/yy_obj_data/binary/745025_1_0/NFIP_Testmimony.pdf.

been criticized for failing to maintain accurate records of how many properties and active policies are in high-risk areas.[210]

The second issue is attributed to consumers' unawareness that flood insurance is available and the "it won't happen to me" syndrome.[211] A person in a low to moderate risk flood area is less likely to perceive a threat to his or her property; the misperception that the 100-year flood zone, or one percent annual risk, means that a flood will only happen once every one hundred years, only exacerbates this perception of remoteness.[212]

3. Scientific Limitations on Flood Prediction

The scientific prediction of floods was a topic of great concern in enacting the FFIA, and fifty years later, despite great advancements in science and technology, we still often find ourselves at nature's mercy. Arguably, the root of the program's issues is the underlying problem that science cannot accurately predict floods.[213] The NFIP's purpose is to establish a self-sustaining flood insurance program that reduces the government's payout for disaster relief. But flood prediction with some certainty is necessary in order to establish an actuarial rate and policy holders' premium rates.

The current actuarial rate relies on a FIRM to determine a participating community's flood zone and corresponding premium rates.[214] The FIRMs are not accurate[215] and have been identified as a factor in the NFIP's struggle for sound fiscal ground.[216] President Bush's six-year, $1.475

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210. KING, *supra* note 3, at 22.

211. HIGHER GROUND, *supra* note 206, at 5.

212. *Id.* "In reality, a property owner in a 1-in-100 year flood plain has a 26% chance of being flooded during the course of a 30-year mortgage." *Id.*

213. See ORRIN H. PILKEY & LINDA PILKEY-JARVIS, USELESS ARITHMETIC: WHY ENVIRONMENTAL SCIENTISTS CAN'T PREDICT THE FUTURE (2007) for a current discussion about the inadequacy of reducing complex environmental changes to algorithms. The authors criticize beach erosion modeling, because engineers usually lack expertise in sedimentary geology and do not acknowledge the model's short-comings. *Id.* at 187. They further suggest that environmental cost-benefit analysis cannot be done because accurate quantitative estimates are unattainable. *Id.* at 192-93. The authors suggest that quantitative modelers have predictable responses to criticism, such as, "The storm (flood, sea level rise, pit lake composition) was entirely unexpected due to very unusual conditions." *Id.* at 188.

214. HAYES & SABADE, *supra* note 201, at 8-9.

215. A large percent of RLPs are located outside the FIRM's high risk flood zones, which indicates that FIRMs are not accurate, or at the very least out-of-date. *See* KING, *supra* note 3, at 22.

216. *See id.* at 9.

billion dollar map modernization budget will fund efforts to update flood maps through 2008.[217] But these maps rely on mathematical modeling, a technique criticized as inadequate to predict environmental changes and overly relied upon by policymakers.[218] Our structural accomplishments and confidence in science and engineering may be to our detriment when it comes to objectively analyzing flood management solutions.[219]

C. POST-KATRINA SOLUTIONS

1. Post-Katrina Legislation

In June 2006, the House of Representatives passed a bill to improve the NFIP, although it failed to pass the Senate.[220] The bill phased out subsidies on certain vacation homes and commercial property,[221] and raised premiums at a faster rate.[222] It also increased the coverage amount a property owner can buy[223] and boosted fines for mortgage lenders who fail to tell borrowers that they must buy flood insurance.[224] It increased the NFIP's borrowing power to $25 billion.[225] It required FEMA to review the nation's flood maps to determine which property owners must buy flood insurance[226] and increased the maximum coverage for the dwellings and contents in residential properties.[227] The Bush administration agreed to the

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217. *Id.* See http://www.fema.gov/plan/prevent/fhm/frm_soft.shtm (last visited Mar. 2, 2007), for a listing of currently available FEMA Software developed to support the FIRM updates. For example, CHAMP, Version 1.2, is described as a visual basic program that allows users to perform simulated storm-induced erosion treatments and waive height analysis. *Id.*

218. PILKEY & PILKEY-JARVIS, *supra* note 213, at 190-92 (discussing why policymakers' reliance on such modeling, without an understanding of its limitations and assumptions, is not sound science and is a misdirection of funding).

219. *See generally id.*; HIGHER GROUND, *supra* note 206. In one instance, an Army Corp engineer boasted that he was able to achieve the desired predictive modeling for a beach restoration project by changing the wave trajectory in the calculations, thereby proving that the beach sand would not end up downstream and block the mouth of a river. PILKEY & PILKEY-JARVIS, *supra* note 213, at 129-30.

220. To restore the financial solvency of the national flood insurance, and for other purposes. H.R. 4973, 109th Cong. (2006).

221. *Id.* § 4.

222. *Id.*

223. *Id.* § 7.

224. *Id.* § 6.

225. *Id.* § 10.

226. H.R. 4973, 109th Cong. § 16 (2006).

227. *Id.* § 7.

goals of the legislation, but opposed increasing the scope of coverage because of the potential $22 billion debt burden.[228]

2. Flood v. Wind: The State Farm Case

In *Broussard v. State Farm Insurance*, the judge granted summary judgment to the Broussards and allowed them to recover for flood loss under their homeowner's policy when the insurer failed to prove that wind was not the cause of at least some damage.[229] This decision, if upheld, could threaten the long-time policy exception of flood damage and allow many policy holders to recover for similar damage and drastically reduce the need for the NFIP.[230] But if the decision's purpose was to allow devastated hurricane victims to recover as a matter of public policy, the decision may have harsher long-term public policy consequences to consider. If homeowners may now recover for flood losses under a homeowner insurance policy, the likely result is either unaffordable homeowner's insurance premiums or insolvent carriers.

CONCLUSION

"One thing struck home here and that was the floods of last year. The rains that cause these floods were neither Republican nor Democratic and those who suffered losses were not chosen on the basis of their politics."[231] Mr. Yaffe's observation about the 1955 New England flood applies with equal relevance to the current response to Hurricane Katrina.

The FFIA died a quiet death because there was little incentive for politicians to pursue flood insurance once the crisis had passed. The FFIA was political leaders' good faith response to the 1955 flood destruction, but politics played an undeniable part in its passage and subsequent failure. Proponents used the legislation to gain political favor for the 1956 elections.[232] When the concept of flood insurance was proposed, it was

228. *See* Associated Press, *House Shores Up Flood Plan*, ABC NEWS, June 28, 2006, *available at* http://www.cbsnews.com/stories/2006/06/28/politics/main1758733.shtml.

229. Broussard v. State Farm Fire & Cas. Co., 2007 WL 268344, at * 1-2 (S.D. Miss. 2007).

230. *See* GAO KATRINA CLAIMS, *supra* note 8, at 10 (noting the purpose of the NFIP).

231. Letter from Simon Yaffe, Insurance Agent, to Adlai Stevenson, former U.S. Senator from Illinois and 1956 Presidential Candidate (Sept. 1, 1956) (on file with author).

232. Governor Ribicoff and Senator Prescott Bush were campaigning for re-election, and Congressman Dodd was making a run for Senator against Prescott Bush. Richard H. Parke, *President Leads Connecticut Race,* N.Y. TIMES, Oct. 24, 1956 at 1; *Dodd Will*

easy and safe to pass legislation and allow for its disappearance after the election. Subsequent to the act's signing fanfare, Congress and the administration allowed the FFIA to fade away because of the problems with funding and continued opposition to government involvement.

Despite the recent NFIP crisis, the need for the program still remains. While we had never experienced floods as severe as Hurricanes Katrina and Rita, history shows that Congress repeatedly responds to the public outcry following floods with legislation to fix the problem.[233] It is important to understand what areas are prone to floods, but a qualitative approach would be less costly and arguably no less accurate than quantitative modeling and structural prevention projects that have proven to be inadequate.[234] FEMA should spend less on FIRM updates with costly flood prediction technology, instead spending these funds on improved record keeping. Accurate records would allow FEMA to enforce the NFIP penalties against mortgage lenders authorized under the statute. The benefit would be two-fold: ensure that more policies are maintained, thereby spreading the risk and contributing policy revenue; and contributing penalty revenue that would bolster the program's financial soundness.

The NFIP's intended purpose was to reduce the financial burden that flood damage places on the federal government. This is best realized by aggressive mitigation efforts for properties in high risk areas and a broader risk pool with more low and moderate risk policies. The NFIP continues to subsidize high risk properties well below the actuarial rate with RLPs accounting for a disproportionate number of claims. This should be corrected by bolstering the program's mitigation efforts. As the NWF suggested nearly a decade ago, voluntary buyouts are the best way to recover the nation's floodplains and improve floodplain management;

Oppose Bush for Senator, N.Y. TIMES, July 1, 1956 at 45. Senator Kennedy was seeking the Democratic vice presidential nomination. *See* Arthur Krock, *Democrats Assured of Open Convention,* N.Y. TIMES, July 8, 1956 at 133.

233. *See, e.g.*, Houck, *supra* note 4.

234. Flood risk assessments have changed based on assessments with the latest engineering and technology, but a large number of the RLP's are outside the designated 100-year floodplains. *See* THOMAS L. HAYES & RANDALL A. JACOBSON, NATIONAL FLOOD INSURANCE PROGRAM: ACTUARIAL RATE REVIEW 8, 10 (Fed. Emergency Mgmt. Agency 2002) (describing reassessment for V Zone construction between 1975-1981 because original engineering calculations were not accurate); KING, *supra* note 3, at 22 (describing inaccurate mapping component of RLP issue).

history has shown that leaving floodplain management to local authorities is inadequate.[235]

The NFIP should shift subsidies from high risk properties and offer incentives for low to moderate risk policies. The right incentive program for property owners with low to moderate flood risk may combat the human tendency to shrug off remote risks. This would provide the NFIP with a larger risk pool that is better able to cover claims.

Now that post-Katrina hysteria has subsided, we should take the time to learn from the ill-fated FFIA. We should learn from history and not implement band-aid legislation, but instead focus on solutions that address the underlying problems. If we do not, we can be sure that we will be revisiting these issues with the next flood that results in larger than expected damages.

235. *See, e.g.*, Oliver Houck, *Can We Save New Orleans?*, 19 TUL. ENVTL. L.J. 1 (2006) (criticizing Louisiana's flood-plan management).

CASE NOTE:
A CONGREGATION OF VAPOURS: *CLENDENIN BROTHERS, INC. V. UNITED STATES FIRE INSURANCE COMPANY*, WELDING ROD LITIGATION, THE TOTAL POLLUTION EXCLUSION, THE FUTILITY OF THE JUDICIAL SEARCH FOR AMBIGUITY IN COMMERCIAL GENERAL LIABILITY INSURANCE CONTRACTS, AND THE REASONABLE EXPECTATIONS OF THE INSURED

Thomas Plotkin[*]

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> ...this most excellent canopy, the air, look you, this brave o'erhanging firmament, this majestical roof fretted with golden fire, why, it appears no other thing to me than a foul and pestilent congregation of vapours.

William Shakespeare, *Hamlet*, II.ii

INTRODUCTION

Clendenin Brothers, Inc. v. United States Fire Insurance Co. stands for the proposition that welding rod fumes are not to be construed as "fumes," which are expressly barred from coverage as "pollution" under the plaintiff-insured's Commercial General Liability policy ("CGL").[1] The Court of Appeals of Maryland held that an insurer had a duty to defend and indemnify the claim in the underlying toxic tort litigation because small amounts of fumes generated in the normal course of business operations did not fall within the scope of the total pollution exclusion in the insured's policy.[2] The court arrived at its holding by finding the language of the exclusion ambiguous. This ambiguity was found on several grounds: the term "pollutant" was ambiguous when applied to workplace fumes when the product was used legally and intentionally;[3] the coterminous words attached to "pollutant," "contaminant," and "irritant," were "virtually boundless" when applied to chemical byproducts, and demanded some "limiting principle[;]"[4] and the policy language was ambiguous with respect to welding rod fumes when viewed in the context of the insurer's purpose when drafting the exclusion (which the court held was to avoid liability for traditional environmental harms).[5]

Counsel for both parties pointed to Maryland precedent that could have led the court to decide either way. A case involving an insurer's duty to

1. 889 A.2d 387, 398 (Md. 2006).
2. *Id.* at 399.
3. *Id.*
4. *Id.* at 396.
5. *Id.* at 399.

defend a claim involving carbon monoxide fumes had produced a holding that the term "fumes" in the pollution exclusion was explicit and unambiguous, and hence barred coverage,[6] and a case involving injuries resulting from residential lead paint exposure had produced a holding that the admittedly toxic substance was not pollution because liability for such garden variety negligence is precisely what CGL policies are produced and sold to assuage.[7]

Looming over *Clendenin Brothers* was the only other on-point decision regarding whether welding rod fumes are pollution for the purposes of the exclusion; the Fourth Circuit, in a holding not binding on the Maryland Court, had earlier come to the opposite conclusion of the *Clendenin* court, and found that welding rod fumes were unambiguously "fumes," mentioned by name in the exclusion, and hence barred from coverage.[8]

These cases paint a portrait in miniature of what one commentator has called "one of the most hotly litigated insurance coverage questions [of recent times] . . . the scope and application of the pollution exclusion."[9] That the *Clendenin* court could find that fumes were pollution in a carbon monoxide case in one instance, and that fumes were somehow closer to lead paint, hence not pollution, in another, when the word "fumes" is expressly named in the contested terms as a pollutant in both policies, is an indicia of the confusing nature of insurance contract interpretation. The source of much of the confusion is the choice of interpretive rules courts employ when construing such provisions. In Maryland, the watch-word has been "ambiguity." The court uses a weak version of *contra preferentum*, wherein if the term cannot be susceptible to plain meaning analysis and is found to be ambiguous, and if extrinsic evidence does not suggest otherwise, then the term is construed against the drafter and in favor of coverage.[10] Problems arise when the word "fumes" is found not to mean "fumes," as is the case in *Clendenin Brothers*. Where the ambiguity is latent and not patent, and at odds with case-law going the other way, then it appears that the judicial hunt for ambiguity may be a mask for a search

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6. Bernhardt v. Hartford Fire Ins. Co., 648 A.2d 1047, 1050 (Md. Ct. Spec. App. 1994).

7. Sullins v. Allstate Ins. Co., 667 A.2d 617, 623 (Md. 1995).

8. Nat'l Elec. Mfr. Ass'n v. Gulf Underwriters Ins. Co., 162 F.3d 821, 825 (4th Cir. 1998).

9. Clendenin Bros., Inc. v. U.S Fire Ins. Co., 889 A.2d 387, 394 (Md. 2006) (quoting JEFFREY W. STEMPEL, INTERPRETATION OF INSURANCE CONTRACTS: LAW AND STRATEGY FOR INSURERS AND POLICYHOLDERS 825 (1994)).

10. *See* discussion *infra* Part III.

for the desired result. This would not necessarily be a bad thing if the resulting body of case-law was not an incoherent patchwork, where fumes are fumes in one instance, but somehow closer to lead paint in another.

The Maryland court's ambiguity analysis is rooted in a search for the intentions of the drafter: what did the insurer really mean when it created the exclusion? The court persists in this analysis over screams of protest from the insurer, who persuasively argues "I didn't mean that!" And, as noted before, where fumes can be construed not to be fumes, the results may be bizarre. One way out of these myriad conclusions may be to shift the focus from the drafter's intentions, to the expectations of the insured. Rather than hunting for latent ambiguities, courting inconsistent results, and putting words in the mouth of the insurer, a more commonsense approach to construing the pollution exclusion may be to look for terms that, when viewed in light of the specific expectations of the insurance consumer, would eviscerate the coverage the consumer hoped to purchase. If a term, viewed objectively, would have denied coverage for the very liability the insured sought protection for, then that term is oppressive and unreasonable, and coverage should not be barred.

This paper will examine the Maryland courts' encounters with the pollution exclusion through the lens of *Clendenin Brothers*. This case is useful, aside from its freshness, because welding rod litigation is a relatively new toxic tort, so we get to see a court wrestling with the exclusion in a novel context, reasoning by analogy to other, familiar yet no less contested toxic tort claims. Part I is a brief history of welding rod litigation. Part II is a brief history of the adoption and refinement of the pollution exclusion by the insurance industry. Part III is a survey of the two key Maryland pollution exclusion cases and the Fourth Circuit's decision in the only other welding rod coverage case to date. Part IV is an analysis of *Clendenin Brothers*, and Part V is a discussion of the weakness of ambiguity analysis in the cases surveyed, and an assessment of the controversial reasonable expectations doctrine as a more satisfactory alternative means of deciding pollution exclusion disputes.

I. WELDING ROD LITIGATION: THE BACKGROUND TO *CLENDENIN'S* UNDERLYING CAUSE OF ACTION

"Welding is a method of joining two pieces of metal by applying heat[;]...to create an effective weld;" welding rods, which are heated to form a metal base to augment the welded pieces, must be made from

elements which match the pieces being joined.[11] In the welding of steel, manganese, a component of steel which contributes to that metal's strength and durability, is the basic fabric of the welding rod.[12] When the metals are heated during the welding process, smoke and fumes are released into the air, composed of the constituent elements of the weld, including manganese fumes.[13] Manganese is a naturally occurring metal, and the twelfth most abundant element on earth.[14] Manganese is found in many vitamin and mineral supplements, as it is essential for human health; tea, nuts, grains and leafy vegetables all contain manganese.[15] In recent years, various plaintiffs, armed with statistical studies and medical evidence, have alleged that manganese fumes inhaled upon their release during welding can have adverse effects on human health. It is claimed that inhalation of these fumes may result in a menu of neurotoxic effects known as manganism. This disorder is the catalyst for a wave of lawsuits against welding rod manufacturers, retailers, distributors, and industrial users of welding products.[16]

While small quantities of manganese are harmless to humans, even beneficial,[17] preliminary conclusions in ongoing studies suggest that high level exposure to the element can produce symptoms akin, but not identical to, Parkinson's Disease.[18] Manganism implicates the basal ganglia of the brain, and the purported symptoms include difficulty walking, speech impairment, facial immobility, balance difficulties, and tremors.[19]

In 2005, an Illinois Appellate Court upheld a $1 million award to a welder who alleged to have suffered irreparable neurological damage as a result of exposure to manganese welding rod fumes.[20] The case marked the first jury verdict favoring recovery in the context of the novel toxic tort of

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11. Q&A: COMMON QUESTIONS ABOUT MANGANESE-RELATED WELDING ROD LITIGATION, http://www.weldinginfonetwork.com/qa/index.html (last visited January 19, 2006) [hereinafter COMMON QUESTIONS].

12. *Id.*

13. *Id.*

14. *Id.*

15. *Id.*

16. R. Hugh Lumpkin, *Coverage for Welding Rod Claims: Not an Oxymoron – The Policyholder's Perspective*, 1-11 MEALEY'S LITIG. REPORT. WELDING RODS 9 (2005).

17. COMMON QUESTIONS, *supra* note 11.

18. Walter J. Andrews et al., *Welding Fume Exposure Claims and their Implications Under Contracts for General Liability Insurance*, 2-11 MEALEY'S LITIG. REPORT. WELDING RODS 15 (2005).

19. *Id.*

20. Elam v. Lincoln Elec. Co., 841 N.E.2d 1037, 1041 (Ill. App. Ct. 2005)

welding rod fume related injuries.[21] In the wake of the *Elam* victory, plaintiff's attorneys filed hundreds of similar suits; many claims were consolidated by the Judicial Panel on Multi-District Litigation in the District Court in Cleveland.[22] Talk of welding rod litigation as "the new asbestos" had percolated for some time before this, as illustrated by solicitations for clients in actions against the welding industry on websites such as "Big Class Action" (www.bigclassaction.com).[23] Co-lead counsel in the Multi-District litigation was quoted as saying that "If every welder in the country gets tested, that's going to translate into probably 35,000 cases...[t]he industry is in big trouble."[24]

The issue of the link between manganism and welding is clouded by the absence of scientific consensus on the matter. The plaintiff in *Elam* successfully pointed to studies dating back to the 1930's connecting the illness to industrial activity.[25] In recent years, however, the welding rod industry has responded by marshaling an impressive number of studies showing that the link between manganese fumes and Parkinson's-like neurological disorders is tenuous.[26]

In the two years since the *Elam* award was upheld, the prediction of big trouble for the welding industry has not quite materialized, due in large part to the difficulty plaintiffs have had in drawing a conclusive causal chain between their injuries and welding rod fumes.[27] *Elam* remains the sole plaintiff's victory within this class of cases, and that has allowed counsel for the industry to breathe easier and label *Elam* an aberration; however, plaintiff's lawyers have countered that many cases have quietly settled, permitting hope at the plaintiff's bar to spring eternal.[28] Notwithstanding the persistence of suits, given a string of jury verdicts for the defense in 2005-2006, it appears that manganese fumes, barring conclusive studies linking them to the alleged injuries, while they may continue to waft over

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21. *See* Andrews et al., *supra* note 18, at *1.

22. *Id. See also* COMMON QUESTIONS, *supra* note 11.

23. Lumpkin, *supra* note 16, at 9.

24. *Id.* (quoting Jean Hellwege, *Welding Rod Litigation Heats Up; Workers Claim Toxic Fumes Cause Illness*, TRIAL, July 2004, at 1).

25. *See Elam*, 841 N.E.2d at 1044-1045.

26. Welding Rod Litigation Information Network, Studies, http://www.weldinginfo network.com/studies/index.html (last visited Jan. 20, 2007).

27. *See State of the Litigation Depends On Who You Ask: Defendants Optimistic; Plaintiffs Resolved*, 3-2 MEALEY'S LITIG. REP. WELDING RODS 11 (2006).

28. *Id.*

dockets in the years to come, have already become last year's "new asbestos."[29]

More intriguing than the question of welding rod litigation's significance to the mass tort bar is a recent decision in Maryland regarding an insurer's duty to defend a welding fumes case pursuant to the Total Pollution Exclusion in the defendant's CGL policy. Manganese claims may come and go, but the issue of what constitutes "pollution" under such exclusions has been clogging the courts for the last twenty-five years and does not appear to be going away any time soon.

II. THE POLLUTION EXCLUSION: FUMES AND VAPORS

Clendenin Brothers Inc. v. United States Fire Insurance Co. was argued contemporaneously with *Elam*, while the insurance industry was still bracing itself for the coming onslaught of asbestos-like welding rod claims. The underlying litigation was brought in the District Court in Maryland by "individuals who allege that [the] proper use of the Insureds' welding products produced harmful localized fumes containing manganese which caused bodily harm and neurological damage."[30] The defendant's insurer, U.S. Fire Insurance Co., sought a declaratory judgment asserting that it had no duty to defend the claim as welding rod fumes constituted pollution and was therefore barred from coverage under the CGL policy's Total Pollution Exclusion.[31] The insureds then filed a motion for Certification, asking the District Court to request that the state appellate court clarify, under Maryland law, the scope of the exclusion with regard to manganese welding rod fumes.[32] The Court of Appeals of Maryland held that U.S. Fire Insurance did in fact have a duty to defend the claim, as the language of the exclusion was ambiguous.[33]

The Court of Appeals of Maryland concluded its decision with these words: "We expect that, our decision not withstanding, interpretation of the scope of pollution exclusion clauses likely will continue to be ardently

29. *See* Welding Rod Litigation Information Network, http://www.weldinginfo network.com (last visited Jan. 20, 2007) (citing defense verdicts in the first two multi-district litigation trials in the District Court in Ohio in November 2006, and stating that the industry has thus far won 16 out of 17 welding rod-related trials).

30. Clendenin Bros., Inc. v. U.S. Fire Ins. Co., 889 A.2d 387, 389 (Md. 2006).

31. *Id.* at 389-90. For the purposes of this paper, the distinctions between the "Total" and "Absolute" pollution exclusions are minimal, and the terms will be used interchangeably.

32. *Id.* at 390.

33. *Id.* at 398.

litigated throughout state and federal courts. We are aware also that courts may arrive at divergent decisions from our own within the specific context of manganese welding fumes."[34]

This is not idle prognostication on the court's part. A judicial divergence of opinion had in fact already occurred on the question of welding rod fumes as pollution; in 1998, the Fourth Circuit had handed down the only other extant opinion regarding an insurer's duty to defend a manganese fumes claim, and, adhering to the plain meaning of the exclusion language, held that the policy unambiguously barred such a claim.[35]

The issue of what constitutes pollution under a CGL pollution exclusion has been, and remains, one of the most hotly litigated questions in insurance law since the policy provisions first appeared in the early 1970's.[36] The exclusion was prompted by the first wave of highly publicized environmental disasters in the late 1960's and the accompanying heightened public calls for governmental regulation protecting the environment;[37] insurers used the exclusions as a tool for countering "the potential for the imposition of environmental liability in scope and magnitude not previously experienced."[38]

Initially, the language of the exclusion barred coverage for claims arising out of damage inflicted by the release of pollutants "into or upon land, the atmosphere, or any . . . body of water" unless such release was "sudden or accidental."[39] As litigation arising from environmental hazards exploded in the 1970's and 1980's, and the government responded with the Comprehensive Environmental Response, Compensation, and Liability Act ("CERCLA"), exposure to environmental liability soon came to dwarf the total net worth of the entire property and casualty insurance industry.[40]

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34. *Id.* at 399.

35. Nat'l Elec. Mfr. Ass'n v. Gulf Underwriters Ins. Co., 162 F.3d 821, 825 (4th Cir. 1998).

36. JEFFREY W. STEMPEL, STEMPEL ON INSURANCE CONTRACTS, §14.11, at 135 (3d ed. 2007).

37. Kenneth S. Abraham, *The Rise and Fall of Commercial Liability Insurance*, 87 VA. L. REV. 85, 93 (2001).

38. *Id.*

39. STEMPEL, *supra* note 36, at 137 (quoting Insurance Service Office, Commercial General Liability Form (1970 version)).

40. Abraham, *supra* note 37, at 94-95 (stating that estimates of CERCLA clean-up costs, as well as costs of analogous state clean-up regimes, exceeded $500 billion by 1990, and that the total surplus of the property/casualty industry was a mere twenty-five per cent of this price tag).

Adding insult to injury, as far as the insurance industry was concerned, courts proceeded to demolish its first line of defense by often refusing to allow insurers to apply the "sudden and accidental" pollution exclusion to damage caused by the *gradual* discharge of pollution.[41] Courts in many jurisdictions construed the word "sudden" not by its temporal meaning, as the industry would have it, but as "abrupt" or "unexpected."[42] Under the principle of *contra proferentem*, this rendered the policy language ambiguous, and the term was often construed against the insurer in favor of coverage; sometimes courts went still further and affirmed coverage under "regulatory estoppel."[43]

In response, the insurance industry replaced the "sudden and accidental" language with the "absolute" pollution exclusion in 1986.[44] Aside from removing the "temporal" language, the new policy language barred claims for "the actual, alleged or threatened discharge, dispersal, seepage, migration, release, or escape of pollutants *at any time.*"[45] Additionally, the insurance industry removed any reference to "land, the atmosphere . . . or any body of water."[46] Instead, the site of pollution releases barred by the exclusion was extended to "premises you rent, own or occupy . . . . or. . . site[s] used for the handling . . . of waste . . . . or . . . any site on which you . . . are performing operations."[47]A "pollutant" is defined as "any solid, liquid, gaseous or thermal irritant or contaminant, including smoke, vapor, soot, fumes, acids, alkalis, chemicals and waste."[48]

The language of the absolute pollution exclusion is thus quite broad. The removal of explicit reference to the environment (land, air, water) has the effect of muting the "original intent" of the exclusion and broadening its ambit beyond traditional environmental harms, the very harms a lay

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41. *Id.* at 97.

42. *Id.*

43. *Id.* (invoking earlier representations by the industry to regulatory bodies at the time the exclusion was being drafted promising that the new policy language would not otherwise diminish existing coverage, courts barred insurers from applying the exclusion if they asserted that the language meant something other than what they had earlier told regulators).

44. STEMPEL, *supra* note 36, at 165-66, n.345.

45. Clendenin Bros., Inc. v. U.S Fire Ins. Co., 889 A.2d 387, 390 (Md. 2006) (emphasis added).

46. *See* KENNETH S. ABRAHAM, ENVIRONMENTAL LIABILITY INSURANCE LAW 161 (1991).

47. *Id.*

48. STEMPEL, *supra* note 36, at 166.

person would believe such an exclusion to cover.[49] Predictably the insurance industry has taken advantage of this breadth of language to bar all manner of claims arising from commonplace non-environmental hazards such as lead paint, carbon monoxide, contamination resulting from backed-up sewage, cement, photographic chemicals, gasoline, and exhaust from Zambonis at indoor hockey rinks.[50] In other words, the absolute pollution exclusion may, if read literally, bar claims arising from *any* involvement of chemicals or irritants. Moreover, as one court has stated, "the [term] irritant . . . when viewed in isolation, [is] virtually boundless, for there is virtually no substance or chemical in existence that would not irritate or damage some person or property."[51]

Further, fumes, mentioned expressly by name as a pollutant in the language of the exclusion, have proven to be the largest category of claims found by courts not to fall within the exclusion's ambit.[52] Even so, a glance at the case-law in this area shows division in judicial thinking regarding fumes. For example, carbon monoxide has been held both to be a pollutant in some jurisdictions,[53] and not a pollutant in others.[54] Fumes from ammonia,[55] glue, and sealants,[56] have similarly divided courts as to whether the pollution exclusion bars related claims from coverage.

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49. John N. Ellison & Richard P. Lewis, *Recent Developments in the Law Regarding the "Absolute" and "Total" Pollution Exclusion, the "Sudden and Accidental" Pollution Exclusion, and Treatment of the "Occurrence" Definition*, ALI-ABA COURSE OF STUDY ENVIRONMENTAL INSURANCE: PAST, PRESENT, AND FUTURE at 3-5 (June 13-14, 2002).

50. *See id.* at 43-46.

51. Ctr. for Creative Studies v. Aetna Life & Cas. Co., 871 F. Supp. 941, 945 (E.D. Mich. 1994).

52. Ellison & Lewis, *supra* note 49, at 44.

53. *See, e.g.*, Essex Ins. Co. v. Tri-Town Corp., 863 F.Supp. 38 (D. Mass. 1994); Longaberger Co. v. U.S. Fid. & Guar. Co., 31 F.Supp. 2d 595 (S.D. Ohio 1998). *See* discussion of the Maryland cases *infra* Part III.B and III.C.

54. *See, e.g.*, Reg'l Bank of Colo. v. St. Paul Fire & Marine Ins. Co., 35 F.3d 494 (10th Cir. 1994); Stoney Run Co. v. Prudential-LMI Commercial Ins. Co., 47 F.3d 34 (2d Cir. 1995); Motorists Mut. Ins. Co. v. RSJ, Inc., 926 S.W.2d 679 (Ky. Ct. App. 1996).

55. *Compare* TerraMatrix, Inc. v. U.S. Fire Ins. Co., 939 P.2d 483 (Colo. Ct. App. 1997), *and* Deni Assocs. of Fla., Inc. v. State Farm Fire & Cas. Ins. Co., 711 So.2d 1135, 1140-41 (Fla. 1998) (holding that ammonia was a pollutant under the absolute pollution exclusion), *with* Ekleberry, Inc. v. Motorists Mut. Ins. Co., No. 3-91-39, 1992 WL 168835 (Ohio Ct. App. July 17, 1992) (indicating a question of fact existed as to whether ammonia fell within the definition of "pollution").

56. *Compare* Technical Coating Applicators, Inc. v. U.S. Fid. & Guar. Co., 157 F.3d 843 (11th Cir. 1998), *and* Cook v. Evanson, 920 P.2d 1223 (Wash. Ct. App. 1996) (holding that glue and sealant fumes are both pollution under the absolute pollution exclusion), *with* W. Am. Ins. Co. v. Tufco Flooring E., Inc., 409 S.E.2d 692 (N.C. Ct. App. 1991), *and*

The Maryland Court of Appeals, in deciding *Clendenin Brothers*, while finding that the issue of coverage of welding rod fumes under the exclusion was a case of first impression,[57] was wading into an area of insurance litigation which, by its own admission, was already a topic of jurisprudential controversy.[58] As further evidence of this controversy, in reaching its decision the court had a line of cases to draw upon that reflected the split of authority regarding the scope of the exclusion. Aside from the one prior welding rod fume case in the Fourth Circuit, *NEMA v. Gulf Underwriters Insurance Co.*, the precedents discussed in *Clendenin* were cases involving carbon monoxide fumes and lead paint. In the carbon monoxide case, the court found that, under the plain meaning of the absolute pollution exclusion, the fumes were a pollutant, and the claims were barred from coverage.[59] In the lead paint case, the court held that the pollution exclusion was ambiguous regarding lead paint, therefore the policy provision was construed against the insurer and the claim was covered.[60] It is worth examining these cases in some detail, to get a sense of how Maryland courts and the Fourth Circuit interpreted the policy language of the exclusion prior to *Clendenin*, and what factors led the court to choose the lead paint model (definitely not a fume or vapor) over the carbon monoxide model (definitely a fume or vapor) when deciding welding rod fumes cases.

Beyond the relevance of these cases to the outcome in *Clendenin*, the Maryland decisions reflect, in miniature, the somewhat bewildering diversity of opinion in judicial review of the pollution exclusion that has existed from the contract provision's inception. Moreover, these cases highlight the inconsistencies that result from the courts' reliance on certain established interpretive principals. Be it plain meaning, the search for ambiguities that may be construed against the insurer, or the examination of the history and purpose of the term, these inconsistencies make clear the utility of a more satisfactory, if controversial, method of construing the pollution exclusion specifically, and insurance contracts generally.

Calvert Ins. Co. v. S & L Realty Corp., 926 F. Supp. 44 (S.D.N.Y. 1996) (holding that glue and sealant fumes are not pollution under the absolute pollution exclusion).

57. Clendenin Bros., Inc. v. U.S. Fire Ins. Co., 889 A.2d 387, 390 (Md. 2006).

58. *Id.* at 399.

59. *See* Bernhardt v. Hartford Fire Ins. Co., 648 A.2d 1047, 1051 (Md. Ct. Spec. App. 1994).

60. Sullins v. Allstate Ins. Co., 667 A.2d 617, 623 (Md. 1995).

III. THE LINE OF CASES PRECEDING *CLENDENIN BROTHERS*

A. BACKGROUND: GENERAL PRINCIPLES OF INSURANCE CONTRACT INTERPRETATION IN MARYLAND

Like *Clendenin Brothers*, the earlier cases all involve an insurer seeking a judgment absolving it from its duty to defend a claim that it alleges is barred under the express language of the pollution exclusion in the insured's CGL policy. The Maryland Court of Appeals framed the issue thus:

> [A]n insurance company has a duty to defend its insured for all claims which are potentially covered under an insurance policy. If there is a possibility, even a remote one, that the plaintiff's claims could be covered by the policy, there is a duty to defend. To determine . . . whether an insurer has a duty to defend, we engage in a two-part inquiry . . . . 1) what is the coverage and what are the defenses under the terms and requirements of the insurance policy? 2) do the allegations in the tort action potentially bring the tort claim within the policy's coverage? The first question focuses upon the language and requirements of the policy, and the second question focuses upon the allegation of the tort suit.[61]

When interpreting the insurance contract under the first prong of this inquiry, the court must construe the contract as a whole to determine the intention of the parties.[62] Specific policy terms will be given their "usual, ordinary and accepted meaning" absent evidence the parties used the word in a specialized or technical sense.[63] The court will further examine "the character of the contract, its purpose, and the facts and circumstances of the parties at the time of execution."[64]

If the disputed contract terms are found to be clear and unambiguous, the court "will determine the meaning of the terms . . . as a matter of

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61. *Clendenin Bros.*, 889 A.2d at 392-93 (Md. 2006) (citations omitted).

62. *Id.* at 393.

63. Clendenin Bros., Inc. v. U.S. Fire Ins. Co., 889 A.2d 387, 393 (Md. 2006) (internal citations omitted).

64. *Id.* (internal citations omitted).

law."[65] The court has given two definitions of an ambiguous contract term. It may be "intrinsically unclear," that is, a person reading it without some extrinsic knowledge cannot understand its meaning; or its intrinsic meaning may be clear, but its application in a particular instance may be uncertain.[66] An ambiguity may exist if "a term . . ., to a reasonably prudent person, is . . . susceptible to more than one meaning."[67] Courts in Maryland do not strictly follow *contra preferentem*, the principle that ambiguity in an insurance contract is automatically construed against the insurer.[68] However, if ambiguity remains after the consideration of extrinsic evidence, "it will ordinarily be resolved against [the drafter]."[69]

B. *BERNHARDT V. HARTFORD FIRE INSURANCE CO.*[70]

In *Bernhardt*, a landlord was being sued in the underlying tort case for failing to properly maintain an apartment building's central heating system; when debris blocked the free passage of air from the boiler, carbon monoxide built up, and eventually permeated the building, with the result that several tenants suffered carbon monoxide poisoning and were hospitalized for their injuries.[71] The landlord's insurer denied coverage and refused to provide a defense, contending that the pollution exclusion in the landlord's CGL policy barred coverage for claims based on carbon monoxide fumes.[72] On appeal, the landlord argued that because the language of the exclusion was ambiguous, it should be construed against the insurer.[73] The court disagreed, and affirmed the trial court's grant of summary judgment to the insurer. While conceding that "the title of the endorsement – 'pollution exclusion' – is, standing alone, ambiguous, and that an insured glancing only at the endorsement would not understand the breadth of the exclusion,"[74] it also found that carbon monoxide fumes fell

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65. *Id.* (internal citations omitted).

66. Bernhardt v. Hartford Fire Ins. Co., 648 A.2d 1047, 1051 (Md. Ct. Spec. App. 1994) (citation omitted).

67. *Clendenin Bros.*, 889 A.2d at 393 (citation omitted).

68. *See id.* at 394.

69. Clendenin Bros., Inc. v. U.S. Fire Ins. Co., 889 A.2d 387, 394 (Md. 2006) (citation omitted).

70. 648 A.2d at 1047.

71. *Id.* at 1047-48.

72. Bernhardt v. Hartford Fire Ins. Co., 648 A.2d 1047, 1048 (Md. Ct. Spec. App. 1994).

73. *See id.* at 1050-51.

74. *Id.* at 1051.

firmly within the express provisions of the exclusion.[75] The court looked to the policy language listing pollutants, the release of which would bar coverage:

> The carbon monoxide in this case was a "gaseous . . . irritant or contaminant" and constituted "fumes" and "chemicals" within the clear language of the definition of "pollutant." Moreover, the . . . injury claimed by the tenants "arose out of the actual . . . discharge, dispersal, . . . or escape" of the carbon monoxide "at . . . premises owned by the named insured."[76]

The court also disposed of the landlord's contention that the absolute pollution exclusion harbored ambiguity because policy language potentially barring coverage for *any* chemical in *any* context was broader than the insurance industry's alleged original intention of excluding "coverage for entities which knowingly pollute the environment over a substantial period of time," in other words, traditional environmental polluters.[77] Looking to the Louisiana carbon monoxide case cited to support this claim, *Thompson v. Temple,*[78] the court found that decision's reasoning insufficient to sustain any divination of the insurance industry's intentions in adopting the absolute pollution exclusion.[79]

Having held that the sweeping language of the absolute pollution exclusion passed muster, the court allowed itself a moment of regret in the closing words of its decision. The insurer in *Clendenin Brothers* would rely heavily on the *Bernhardt* decision in arguing that welding rod fumes claims were barred from coverage under the pollution exclusion,[80] but the *Bernhardt* court's closing dicta might have given them pause:

> [T]he landlord's arguments have substantial emotional appeal. . . . [T]he insurance industry, perhaps acting out of frustration resulting from its unfair treatment in the courts, or perhaps

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75. *Id.*

76. *Id.*

77. *Id.* at 1050 (quoting Thompson v. Temple, 580 So.2d 1133, 1135 (1991)). *See generally* Abraham, *supra* note 37, at 93.

78. 580 So.2d at 1133.

79. *See* Bernhardt v. Hartford Fire Ins. Co., 648 A.2d 1047, 1050 (Md. Ct. Spec. App. 1994).

80. *See* Respondent's Brief in Response to Briefs of Amici Curiae ESAB Group, Inc. & the Gas & Welding Distribs. Ass'n. at 12-15, Clendenin Bros., Inc., v. U.S. Fire Ins. Co., 889 A.2d 387 (Md. 2006) (No. 1:03-CV-3308), 2005 WL 4122758.

> because of the inherent difficulty in defining that which it desires to exclude, has cut with a meat axe rather than a scalpel. The insurance industry has constructed an "absolute" exclusion so broad in its application that it sweeps away coverage well beyond that which it might be required to meet the industry's legitimate aims . . . . It may well be . . . that because of the breadth of the exclusion as written . . . and the lack of effective bargaining power on the part of many insureds, the Insurance Commissioner and/or the General Assembly may wish to consider mandatory revision of the . . . exclusion.[81]

Needless to say, no such revision occurred, and the Court of Appeals found itself wrestling with the language of the absolute pollution exclusion one year later, this time with quite a different outcome.

C. *SULLINS V. ALLSTATE INSURANCE CO.*[82]

The tort litigation underlying *Sullins* involved a suit brought in Federal District Court by a woman whose child suffered lead poisoning as a result of ingesting lead paint dispersed or released at the defendant landlord's property.[83] The landlord's insurer claimed in turn that it had no duty to defend or indemnify the landlord, as lead paint is a "a toxic chemical" and as such is a "pollutant," barring coverage under the absolute pollution exclusion in the landlord's CGL policy.[84] The District Court (as it would in *Clendenin Brothers* a decade later) sent the question to the Court of Appeals for Maryland for certification, asking whether an insurer has a duty to defend or indemnify the claim under the language of the exclusion when the exposure is to lead paint.[85]

The court held that lead paint was not a pollutant, and therefore the insurer had the duty to defend and indemnify the claim.[86] The court reached its holding by looking to ambiguity in the contract terms,[87] by finding that conflicting decisions in different jurisdictions regarding lead

81. *Bernhardt*, 648 A.2d at 1052.
82. 667 A.2d 617 (Md. 1995).
83. *Id.* at 618-19.
84. *Id.*
85. *Id.* at 618.
86. *Id.* at 623-24.
87. *Id.* at 619-22.

paint's status as a "pollutant" affirmed the existence of this ambiguity,[88] and by examining extrinsic evidence regarding the purpose of the exclusion.[89]

The court held that the relevant language barring the claim in the exclusion, "contaminant," "pollutant," "irritant," and "toxic chemical," were susceptible to diametrically opposed interpretations when applied to lead paint.[90] On the one hand, a reasonably prudent layperson could find that the terms encompass lead paint and thus bar coverage;[91] on the other hand, a reasonably prudent layperson could read the terms as applying only to traditional cases of environmental pollution, and thus lead paint in a residence would not fall within the scope of the pollution exclusion.[92] Under Maryland law, the existence of such a diversity of interpretations creates ambiguity, and the terms must be construed against the insurer as the drafter of the policy.[93] Regarding the question as to whether lead is a "toxic chemical," the court conceded that lead is clearly toxic.[94] But the court found that under the dictionary definition of "chemical" ("a substance . . . obtained by a chemical process, prepared for use in chemical manufacture, or used for producing a chemical effect"), a person may reasonably find that lead is not a chemical.[95] Inquiry into the term "irritant" reached a similar result.[96]

Thumbing further through the dictionary, the court found that the terms "contaminant" and "pollutant" are susceptible to multiple meanings. A contaminant is something that can "soil, stain, corrupt, or infect by association" or "make inferior or impure by mixture."[97] This definition may be read by a reasonable layperson as encompassing lead paint.[98] Pollution is defined as rendering things "physically impure or unclean," and this too may reasonably include lead paint.[99] However, case-law in other jurisdictions had found lead paint to be neither a contaminant nor a pollutant. One such holding is quoted at length:

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88. Sullins v. Allstate Ins. Co., 667 A.2d 617, 623-24 (Md. 1995).
89. *Id.* at 622-23.
90. *See id.* at 620-21.
91. *See id.* at 620.
92. *Id.*
93. *Id.* At 619
94. Sullins v. Allstate Ins. Co., 667 A.2d 617, 620 (Md. 1995).
95. *Id.* (quoting WEBSTER'S THIRD NEW INTERNATIONAL DICTIONARY 384 (1981)).
96. *Id.*
97. *Id.* (quoting WEBSTER'S THIRD NEW INTERNATIONAL DICTIONARY 291 (1981)).
98. *Id.*
99. *Id.* (quoting WEBSTER'S THIRD NEW INTERNATIONAL DICTIONARY 1756 (1981)).

> We conclude that an insured could reasonably have understood the provision . . . to exclude coverage for injury caused by certain forms of industrial pollution, but not coverage for injury allegedly caused by the presence of leaded materials in a private residence. There simply is no language in the exclusion provision from which to infer that the provision was drafted with a view towards limiting liability for lead paint related injury. The definition of "pollutant" in the policy does not indicate that leaded materials fall within its scope. Rather, the terms used in the pollution exclusion such as "discharge," "dispersal," "release," and "escape," are terms of art in environmental law which generally are used with reference to damage or injury caused by improper disposal or containment of hazardous waste.[100]

A single decision from another jurisdiction holding that lead paint does not fall under the scope of the exclusion seems a slender reed to grasp at in finding ambiguity in the term "pollutant," particularly when the court acknowledges decisions in other jurisdictions which go the other way.[101] However, in addressing the purpose of the exclusion *as understood by a reasonable insured*, the holding quoted above allowed the court to slide into another grounds for ambiguity, departing from the dictionary definition of the words of the provision. Those terms of art of environmental law, "discharge, dispersal, release and escape," lead the court into a more generalized inquiry. "Some courts have held that products, despite their toxic nature, are not 'pollutants' or 'contaminants' when used intentionally or legally . . . . Without some limiting principle, the pollution exclusion clause would extend far beyond its intended scope and lead to some absurd results."[102]

For the court, the limiting principle for the breadth of the exclusion's language lies ultimately within the history of its adoption in the context of the dawning of the age of massive environmental liability discussed

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100. Sullins v. Allstate Ins. Co., 667 A.2d 617, 620-21 (Md. 1995) (quoting Atl. Mut. Ins. Co. v. McFadden, 595 N.E.2d 762, 764 (Mass. 1992)).

101. *Id.* at 620 (citing U.S. Liab. Ins. Co. v. Bourbeau, 49 F.3d 786, 789 (1st Cir. 1995); St. Leger v. Am. Fire & Cas. Ins. Co., 870 F. Supp. 641, 641-43 (E.D. Pa. 1994) (both holding that lead paint is unambiguously a pollutant and hence coverage is barred under the pollution exclusion)).

102. *Sullins*, 667 A.2d at 621 (citations and quotations omitted).

above.[103] The dispositive evidence that the industry was concerned with traditional environmental harms, not toxic products used intentionally or legally, or lead paint flaking off an apartment's walls and windows, lies in the use of those terms of art in environmental law.[104] From this the court concludes:

> It appears [viewed in light of the genesis of the "sudden and accidental" pollution exclusion in the early '70's] that the insurance industry intended the pollution exclusion to apply only to environmental pollution. That supports our conclusion that a reasonably prudent layperson may interpret the terms 'pollution' and 'contamination' [in the instant case] as *not* encompassing lead paint, a product used legally and intentionally. Since [those terms] suggest more than one meaning . . ., they are ambiguous and must be construed against Allstate.[105]

Finally, noting the existence of contradictory holdings in the case law on lead paint, the court indicated that conflicting holdings may in themselves connote ambiguity:[106]

> We hold that conflicting interpretations of policy language in judicial opinions is not determinative of, but is a factor to be considered in determining the existence of ambiguity . . . . [I]f other judges have held alternative interpretations of the same language to be reasonable, that certainly lends some credence to the proposition that the language is ambiguous.[107]

The court in *Bernhardt*, in holding that carbon monoxide fumes released into a residence from a faulty heating system was "pollution" under the exclusion and hence barred from coverage, deployed the principle of "plain meaning" of the contract term "fumes" (i.e., "fumes" always equals "fumes" if the presence of vapours is an express bar to coverage) to reach its decision. In contrast, the *Sullins* court went on a multi-step hunt for ambiguity to reach an opposite holding with respect to lead paint in a residential context. Dictionary definitions susceptible to

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103. *See* Abraham, *supra* note 37, at 93.
104. *Sullins*, 667 A.2d at 622-23.
105. *Id.* at 623.
106. Sullins v. Allstate Ins. Co., 667 A.2d 617, 623 (Md. 1995).
107. *Id.* at 624.

multiple interpretations, the history and purpose of the exclusion, and conflicting judicial interpretations on the same policy language were all grist for the mill. Using these inquiries in the context of lead paint seems sensible. An insured might well imagine, untainted by after-the-fact subjective pique at being denied coverage, that chips of flaking paint in a residence falls under the ambit of garden-variety negligence that a CGL policy is supposed to protect her from, rather than the CERCLA-type liability conjured up by the language of a pollution exclusion.

But the seeds of potential future confusion were sown in *Sullins* when the court departed from the strict language of the policy terms in its hunt for ambiguity. For example, the conclusion that the broad language of the absolute pollution exclusion was adopted for the same purpose as the earlier "sudden and accidental" language, to counter CERCLA liability, has no foundation.[108] As one commentator has put it, "[C]ertainly the [e]xclusion 'has to do with' manufacturing byproducts and environmental cleanup. But this insight . . . no more compels the conclusion that the [e]xclusion is limited to such liabilities than it can be said that an exclusion for professional services liability, introduced because of the medical malpractice crisis, applies to doctors but not . . . to lawyers or law enforcement officials."[109]

Further, the use by the *Sullins* court of conflicting judicial interpretations of the same policy terms as a factor, even if not a dispositive one, has been roundly rejected by the majority of courts,[110] and the logic of such a rejection is persuasive. As the Wisconsin Supreme Court has stated, "[i]f the existence of differing court interpretations inevitably meant ambiguity, then only the first interpretation would count."[111] It becomes an invitation to syllogistic logic to permit a single court to determine the outcome in all subsequent coverage disputes, erasing any distinctions among the specific facts along the way.[112] "The Catch-22 . . . is that once ambiguity has been found, the insurer will lose even if the insurer has the better argument about how to construe its clause."[113] Finally, the quest for multiple meanings in the policy terms when applied to lead paint allowed the *Sullins* court to take interpretive shortcuts in reaching its decision.

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108. William P. Shelley & Joshua A. Mooney, *Toxic Torts and the Absolute Pollution Exclusion Revisited*, 39 TORT TRIAL & INS. PRAC. L.J. 55, 72 (2003).

109. *Id.* at 73.

110. *Id.* at 57.

111. Peace *ex rel.* Lerner v. Nw. Nat'l Ins. Co., 596 N.W.2d 429, 442 (Wis. 1999).

112. *See* Shelley & Mooney, *supra* note 108, at 57-58.

113. *Peace*, 596 N.W.2d at 444.

Courts that have found lead paint is a pollutant or a contaminant have zeroed in on its harmful effects on the human body.[114] In *Sullins*, the court sidestepped any meaningful analysis of lead's polluting capabilities by parsing the term "toxic chemical," so dispositive in pro-insurer lead decisions, as being susceptible to the reading that lead is unambiguously "toxic," but ambiguously a "chemical."[115] Such reasoning further points to a court deciding in the right party's favor by fabricating ambiguity where none exists.

Just as *Bernhardt* would be central to the insurer's argument in *Clendenin Brothers*, *Sullins* would be crucial to the insured's case,[116] and would carry the day with the Court of Appeals in Maryland. While the outcome of *Sullins* may seem just, when taking into account the insured's expectation of coverage in a lead paint claim, when applied to a welding rod fumes case the analogy seems wobbly. This becomes apparent when viewed in light of the only other coverage decision regarding a welding fumes claim, which occurred ironically enough, within the Court of Appeals of Maryland's home circuit (though not while applying Maryland law), the Fourth Circuit.

D. *NATIONAL ELECTRICAL MANUFACTURERS ASSOCIATION V. GULF UNDERWRITERS INSURANCE CO.*[117]

The holding in this case is short and to the point, and directly at odds with the subsequent holding on welding rod fumes in *Clendenin Brothers*. NEMA is a trade association for manufacturers of electrical products, including makers of welding equipment.[118] It was a named defendant in the tort litigation underlying the coverage dispute. The complaint, brought by welders suing for injuries suffered as a result of exposure to welding rod fumes, alleged that NEMA witheld knowledge of the dangers of manganese fumes to the human nervous system when promulgating standards for the welding industry.[119] While NEMA was not found liable at trial, it incurred

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114. *See* Shelley & Mooney, *supra* note 108, at 67-68 (citing *Peace*, 596 N.W.2d at 443 n.19 and Lititz Mut. Ins. Co. v. Steely, 785 A.2d 975, 980 (Pa. 2001)).

115. *See id.* at 68-69 (citing Sullins v. Allstate Ins. Co., 667 A.2d 617, 620 (Md. 1995)).

116. Brief for the ESAB Group, Inc. as Amici Curiae at 4, Clendenin Bros., Inc. v. U.S. Fire Ins. Co., 390 Md. 449, 465 (Ct. App. Md. 2006).

117. 162 F.3d 821 (4th Cir. 1998).

118. *Id.* at 823.

119. *Id.*

significant costs in defending the suits, and sued its primary insurers before the trial.[120] The defendant in the coverage dispute, Gulf Underwriters, refused to settle.[121] A flurry of proceedings in the District Court concluded with a determination that the absolute pollution exclusion did not relieve Gulf of its duty to defend NEMA.[122] Gulf appealed the decision to the Fourth Circuit, which reversed the lower court decision.[123]

The Fourth Circuit arrived at its holding, that the insurer had no duty to defend the insured where welding rod fumes were barred from coverage under the pollution exclusion, by looking to the plain language of the CGL policy. NEMA had procured Specialty Errors and Omissions coverage directly related to its promulgation of standards for welding rod products which covered "the development, publication and dissemination of . . . process and procedure standards;" however the court found that Gulf's liability was limited by a specific exclusion barring coverage for "claims arising directly or indirectly from certain events."[124] This additional pollution exclusion contained the now-familiar broad language denying coverage for the "discharge, dispersal, release of any pollutant . . . . whether or not the pollution was sudden, accidental, gradual, intended, expected or preventable, or whether or not [the insured] caused or contributed to the pollution. 'Pollutant' includes any solid, liquid, gaseous or thermal irritant or contaminant, including . . . . *fumes*."[125]

The court then stated that to be effective, a provision barring coverage must be explicit, and thus "[t]his court need look no further than the exclusion's plain language to conclude that it explicitly applies to the underlying actions."[126] Citing decisions from the 9th, 10th, 11th, and 2nd Circuits, NEMA argued in turn that the court should consider the insured's "reasonable expectation of coverage and...restrict application of the exclusion to only environmental pollution."[127] The court responded that applicable District of Columbia law had rejected the reasonable expectations test where, as here, the terms are unambiguous and contain no

120. *Id.*
121. *Id.*
122. *Id.*
123. Nat'l Elec. Mfrs. Ass'n v. Gulf Underwriters Ins. Co., 162 F.3d 821, 823 (4th Cir. 1998).
124. *Id.* at 824 (quotations omitted).
125. *Id.* (quotations omitted)(emphasis added).
126. *Id.* at 825
127. *Id.*

terms of art.[128] Since the terms were unambiguous and explicit, the terms shall be construed as written, with no reference to "any acts or conduct of the parties . . . which evince their interpretations of [the contract]," thus disposing of the reasonable expectations of the insured and the purported intent of the exclusion.[129] The plain meaning analysis of the term "fumes" thus demands that coverage for welding rod fumes claims be barred.[130]

The stage was now set for *Clendenin*; arguing before the Court of Appeals of Maryland, the parties would deploy arguments with respect to judicial construction of the pollution exclusion ranging from the plain meaning analysis applied to carbon monoxide fumes in *Bernhardt*, the inquiry into ambiguity and the drafter's purpose in *Sullins*, and the sole on-point (if merely persuasive) welding rod fumes case, *NEMA*. Like *Sullins*, the outcome in *Clendenin* appears just, yet when considered more analytically, the decision appears to have been wrongly decided.

IV. *CLENDENIN BROTHERS:* WELDING ROD FUMES ARE NOT POLLUTION

The facts of *Clendenin Brothers* have been discussed above.[131] The issue confronting the Court of Appeals of Maryland was whether the pollution exclusion in the insureds' CGL policy relieved the insurer of its duty to defend and/or indemnify the claim where the alleged harm in the underlying tort litigation was caused by workplace manganese welding fumes.[132] The relevant policy provision read as follows:

> TOTAL POLLUTION EXCLUSION: This Insurance does not apply to: Bodily injury or property damage which would not have occurred in whole or part but for the actual, alleged or threatened discharge, dispersal, seepage, migration, release, or escape of pollutants *at any time*.
> ***
> *Pollutants means any* solid, liquid, *gaseous* or thermal *irritant or contaminant*, including smoke, vapor, soot, *fumes*, acid, alkalis,

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128. *Id.* For an explication of the reasonable expectations doctrine and its varied applications, see discussion *infra* Part V.

129. *See* Nat'l Elec. Mfrs. Ass'n v. Gulf Underwriters Ins. Co., 162 F.3d 821, 825 (4th Cir. 1998) (citations and quotations omitted).

130. *Id.*

131. *See* discussion *supra* Part II.

132. Clendenin Bros., Inc. v. U.S. Fire Ins. Co., 889 A.2d 387, 391 (Md. 2006).

> chemicals and waste. Waste includes material to be recycled, reconditioned or reclaimed.[133]

The insurer argued that the policy term "fumes," a pollutant by virtue of being a "gaseous . . . irritant or contaminant," when discharged "at any time," is unambiguous in the context of manganese fumes released during welding activities.[134] Therefore, since the policy terms are unambiguous, the holding in *Bernhardt* controlled.[135] The insured argued that the language of the exclusion was ambiguous, and hence should be construed against the drafter and permit coverage.[136] That ambiguity may be found on several grounds. First, the terms "discharge," "dispersal," "release," and "escape" are terms of art in environmental law, and indicate that only traditional environmental harms should be barred from coverage under the policy provision;[137] second, the words "pollutant, "contaminant," and "irritant" are ambiguous when applied to welding rod fumes, and while susceptible to interpretations that would bar coverage, they are also susceptible to an opposite interpretation, as such fumes were a product of a raw material used legally and intentionally in the course of the insureds' normal business activity.[138] Third, without the application by the court of some limiting principle, terms like "irritant" and "contaminant" become virtually boundless (since most substances will irritate or contaminate when exposure is excessive), leading to absurd results. Finally, a finding of ambiguity was supported by looking to the context of the avalanche of environmental liability that prompted the initial adoption of the exclusion, pointing to the likelihood that the insurance industry was responding to cleanup costs and not toxic tort negligence claims.[139] For all of these reasons, the insured contended that the holding in *Sullins* was controlling.[140]

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133. *Id.* at 389 (internal quotations omitted) (emphasis added).

134. *See* Brief of Respondent as Response to Amici Curiae of The ESAB Group, Inc. and The Gas and Welding Distrib. Ass'n at 14, Clendenin Bros. Inc. v. U.S Fire Ins. Co., 889 A.2d 387 (Md. 2006) (1:03-CV-3308), 2005 WL 4122758.

135. *Id.*

136. Brief for the ESAB Group, Inc. as Amicus Curiae Supporting Petitioners at 12, Clendenin Bros., Inc. v. U.S. Fire Ins. Co., 889 A.2d 387 (Md. 2006) (No. 1:03-cv-3308), 2005 WL 1826581.

137. *Id.*

138. *Id.* at 13.

139. *See generally id.*

140. *Id.* at 4.

The court, in finding for the insured, adopted all of its arguments. Citing *NEMA*, it found that a reasonable person could find manganese fumes to be a pollutant under the exclusion.[141] On the other hand, a reasonable person could come to the contrary conclusion. The court cited studies showing that while manganese is poisonous in large amounts, it is a naturally occurring element, often beneficial to human health.[142] Further, in the context of welding, when manganese is used in the ordinary course of business intentionally and legally, generating only a small quality of fumes, a layperson could find that it is not a pollutant.[143]

The court recapitulated the logic of *Sullins*, when it insisted upon a limiting principle for the "virtually boundless" terms "contaminant" and "irritant."[144] Like the earlier decision, it found support for this limiting principle in the assertion that the insurance industry only intended the exclusion for environmental liability and not product liability related negligence in toxic tort cases.[145] Again, as in *Sullins*, the court drew support from the presence of terms of art in environmental law in the exclusion which connote pollution ("discharge," "release," etc.).[146]

The court, in dicta, noted that the exclusion, if applied to workplace manganese fumes emitted in the normal course of business, is at odds with the general purpose of a CGL policy.[147] "To read the exclusion more broadly ignores the insurers' objective in creating the exclusion and ignores the general coverage provisions of the policy."[148] Observing that since insureds purchase CGL coverage and pay their premiums to protect against routine commercial hazards, the insurer would be subverting the very purpose of the product that they are selling by denying coverage to a welding business for workers injured by welding fumes within the normal scope of business.[149]

The Court of Appeals of Maryland thus broadened the *Sullins* holding, which only applied to a residential lead paint context, and definitively held that the "pollution exclusion clause, when read in its entirety, supports the conclusion that noxious workplace fumes were not intended to be excluded

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141. Clendenin Bros., Inc. v. U.S. Fire Ins. Co., 889 A.2d 387, 394 (Ct. App. Md. 2006).

142. *Id.* at 395 (internal citations and quotations omitted).

143. *Id.* at 395-96 (citations and quotations omitted).

144. *Id.* at 396.

145. *See id.* at 396-97.

146. *Id.* at 398.

147. Clendenin Bros., Inc. v. U.S. Fire Ins. Co., 889 A.2d 387, 397 (Md. 2206).

148. *Id.* at 397 (citations and quotations omitted).

149. *See id.* at 398.

. . . . [and the exclusion] was not intended to bar coverage where Insureds' liability may be caused by non-environmental localized workplace fumes."[150] The result seems reasonable; given some sort of "insurance coverage Rorschach test," a typical insurance consumer shown the "ink-blot" for garden variety negligence suits stemming from the ordinary course of business would not be likely to blurt out the words "The pollution exclusion bars coverage!" However, this silly hypothetical test suggests a problem with the *Clendenin* court's rationale. The decision's emphasis on the ambiguity of the policy language seems unsatisfactory in light of the *NEMA* and *Bernhardt* holdings, which found "fumes" to be unambiguously "pollutants," and seems far closer factually to the welding rod case than does *Sullins*, whose reasoning is adopted almost in its entirety in *Clendenin Bros.* The differences in the opinions with respect to "ambiguity" are logically inconsistent. The practice of searching for latent ambiguities in seemingly clear-cut policy terms breeds peculiar results, i.e. that welding rod fumes are somehow closer to lead paint than carbon monoxide fumes.

Moreover, the court drew support for its finding of ambiguity by looking to the intent of the *insurer*, an intent that is not so clear-cut as the court would have it. The court stated with some confidence that the insurance industry's purpose in drafting the exclusion was to bar coverage only for CERCLA-style environmental liability. While the court drew primarily on case-law as the source for this assertion,[151] the parties' briefs went into this subject in some detail; examining the arguments found there leaves the reader feeling that the assertion is as latently ambiguous as the clause itself may be.

The amicus curiae brief of the ESAB Group cited, as evidence of the insurance industry's intent to merely bar coverage for CERCLA-type environmental harm, representations made by the industry to regulatory bodies during hearings for the provision's approval.[152] While there was a consensus among the industry spokesmen that the provision was "overdrafted," that is, perhaps too broad in its language, there is no testimony presented that would facially establish that welding rod fumes could not possibly fall under the reach of the exclusion.[153]

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150. *Id.* at 398-99.

151. *Id.* at 397-98.

152. Brief of Amicus Curiae, *supra* note 136, at 19.

153. *Id.* at 19-21. At a hearing before New Jersey regulators in 1985, one insurance spokesman averred that the exclusion is not absolute, but went on to say that its purpose is to bar coverage for "on-site emission and [some] off-site" instances. *Id.* at 19. Welding rod fumes would certainly qualify as an on-site emission. At the same hearing, another

U.S. Fire Insurance's lawyers made a gallant, yet failed, attempt to contradict the assertion that the exclusion was only meant to bar environmental pollution.[154] The defendant argued that in asserting that the exclusion only covered this one class of claims, the plaintiffs (and subsequently the court) were writing non-existant terms into the provision.[155] These terms would include limitations on the exclusion where the claims arose out of "normal business activities," "workplace exposure," and "lawful use of products in their intended fashion."[156] The defense brief further pointed to the phrase in the provision "at any time" (not present in the *Sullins* policy), as proof that the terms were not limited to any one type of pollution.[157] Finally, the defense brief argues that any ambiguity as to whether welding rod fumes are pollutants stretches logic impermissibly; decisions the plaintiff relied on, including *Sullins*, when invoking the exclusion's use of terms of art in environmental law, often included the accompanying language ". . . into the soil, water, and air."[158] The brief argues that since the fumes in question caused injury when inhaled upon dispersal into the air (and noting that Maryland courts have held that indoor air pollution is pollution), then such fumes constitute air pollution.[159]

While both sets of arguments with respect to the drafting history seem sound, the fact remains that the evidence on both sides is inconclusive of any intent of the drafters. If the court's use of the drafter's intentions is unsatisfactory, this leads us back to an examination of the efficacy of judicial arguments regarding latent ambiguity: when are "fumes" not "fumes?"

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insurance representative gave a product liability hypothetical indicating where the exclusion would not apply: a manufacturer of an underground tank would be protected from claims in the event of a leak. *Id.* This does not present a precise fit with the facts in *Clendenin Bros.*, where noxious fumes were being deliberately discharged into the air. A similar colloquy in Texas produced another illustrative hypothetical from an industry representative, where protection was promised to a grocery store if a Clorox bottle fell off the shelf, resulting in injury. *Id.* at 21. Again, this does not match the welding fumes scenario.

154. Brief of Respondents, *supra* note 134, at 7-11.

155. *Id.* at 7.

156. *Id.*

157. *Id.* at 9.

158. *Id.*

159. *Id.* at 9-10.

V. THE REASONABLE EXPECTATIONS OF THE INSURED: TOWARDS A BETTER WAY OF CONSTRUING THE POLLUTION EXCLUSION

If one accepts the exclusion term "fumes" in the *Clendenin Brothers* CGL policy as encompassing welding rod fumes, one is not guilty of torturing the English language, and the court's holding in *Bernhardt* supports such a reading. In light of *Bernhardt,* the *Clendenin* court appears to be manufacturing an ambiguity to achieve a desired result. One commentator has referred to this tendency in insurance jurisprudence as a finding of "constructive ambiguity," that is, a justification for coverage where no such ambiguity exists.[160] Proponents of the reasonable expectations doctrine have suggested that the search for constructive ambiguity is intellectually and philosophically dishonest, and an attempt to justify a hidden agenda.[161] One such proponent, Jeffrey Stempel, has labeled the judicial search for ambiguity as "artificially bipolar," since once adopted as an interpretive tool, it paints the court into the corner by limiting its choices to either apply dictionary definitions to the term mechanically (as in *Bernhardt*), or "construct" ambiguity where it does not exist (as in *Clendenin).*[162] Stempel argues that the pollution exclusion in particular cries out for an examination of the reasonable expectation of the insured as a *prerequisite* to any search for ambiguity, because ambiguity is not merely a product of the dictionary definitions of the words of the contract, but is also evidence of the conflicting intents of the parties; when those intents are radically at odds, circumstances may dictate giving the benefit of the doubt to the insured without resort to Webster's.[163]

Those circumstances, which obtain in *Clendenin Brothers*, may include the loss of long-standing coverage absent clear language consistent with the context of the change in coverage, the expectations of the policyholder at point of purchase, and the possibility that the denial of coverage was "post-claim underwriting," that is, the exploitation of broad policy language with neither notice nor an offer in premium reduction.[164]

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160. Peter Nash Swisher, *Judicial Rationales in Insurance Law: Dusting Off the Formal for the Function*, 52 OHIO ST. L.J. 1037, 1059 (1991).

161. *See id.* at 1061.

162. Jeffrey Stempel, *Reason and Pollution: Correctly Construing the "Absolute" Pollution Exclusion in Context and in Accord With Its Purpose and Party Expectations*, 34 TORT TRIAL & INS. PRAC. L.J.1, 42 (1998).

163. *See id.* at 42-43.

164. *See id.* at 43-44.

Central to the reasonable expectations doctrine is its most controversial tenet: the search for ambiguity utilized in *contra preferentum* will be replaced by an extracontratual analysis. Because an insurance contract is different from an ordinary contract, in that the contract may not recognize certain rights of the insured, the court may depart from traditional analysis of the clear language of the document to enforce those rights.[165]

The reasonable expectations doctrine was first enunciated by name by Robert Keeton in a 1970 article, and may be summed up in a widely-quoted phrase: "Objectively reasonable expectations of applicants and intended beneficiaries will be honored regarding the terms of insurance contracts even though painstaking study of the policy provisions would have negated those expectations."[166] In other words, a court may mandate coverage consistent with an insured's expectations even if clear policy language is to the contrary.[167] A wonderful explication of the doctrine was enunciated by the Iowa Supreme Court:

> The doctrine of reasonable expectations is more than a rule of interpretation. It seeks to avoid the frustration of an insured's expectations notwithstanding policy language that appears to negate coverage. It is a narrow doctrine that is primarily employed when the insurance coverage provided eviscerates terms explicitly agreed to or is manifestly inconsistent with the purpose of the transaction for which the insurance was purchased.[168]

Once the firestorm of controversy cleared from around such an obvious breach with traditional contract interpretation, it became apparent that Keeton's formulation did not spring fully-grown like Athena from the head of Zeus.[169] Insurance law prior to 1970 recognized numerous doctrines that acknowledged at least to some extent the expectations of the insured in coverage disputes: unconscionability, waiver, equitable and promissory

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165. Robert H. Jerry II, *Insurance, Contract, and the Doctrine of Reasonable Expectations*, 5 CONN. INS. L.J. 21, 38 (1998).

166. Robert E. Keeton, *Insurance Law Rights at Variance with Policy Provisions*, 83 HARV. L. REV. 961, 967 (1970).

167. *See* Stempel, *supra* note 162, at 16.

168. Monroe County v. Int'l Ins. Co., 609 N.W.2d 522, 526 (Iowa 2000) (quoting C&J Fertilizer, Inc. v. Allied Mut. Ins. Co., 227 N.W.2d 169, 176 (Iowa 1975)).

169. *See* Peter Nash Swisher, *A Realistic Consensus Approach to the Insurance Law Doctrine of Reasonable Expectations*, 35 TORT TRIAL & INS. PRAC. L.J. 729, 734 (2000).

estoppel, adhesion contracts violating public policy, and reformation of contract.[170] Keeton's doctrine was thus at once a synthesis of these existing doctrines, and a logical step beyond them.

The justification for the reasonable expectations doctrine lies in the notion that since insurance contracts differ in crucial ways from ordinary contracts, a departure from the text's plain meaning may be justified. These differences include: 1) insurance contracts are typically too long and complex to be readily comprehended by the insured;[171] 2) typical insurance sales transactions do not include the insured perusing her contract. Only after application, payment, conditional receipt, review, and decision does the insured ever receive the incomprehensible document. Thus it is fair to say the insured probably bought the coverage based on reasonable expectations of coverage rather than the content of the contract; 3) insurance marketing practices which lead the insured into the transaction foster these expectations; 4) insurance policies are less contracts than products, purchased for the insured's peace of mind and backed by the insurer's fiduciary duty and a duty of good faith and fair dealing;[174] 5) the standardized CGL policy is a classic contract of adhesion, drafted by one party with superior information and sold to a party unsophisticated in the byways of insurance law on a "take-it-or-leave-it" basis.[175] This imbalance of power between the insured and insurer, militating against freedom of contract,[176] is exacerbated by the fact that the purchase of insurance is often mandatory.[177] When the reasonable expectation of coverage is denied, even where the meaning of the provision barring coverage is plain, then the policy "is not fulfilling its intended purpose, unless the court is willing to conclude that the only recognizable purpose is to enrich the insurer . . . . [the policy] has failed in its purpose unless expectations analysis is used to bring the written product into line with the marketed product and the use for which the policy was sold."[178]

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170. *Id.* at 735.

171. *See* STEMPEL, *supra* note 36, at 110.

174. Eugene R. Anderson & James J. Fournier, *Why Courts Enforce Insurance Policyholders' Objectively Reasonable Expectations of Coverage*, 5 CONN. INS. L.J., 335, 379-80 (1998).

175. *Id.* at 361-62.

176. *See id.* at 362.

177. *Id.* at 368.

178. Jeffery W. Stempel, *Unmet Expectations: Undue Restriction of the Reasonable Expectations Approach and the Misleading Mythology of Judicial Role*, 5 CONN. INS. L.J. 181, 291-92 (1998).

Lest these expectations of the insured seem more like after the fact whining, it should be remembered that Keeton stated that these expectations must be objective.[179] One commentator has defined this objective standard as "those [expectations] that are likely to be held by the majority of policyholders."[180] Another commentator has looked to the relationship between the parties for a more nuanced objective standard: where the insurer has so much more information about underwriting considerations, the practices surrounding the enforcement of provisions barring coverage, and the specific needs of a particular insured, the insurer may well have a reason to believe that the insured would not have assented to a particular term if the insured had known at point of purchase that term would have eviscerated coverage.[181]

The reasonable expectations doctrine has had a mixed reception in the courts. After an initial surge of adaptation in many states, its application had gone into decline by the 1980's.[182] Today, it is used, at least as dictum, in half the states,[183] but usually in its weakest form, where the doctrine is resorted to only after a finding of ambiguity in the policy terms.[184] By one reckoning, the number of jurisdictions that apply reasonable expectations in its purest form, where the policy language expressly denies coverage yet the objectively reasonable expectations of the insured must be honored in contravention of the terms, numbers around half a dozen.[185] The current judicial *zeitgeist* of neo-formalism, tort reform, and distrust of judicial activism appears to explain judges' reluctance to embrace the re-writing of the plain language of contract terms employed in the reasonable expectations analysis.[186] Maryland is among the jurisdictions that has never embraced the doctrine at all.[187]

The court in *Clendenin* tiptoed up to a reasonable expectations analysis as dicta, but did not take the plunge, satisfying itself with a finding of

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179. *See* Keeton, *supra* note 166, at 967.

180. Kenneth S. Abraham, *A Theory of Insurance Policy Interpretation*, 95 MICH. L. REV. 531, 559 (1994).

181. Roger C. Henderson, *The Formulation of the Doctrine of Reasonable Expectations and the Influence of Forces Outside Insurance Law*, 5 CONN. INS. L.J. 69, 77 (1998).

182. *See* STEMPEL, *supra* note 36, at 104.

183. *Id.*

184. *Id.* at 4-148.

185. *Id.* at 4-150-51.

186. *See id.* at 162-64.

187. *See id.* at 106, n.348.

ambiguity.[188] Towards the close of the decision, the court observed that the insured has paid premiums for a routine commercial hazard, and that the insurer's utilization of the pollution exclusion to deny coverage to a welding business for workers injured by welding fumes within the normal scope of business would subvert the very purpose of the product that they are selling.[189] But by folding this into a broader examination of the purposes of the exclusion from the insurers standpoint,[190] the court sidestepped the expectations of the insured as grounds for granting coverage.

Clendenin appears to be tailor-made for a reasonable expectations analysis, given the court's dicta implying that coverage should not be eviscerated where denial for welding fumes would negate the purpose of the contract to protect the insured from claims for routine commercial hazards. This dicta could easily be reformulated to jibe with the reasonable expectations doctrine, as one proponent of the principle has succinctly done for us:

> Policyholders have an objectively reasonable expectation that a CGL sold to them by an insurer aware of the policyholder's business activity will provide coverage for the foreseeable and ordinary tort claims that tend to arise out of this activity. This framework requires a constrained, common sense reading of the exclusion when insurers attempt to invoke the exclusion to deny coverage for insured business activity that is not ordinarily referred to as pollution by laypersons.[191]

The plaintiff welding business in *Clendenin* presumably purchased a CGL policy designed to provide coverage when the business injured another through negligence.[192] While the policy contained an exclusion expressly naming "fumes" as a pollutant and would thus seem to bar any fumes-related claim from coverage, a common sense view of commercial activity suggests that small amounts of welding rod fumes are not "pollution" when the manganese is used intentionally and legally in the normal course of the insured's business operations.[193] Any injuries welders

188. Clendenin Bros., Inc. v. U.S. Fire Ins. Co., 889 A.2d 387, 394 (Md. 2006).
189. *See id.* at 398.
190. *See* discussion *supra* Part IV.
191. Stempel, *supra* note 162, at 50.
192. *See id.* at 53.
193. *See id.*

sustained as a result of this predictable use of manganese on the job thus would appear to be covered, as a claim like this one would be precisely the kind the insured bought the policy to cover. The insurer, cognizant of the business of the insured and the type of claims that ordinarily arise from that business, would also likely be aware that a term barring such coverage would be rejected by the insured if it was alerted to the possibility of any such denial of protection.

When *Clendenin* is read in tandem with *Sullins* and *Bernhardt*, through the lens of this brief reasonable expectations analysis, the inconsistent outcomes now make a kind of sense. The welding product manufacturer and the landlord in *Sullins* would both be granted coverage based on the expectation of protection under the policy in the event of ordinary negligence arising out of their respective businesses. As for *Bernhardt*, the fumes in that case might reasonably be seen as pollution, in that the noxious gases emitted, unlike the welding rod fumes, were not an ordinary consequence of the landlord's normal use of the heating systems. Under this reading, it is no longer inconsistent and outcome-oriented to hold that fumes are not pollution in *Clendenin*, while they are pollution in *Bernhardt*, where the language of the policy is nearly identical in both cases. Constructive ambiguity is replaced by a pragmatic, real-world approach.

CONCLUSION

The pollution exclusion remains one of the most hotly contested areas of coverage litigation. Given the murk and uncertainty surrounding the occult science of judicial interpretation of insurance contract language, the law is not well-served by courts hunting for constructive ambiguities. The Maryland courts have staked themselves to giving strained interpretations to the dictionary meaning of the word "fumes," by pursuing ambiguities that may not exist. The next time it is confronted with a carbon monoxide claim case like *Bernhardt*, it may either have to reverse itself, or alternatively torture the English language still further to reconcile a finding for the insurer with *Clendenin* in the name of *stare decisis*. Application of the reasonable expectations analysis would have brought forth the same outcome in *Clendenin*, without inviting the confusions which follow mauling beat-up copies of Webster's. The reasonable expectations doctrine further looks to the real world, which governs the relationship between insureds and insurers, and hence would bring insurance law into the currents of legal realism which trumped formalist textualism generations ago. The reasonable expectations doctrine is redolent of the great tradition of American pragmatic thought, which is one of our gifts to the world, and

not an invitation to deconstructionist subjectivity. We should not fear Judge Keeton's doctrine, but honor it.

COMMENT: STRENGTHEN PHARMACEUTICAL PATENT RIGHTS: LOWERING THE COST OF PRESCRIPTION DRUGS BY STOPPING THE RECKLESS PATENT LITIGATION ABUSE OF GENERIC COMPANIES

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INTRODUCTION

In recent years, lowering the cost of prescription drugs has been a hot topic on Capitol Hill. Many lives are saved and prolonged each year by prescription drugs. In recent years, new drugs have been produced that lower cholesterol and help prevent heart disease,[1] fight cancer,[2] and treat diabetes,[3] just to name a few. Pharmaceutical companies are also developing drugs to treat Alzheimer's disease,[4] Parkinson's disease,[5] and many other illnesses. But are the costs of these life-saving drugs fair or too expensive?

At the outset, it is worth pointing out that there is a general consensus that the cost of prescription drugs is high. However, there are some people who disagree with this assertion and believe that prices are fair or alternatively, that there is no evidence that the cost is high. Others do not believe that the problem lies with the pharmaceutical companies, but instead point the finger at the government and insurance companies. Critics often do not specifically state why they are upset with the high cost of drugs. The criticism seems to be based on three foundations. First, there is a belief that pharmaceutical companies should not be profiting off of drugs that save peoples lives and at the least, the amount of profit should not be as high as it is. Second, some are outraged that pharmaceutical companies profit off of drugs as people around the world die from diseases that are treatable by drugs. Finally, others simply believe that they should not have to pay for prescription drugs or anything that saves or extends their lives. This Comment does not take a position as to whether one

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1. Alex Berenson, *Merck Loses Protection For Patent On Zocor*, N.Y. TIMES, June 23, 2006, at C1 (commenting on how Pfizer's Lipitor and Merck's Zocor are both "drugs that slow the liver's ability to produce low-density lipoprotein cholesterol, often called bad cholesterol because it can build up in blood vessels and lead to heart attacks and strokes").

2. Associated Press, *Leukemia Drug Wins Approval*, N.Y. TIMES, June 29, 2006, at C6 (noting that the Food and Drug Administration approved Bristol Myers Squibb's drug Sprycel to treat chronic myeloid leukemia).

3. Alex Berenson, *4 Diabetes Drugs Are Seen Raising Hope and Profit*, N.Y. TIMES, June 22, 2006, at A1 (the article points out that two new drugs have been approved to treat diabetes, with two more expected to be approved by early in 2007).

4. Phrma.com, New Medicines Database; Alzheimer's Disease, http://newmeds.phrma.org/results.php?drug=&indication=121&company=&status= (last visited Apr. 16, 2007) (website shows that there are currently 62 compounds under development to treat Alzheimer's disease).

5. *Id.* (website shows that there are currently 33 compounds under development to treat Parkinson's disease).

particular side of the debate is correct, but instead concludes by proposing a solution to reducing the cost of prescription drugs.

Some critics try to portray pharmaceutical companies as villains raking in profits while average people cannot afford the drugs that they need to live.[6] Other critics blame the patent system for the high cost of prescription drugs, since a patent grants a pharmaceutical company exclusivity on its product for a period of years during which the company has no competition.[7] These critics offer the solution of compulsory licensing where the government forces the patentee to license the invention to a third party when the government does not approve of the patentee's use of the patent.[8] The belief is that compulsory licensing would lead to more competition, increase the amount of the prescription drug available on the market, and lower the overall cost.[9]

Compulsory licensing is not the only threat to a pharmaceutical company's patent. Generic companies have attacked pharmaceutical companies' patents around the globe, attempting to gain access to the marketplace before the patent's period of exclusivity has run. This behavior forces the pharmaceutical companies to spend a great deal of their resources to defend their patents in all countries in which their patent rights are being threatened.

This Comment focuses on the intellectual property aspects of the debate on the cost of prescription medications. One interesting aspect of the United States patent system is that the Patent Office prints the patent for all to see, so that the patent is not a secret.[10] As a result, an infringing company on the other side of the world can produce the exact chemical compound from the patent without having to spend millions of dollars on research, development, and clinical trials to have it approved for human use.[11] In response to the generic company's attempt to access the market,

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6. *See, e.g.*, Oversight.house.gov, Committee on Oversight and Gov. Reform: Investigations; Prescription Drugs, http://oversight.house.gov/investigations.asp?Issue=Prescription+Drugs (last visited April 16, 2007) (Rep. Waxman is the Chairman of the Committee on Oversight and Government Reform and a critic of the pharmaceutical industry).

7. Alan M. Fisch, *Compulsory Licensing of Pharmaceutical Patents: An Unreasonable Solution to an Unfortunate Problem*, 34 JURIMETRICS J. 295, 296 (1994).

8. Cole M. Fauver, *Comments: Compulsory Patent Licensing in the United States: An Idea Whose Time Has Come*, 8 NW. J. INT'L L. & BUS. 666, 667 (1988).

9. Fisch, *supra* note 7, at 296-97.

10. 35 U.S.C. § 122 (2000).

11. As will be discussed later, pharmaceutical companies spend years testing their products in clinical trials. Generic companies only need to show that their products have the

the pharmaceutical company is forced to sue the infringer, sometimes in dozens of countries, to prove the generic company is infringing; defend the validity of its patent; and enjoin the generic company from using, selling, and manufacturing the product.

Additionally, consider the example of a generic company that develops a product from a patent published by the Patent Office. This company, now ready to put its product on the market, begins an aggressive campaign in numerous countries to challenge the validity of the patent. Even if the infringing company is successful in only a few cases, the patent holder's rights are significantly diminished. Moreover, even losing in a couple of jurisdictions can lead to a cascading effect, especially in places like the European Union where the decision of the EU regulatory body can be binding on almost all member countries.

This Comment addresses the need to strengthen, not weaken, the patent regime under which pharmaceutical companies operate, which will in turn lower the price of prescription drugs. Part I of this Comment introduces the patent system. Part II discusses criticisms of the pharmaceutical industry, the role that patent protection plays in the pharmaceutical industry, and concludes with a discussion of the negative effects which compulsory licensing would have on the pharmaceutical industry. Part III focuses on litigation between pharmaceutical companies and generic companies, specifically looking at Pfizer's legal battles with Ranbaxy over Lipitor. Finally, Part IV discusses insurance in the intellectual property field and suggests methods of lowering the cost of prescription drugs by strengthening the patent system through deterrence of abusive patent litigation by generic companies.

I. INTRODUCTION TO THE PATENT SYSTEM

The United States Constitution gives Congress the authority "[t]o promote the progress of science and useful arts, by securing for limited times to authors and inventors the exclusive right to their respective writings and discoveries."[12] In 1790, Congress enacted the first law establishing a patent system.[13] The goal of the patent system is to

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same effect as the patented/approved product to gain access to the market through an Abbreviated New Drug Application (ANDA).

12. U.S. CONST. art I, § 8, cl. 8.

13. Act of Apr. 10, 1790, ch. 7, 1 Stat. 109 (1790) (the Act "authorized patents for 'any useful art, manufacture, engine, machine, or device, or any improvement therein not before known or used,' provided a designated group of executive officers (the Secretary of

encourage research, development, and innovation by giving inventors an incentive to carry on their work.[14] The incentive for the inventor is that the award of a patent gives a period of exclusivity such that others cannot use the new technology during that period, thereby allowing the inventor to enter the market without competition during that time of exclusivity.[15] Patents also help the public by disseminating technical information that, without the protection of the patent, would remain secret.[16] This gives the public the opportunity to build on the work of previous innovators and bring more inventions to the marketplace.

An invention will only receive patent protection if it is of patentable subject matter.[17] That means that the patent must fall into one of four statutorily defined classes: (1) a process, (2) a machine, (3) a composition of matter, or (4) a manufacture.[18] Simply put, if the invention does not fall within one of these four statutory classes, it cannot be patented.[19] Moreover, ideas and theories cannot be patented.[20] Process is defined as "process, art or method, and includes a new use of a known process, machine, manufacture, composition of matter, or material."[21] More specifically, the process is a way to produce a desired result.[22] Process inventions include such things as the manufacture of chemicals, the treating of metals, mechanical processes, and electrical processes.[23] But processes that require mental participation or emotional reactions are not patentable.[24] Machines, the second statutory class, are generally defined as "an assemblage of parts that transmit forces, motion, and energy to one another

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State, the Secretary of War, and the Attorney General) determined that the invention was 'sufficiently useful and important.'"). *See also* 1 DONALD S. CHISUM, CHISUM ON PATENTS § OV[2] (2007).

14. *See* PAUL GOLDSTEIN, COPYRIGHT, PATENT, TRADEMARK AND RELATED STATE DOCTRINES, CASES AND MATERIALS ON THE LAW OF INTELLECTUAL PROPERTY 16 (4th ed. 1997).

15. *Id.*

16. *Id.*

17. *See* HERBERT F. SCHWARTZ, PATENT LAW AND PRACTICE § 4 (4th ed. 2003).

18. 35 U.S.C. § 101 (2000). *See also* ARTHUR H. SEIDEL ET AL., WHAT THE GENERAL PRACTITIONER SHOULD KNOW ABOUT PATENT LAW AND PRACTICE § 2.03 (5th ed. 1993).

19. *Id.*

20. *See* Parker v. Flook, 437 U.S. 584, 585 (1978) ("...the discovery of a novel and useful mathematical formula may not be patented.").

21. 35 U.S.C. § 100(b) (2000).

22. SCHWARTZ, *supra* note 17, § 4.I.A.1.

23. *See* SEIDEL ET AL., *supra* note 18, § 2.03(a).

24. SCHWARTZ, *supra* note 17, § 4.I.A.1.

in a predetermined manner."[25] Engines, lathes, and computers are examples of machines.[26]

The third statutory class, composition of matter, is the combination of two or more substances creating a new substance.[27] Composition of matter can include mixtures of chemicals, polymers or other chemical compounds, organic compounds, and many others.[28] The fourth and final statutory class, manufacture or article of manufacture, is anything man-made and not a machine or composition of matter.[29] Manufacture includes things such as clothing, tables, and tools lacking moving parts.[30]

In addition to the requirement that the invention be of a patentable subject matter, the patent must also be useful, new, and nonobvious.[31] To be useful, at the bare minimum the product or process must work, although it does not need to work perfectly.[32] Even when a product works, it may not be considered useful if it is being used for an illegal or immoral purpose and a process will not be useful if it leads to products that are not useful.[33] The threshold for usefulness, however, is not high.[34]

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25. *Id.* at § 4.I.A.2.

26. SEIDEL ET AL., *supra* note 18, § 2.03(b).

27. Diamond v. Chakrabarty, 447 U.S. 303, 308 (1980). In *Diamond*, the Supreme Court held that a genetically engineered bacteria was patentable after the patent examiner decided that a living material could not be patent protected. *Id.* at 310. Because the genetically engineered bacteria displayed characteristics not found in nature, the bacteria was patentable. *Id.*

28. *See* SEIDEL ET AL., *supra* note 18, § 2.03(d).

29. *See* SCHWARTZ, *supra* note 17, § 4.I.A.4. Note that in *Diamond*, the Supreme Court never explicitly decided whether the genetically engineered bacteria was a manufacture or a composition of matter. So while a manufacture is not a composition of matter, it could qualify as either, and the patent application does not need to specify in which statutory class the invention fits. *Id.*

30. SEIDEL ET AL., *supra* note 18, § 2.03(c).

31. SCHWARTZ, *supra* note 17, § 4.

32. *Id.* at § 4.I.B.

33. *Id. See, e.g.*, Brenner v. Manson, 383 U.S. 519, 535 (1966) (holding that a patent could not be given to a process that produced no useful products).

34. *See, e.g.*, Juicy Whip, Inc. v. Orange Bang, Inc., 185 F.3d 1364, 1366 (Fed. Cir. 1999) ("The threshold of utility is not high: An invention is "useful" under section 101 if it is capable of providing some identifiable benefit."); Brooktree Corp. v. Advanced Micro Devices, Inc., 977 F.2d 1555, 1571 (Fed. Cir. 1992) ("To violate § 101 the claimed device must be totally incapable of achieving a useful result"); Fuller v. Berger, 120 F. 274, 275 (7th Cir. 1903) (the test for utility is whether invention "is incapable of serving any beneficial end").

For a product or process to be novel, it must differ in a significant way from previous inventions.[35] To determine if the invention is new, it will be compared to the prior inventions in that field.[36] The investigation into the novelty of the invention will take place by looking at whether the invention was known to, or used by, others prior to the patent applicant's invention.[37] Additionally, the investigation will determine if the invention was patented, described, used, or sold more than a year prior to the patent application.[38] Novelty will also compare the timing of the patent application submission with the publication by the USPTO of any similar patent applications.[39] Finally, the novelty of an invention can become an issue where an initial person pursuing an idea abandons, suppresses, or conceals the invention and a second person attempts to patent the invention.[40]

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35. *See* SEIDEL ET AL., *supra* note 18, § 2.04.

36. *See* SCHWARTZ, *supra* note 17, § 4.I.C.

37. 35 U.S.C. § 102(a) (2000) ("A person shall be entitled to a patent unless...the invention was known or used by others in this country, or patented or described in a printed publication in this or a foreign country, before the invention thereof by the applicant for patent").

38. 35 U.S.C. § 102(b) (2000) ("A person shall be entitled to a patent unless...the invention was patented or described in a printed publication in this or a foreign country or in public use or on sale in this country, more than one year prior to the date of the application for patent in the United States").

39. 35 U.S.C. § 102(e) (2000) ("A person shall be entitled to a patent unless...the invention was described in (1) an application for patent, published under section 122(b), by another filed in the United States before the invention by the applicant for patent or (2) a patent granted on an application for patent by another filed in the United States before the invention by the applicant for patent, except that an international application filed under the treaty defined in section 351(a) shall have the effects for the purposes of this subsection of an application filed in the United States only if the international application designated the United States and was published under Article 21(2) of such treaty in the English language"). Since the USPTO is required to publish patent applications, Section 102(e) is concerned with individuals who may have taken the idea for the patent from an application already under consideration by the USPTO.

40. 35 U.S.C. § 102(g) (2000) ("A person shall be entitled to a patent unless...(1) during the course of an interference conducted under section 135 or section 291, another inventor involved therein establishes, to the extent permitted in section 104, that before such person's invention thereof the invention was made by such other inventor and not abandoned, suppressed, or concealed, or (2) before such person's invention thereof, the invention was made in this country by another inventor who had not abandoned, suppressed, or concealed it. In determining priority of invention under this subsection, there shall be considered not only the respective dates of conception and reduction to practice of the invention, but also the reasonable diligence of one who was first to conceive and last to reduce to practice, from a time prior to conception by the other.").

Even if an invention is useful and new, a patent will not be issued unless the invention also meets the criteria for being nonobvious. Congress codified the requirement that an invention must be nonobvious from the judicially-created requirement of "invention."[41] To be nonobvious, the invention must be something that an ordinary person in the field would not have been able to figure out.[42] The invention must be more than a simple improvement; it must be something special, something worthy of patent protection.

After an investigation, if the Patent Office establishes that a patent application meets the legal requirements, it will issue a patent to the inventor.[43] A patent establishes a period of exclusivity for twenty years from the date when the patent application is filed.[44] In effect, the period of exclusivity is around seventeen years given that the Patent Office has three years to make a decision.[45]

Once a product is patented, any other person who makes, uses, sells, or offers to sell the product within the United States has infringed upon the patent.[46] To redress infringement of the patent, the patentee may bring a lawsuit against the infringer seeking an injunction and/or monetary damages.[47] In exceptional cases where a court finds willful infringement of

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41. SCHWARTZ, *supra* note 17, § 4.I.D. The requirement of "invention" was presented by the Supreme Court in *Hotchkiss v. Greenwood*, 52 U.S. 248 (1851). In *Hotchkiss*, the patent applicant merely substituted a knob of clay for one made of metal or wood. *Hotchkiss*, 52 U.S. at 254. The Court determined that this improvement did not require any ingenuity or particular skill and that anyone familiar with the process could have made a similar improvement, therefore there was no invention only an improvement. *Id.* at 267.

42. 35 U.S.C. § 103(a) (2000) ("A patent may not be obtained though the invention is not identically disclosed or described as set forth in section 102 of this title, if the differences between the subject matter sought to be patented and the prior art are such that the subject matter as a whole would have been obvious at the time the invention was made to a person having ordinary skill in the art to which said subject matter pertains. Patentability shall not be negatived by the manner in which the invention was made.").

43. *Id.* § 153.

44. *Id.* § 154.

45. *See id.* § 154(b)(1)(B).

46. *Id.* § 154(a)(1).

47. *Id.* § 283-84. *See generally* EBay Inc. v. MercExchange, 126 S. Ct. 1837 (2006) (discussing how district courts should consider an application for permanent injunctive relief in patent cases); Aro Mfg. Co. v. Convertible Top Replacement Co., 377 U.S. 476 (1964) (discussing considerations that should be made when awarding damages and stating that the idea is to put the patent holder in the position he would have been in had the infringement not occurred).

a patent, the court may award attorney's fees and triple damages.[48] After the patent has expired, anyone may make, use, sell, or offer to sell the product within the United States without the danger of infringing upon a patent.

While patents are intangible, they possess the attributes of personal property.[49] That means that the patent holder can sell his or her patent to another party.[50] That sale can include all the rights to the patent or just specific bargained for rights to the patent (such as the right to sell the patented product in a certain state). Additionally, a patent holder can enter into a patent license agreement with a party interested in using the patent without being an infringer.[51] A typical license agreement allows the licensee to make, use, and sell the patented product in exchange for royalty payments.[52]

II. PATENTS IN THE PHARMACEUTICAL INDUSTRY CONTEXT

A. PATENTS ALLOW THE PHARMACEUTICAL INDUSTRY TO EXIST

Patents play an important role in the pharmaceutical industry. It is widely believed that without the protection of patents, all research and development of new drugs by these companies would cease to exist.[53] This is because a competitor could duplicate a drug after analyzing the chemical composition of the drug, and then begin to manufacture the drug without

48. 35 U.S.C. § 284-85 (2000). *See also* Serio-US Indus. v. Plastic Recovery Techs. Corp., 459 F.3d 1311, 1321-22 (Fed. Cir. 2006) ("Exceptional cases usually feature some material, inappropriate conduct related to the matter in litigation, such as willful infringement, fraud or inequitable conduct in procuring the patent, misconduct during litigation, vexatious or unjustified litigation, conduct that violates Federal Rule of Civil Procedure 11, or like infractions. . . . Absent misconduct in the litigation or in securing the patent, a trial court may only sanction the patentee if both the litigation is brought in subjective bad faith and the litigation is objectively baseless.").

49. *See* 35 U.S.C. § 261 (2000).

50. "The patentee may surrender his monopoly in whole by the sale of his patent or in part by the sale of an article embodying the invention. His monopoly remains so long as he retains the ownership of the patented article. But sale of it exhausts the monopoly in that article and the patentee may not thereafter, by virtue of his patent, control the use or disposition of the article." United States v. Univis Lens Co., 316 U.S. 241, 250 (1942).

51. *See generally* Medimmune, Inc. v. Genentech, Inc., 127 S. Ct. 764, 767-68 (2006).

52. *Id.*

53. DAVID SCHWARTZMAN, INNOVATION IN THE PHARMACEUTICAL INDUSTRY 4 (1976).

much difficulty.[54] In this regard, the innovators in the pharmaceutical industry stand at a stark disadvantage to those who are developing satellites, communication devices, and other high-tech hardware that is difficult to replicate.[55] In the pharmaceutical industry, an innovator could pour large amounts of money into developing and bringing to market a new drug, and without patent protection, lose that entire investment to a competitor who merely copied the innovator's invention.

The cost of developing and bringing new pharmaceutical products to market is quite high. Pharmaceutical companies spend on average $897 million to develop a new prescription drug.[56] Thousands of compounds are investigated for every one that makes it to human testing.[57] Of those compounds that make it to human testing, only one in five will eventually gain approval of the Food and Drug Administration (FDA), and make it to market.[58] In addition, the patent is issued years before the pharmaceutical companies can actually sell the product in the marketplace. For example, the average development time of a drug went from 8.1 years in the 1960s to 14.2 years in the 1990s.[59] The amount of time the product spends in development cuts down on the period of exclusivity the product enjoys from patent protection. One estimate puts the average patent life for a pharmaceutical drug at eleven years, which is well below the patent life inventors enjoy in other industries.[60]

Advocates of strong patent protection for pharmaceutical patents point to four important roles patents play in advancing innovation. First, without patent protection in the early stages of research and development, pharmaceutical companies would not be encouraged to make the necessary initial investments to explore and developing new compounds.[61] Second,

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54. *Id.*

55. *Id.*

56 *Total Cost to Develop a New Prescription Drug, Including Cost of Post-Approval Research, is $897 Million* (May 13, 2003), http://csdd.tufts.edu/NewsEvents/RecentNews.asp?newsid=29 (last visited Sept. 10, 2007).

57. Henry Grabowski, *Pharmaceuticals: Politics, Policy and Availability: Patents and New Product Development in the Pharmaceutical and Biotechnology Industries*, 8 GEO. PUBLIC POL'Y REV. 7, 9 (2003).

58. *Id.*

59. PHARMACEUTICAL RESEARCH AND MANUFACTURERS OF AMERICA, DELIVERING ON THE PROMISE OF PHARMACEUTICAL INNOVATIONS: THE NEED TO MAINTAIN STRONG AND PREDICTIABLE INTELLECTUAL PROPERTY RIGHTS 8 (2002), http://www.ftc.gov/os/comments/intelpropertycomments/phrma020422.pdf.

60. *Id.* at 9-10.

61. *Id.* at 2.

patent protection encourages pharmaceutical companies to continue to improve and experiment with already developed products to find more possible uses for the products.[62] Third, patent protection allows the pharmaceutical company to make money, which enables the company to recoup costs and to pursue new avenues of research and drug development.[63] Finally, patent protection enables generic companies to enter the market when the period of exclusivity expires.[64] While patent protection is beneficial to the pharmaceutical industry, patent protection is also beneficial to the consumer who relies on pharmaceutical products to maintain a high quality of life.

Advocates of the current patent regime also point out the vast amount of pharmaceutical research and development costs which are borne by these companies. One study found that between 1981 and 1990, the pharmaceutical industry was responsible for 181 of the 196 compounds approved by the FDA.[65] The pharmaceutical industry accounted for 92.4% of approved drugs while government and academia were the source of only 4.6%.[66] In 2001, the pharmaceutical industry invested $30.3 billion[67] in research and development of new drugs while the National Institute of Health spent $20.3 billion,[68] not all of which was used on research and

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62. *Id.*

63. *Id.*

64. *Id.* Note that generic companies can enter the market when the period of exclusivity expires because they have already developed the product using the description of the patent published by the USPTO. *See id.* at 15-16. Moreover, the generic company usually obtains Food and Drug Administration (FDA) approval before the period of exclusivity is over. *Id.* This allows them to enter the marketplace without having to expend a great deal of funds to replicate the product and to enter the marketplace at the first available opportunity.

65. PHARMACEUTICAL RESEARCH, *supra* note 59, at 5 n.11.

66. *Id.*

67. *Id.* at 6.

68. The National Institutes of Health (NIH) is composed of 27 Institutes and Centers whose collective mission is to sponsor and conduct medical research and research training that leads to better health for all Americans. In this manner, the NIH expands fundamental knowledge about the nature and behavior of living systems; improves and develops new strategies for the diagnosis, treatment, and prevention of disease; reduces the burdens of disease and disability; and assures a continuing cadre of outstanding scientists for future advances. In fiscal year 2001, the NIH received $20.3 billion in support of its mission. Of that amount, nearly 84 percent supports non-Federal researchers working in universities, medical centers, hospitals, and research institutions throughout the country and abroad (collectively referred to as extramural research), and about 10 percent is allocated to in-house research laboratories located on the NIH campus and several off-campus sites (referred to as intramural research). NAT'L INST. OF HEALTH, A PLAN TO ENSURE

development of pioneer drugs. The implementation of strong intellectual property rights leads to innovators being willing to risk money in research and development where otherwise no innovation would take place.[69] If the pharmaceutical industry lost patent protection, there would be little incentive to engage in research and development, and the government would need to heavily invest in research and development to continue bringing new drugs to the market.

B. CRITICISMS OF THE PHARMACEUTICAL INDUSTRY AND THE PROPOSAL TO IMPLEMENT COMPULSORY LICENSING

Critics of the pharmaceutical industry are not happy with the high cost of prescription drugs. For example, state workers in Georgia have a $100 copay for certain brand name medications, which is thought to be the highest copay in the nation.[70] More and more money is spent on prescription drugs. For example, in 2005 prescription drug spending increased 5.8%, the lowest level in a number of years and well down from its peak of 18.2% in 1998.[71] To restrain prescription drug costs, states and employers have pushed for higher rebates on selected name brand drugs, and then forced employees to use these drugs or take generic drugs.[72] The high cost of health care, with a significant portion coming from the cost of prescription drugs, has lead many companies, notably General Motors, to cease giving retirement benefits.[73] The cost of prescription drugs is causing numerous hardships for the government and for most employers.

TAXPAYERS' INTERESTS ARE PROTECTED (July 2001), *available at* http://www.nih.gov/news/070101wyden.htm.

69. PHARMACEUTICAL RESEARCH, *supra* note 59, at 10. The article points out that research and development spending tripled in Mexico after the country adopted intellectual property rights. Similar increases were seen in Canada, South Korea, Japan, and Italy. One notable exception is India, which does not provide full patent protection, and accounts for only .001% of worldwide research and development. *Id.*

70. Barbara Martinez, *Drug Co-Pays Hit $100 --- To Curb Rising Prescription Costs, Companies Try Range of Tactics to Push Employees to Cheaper Medicines*, WALL ST. J., June 28, 2005, at D1.

71. Jane Zhang, *Growth in U.S. Health-Care Spending Slows Again*, WALL ST. J., Jan. 9, 2007, at A2.

72. *Id.*

73. David Wessel et al., *Pressured GM Slashes Pay, Benefits; Pension Curb Accelerates Broad Corporate Shift On Worker Guarantees; The End of Retirement?*, WALL ST. J., Feb. 8, 2006, at A1 (discussing this trend at many companies, notably General Motors).

While the cost of some drugs can be high, pharmaceutical industry proponents point to the significant amount of money that is saved by the use of prescription drugs. In 2000, Congress's Joint Economic Committee estimated that treatments for tuberculosis save $5 billion a year, polio treatments save $30 billion a year, drugs for treating depression save $6.5 billion, and drugs for ulcers save $600 million a year.[74] The Committee also estimated that the cost of drugs for an AIDS patient each year could cost $15,000, but compare that to the cost of a hospital room which would be around $100,000.[75] One treatment for breast cancer victims cost $1,050 a year whereas other treatments such as surgery could cost around $14,000.[76] Additionally, another organization concluded that the increase in life expectancy in the 1970's and 1980's was worth $57 trillion and the gains from the prevention and treatment of heart disease were worth $31 trillion, brought about in part by new development in prescription drugs.[77] Another scholar estimated that drugs developed between 1983 and 1996 reduced the number of people unable to work by 1.4 million, resulting in a benefit of $43 billion a year.[78] Moreover, the lower absenteeism resulted in a further benefit of $10 billion a year.[79] The cost of disease in this nation is quite high, but while prescription medications can be expensive, these medications have greatly aided the American economy and the productivity of the workforce.

But even if prescription drugs do reduce overall medical expenses and generate benefits for the economy as a whole, critics suggest that the high cost of prescription drugs is not justifiable. In response to the high cost of prescription drugs, some suggest the use of compulsory licensing to help reduce the cost of prescription medications.[80] In general, compulsory

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74. Morton M. Kondracke, *Investing Billions in Health Care Can Save Trillions*, ROLL CALL, May 25, 2000, at Pennsylvania Avenue.

75. *Id.*

76. *Id.*

77. *Id.*

78. Frank Lichtenberg, Prof. of Business, Columbia Univ. Bus. Sch., Remarks at the Manhattan Institute's Health For Humanity: How Patent Protection Saves Lives Panel (Dec. 9, 2002), *available at* http://www.manhattan-institute.org/html/cmp12-02.htm.

79. *Id.*

80. *See* Debjani Roy, Note, *In Search of the Golden Years: How Compulsory Licensing Can Lower the Price of Prescription Drugs for Millions of Senior Citizens in the United States*, 52 CLEV. ST. L. REV. 467, 472 (2005); Ruth E. Freeburg, Comment, *No Safe Harbor and No Experimental Use: Is It Time for Compulsory Licensing of Biotech Tools?*, 53 BUFF. L. REV. 351, 408 (2005); Colleen Chien, *Cheap Drugs at What Price to Innovation: Does the Compulsory Licensing of Pharmaceuticals Hurt Innovation?*, 18 BERKELEY TECH. L.J. 853, 853 (2003).

licensing is where the government of a given nation gives a license to a third party to use a patent without the permission of the actual holder of the patent.[81] Most often the government invokes compulsory licensing when the patent holder does not use the patent. The United States government allows compulsory licensing in only a few, specific situations.[82] These situations include matters of national security, environmental national interest, and antitrust disputes.[83] On several different occasions, the United States Supreme Court has discussed the incompatibility of compulsory licensing with the current patent system and Congress's intention for how the patent system works.[84] In fact, patent law explicitly states that a patent owner who would be entitled to damages in an infringement suit cannot be denied relief or be deemed guilty of misuse for failing to license or use the rights of a patent.[85] The United States Congress and Judiciary carefully considered compulsory licensing and decided that it is incompatible with the purpose and goal of the patent system in this country.

Foreign countries are more willing to grant compulsory licenses when the government believes the patent owner is not using the patent in its country, or is not using the patent adequately.[86] Compulsory licensing of pharmaceutical patents, while not currently practiced in the United States, does take place in a number of foreign countries.[87] The use of compulsory licensing by foreign nations, especially countries without much industry and innovation, is not surprising considering that they do not have intellectual property portfolios to protect. In effect, compulsory licensing allows them to take advantage of countries that have invested heavily in

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81. Sara M. Ford, Comment, *Compulsory Licensing Provisions Under the TRIPs Agreement: Balancing Pills and Patents*, 15 AM. U. INT'L L. REV. 941, 945 (2000).

82. *See* Adi Gillat, *Compulsory Licensing to Regulated Licensing: Effects on the Conflict Between Innovation and Access in the Pharmaceutical Industry*, 58 FOOD & DRUG L.J. 711, 713-15 (2003).

83. *Id.* at 714-15.

84. *See* Special Equip. Co. v. Coe, 324 U.S. 370, 378-79 (1945) (stating that failure of the patent holder to use his patent did not affect the validity of the patent); Dawson Chem. Co. v. Rohm & Haas Co., 448 U.S. 176, 215 n.21 (1980) ("Compulsory licensing of patents often has been proposed, but it has never been enacted on a broad scale.").

85. The relevant language provides: "No patent owner otherwise entitled to relief for infringement or contributory infringement of a patent shall be denied relief or deemed guilty of misuse or illegal extension of the patent right by reason of his having done one or more of the following: . . . (4) refused to license or use any rights to the patent . . . ." 35 U.S.C. § 271(d)(4) (2000).

86. *See* Ford, *supra* note 81, at 945.

87. *See* Freeburg, *supra* note 80, at 409 (noting that Denmark, France, Italy, Germany, Spain, Sweden, and Switzerland allow compulsory licensing in their patent laws).

developing new products. So the costs of pharmaceutical products developed in the United States, Canada, Japan, and Europe are borne almost entirely by the consumers in those countries, while consumers elsewhere in the world bear little to none of the cost. That is why industry leaders, not just in the pharmaceutical industry, pushed for a worldwide treaty requiring nations to implement stronger intellectual property rights.[88]

Developing countries believe that compulsory licensing is key to ensuring that their citizens receive affordable access to medicines.[89] Whether compulsory licensing actually improves access to medicines or works as an industrial development tool is unclear.[90] Advocates of compulsory licensing have argued that the current patent regime is preventing HIV/AIDS patients in Africa and elsewhere from receiving the prescription drugs that they need to extend and save their lives.[91] As a result of this criticism, the World Trade Organization gives member nations the right to grant compulsory licenses and to determine what events constitute national emergencies.[92] It is unclear how this policy will actually affect intellectual property rights, however, due to the procedural requirements a country needs to fulfill in order to gain a compulsory license.[93] Needless to say, compulsory license advocates are still not happy with the result, and they continue to press for compulsory licensing here in the United States.[94]

Compulsory licensing is nothing more than an attempt to weaken strong patent protection regimes that encourage and foster innovation and discovery in the pharmaceutical markets. Compulsory licensing advocates argue that only through compulsory licensing can cheaper prescription drugs get to the market. These advocates are correct in saying that compulsory licensing will bring more cheap, existing prescription drugs to

88. *See* PETER DRAHOS, *Intellectual Property Engineering: The Role of the Chemical, Pharmaceutical and Biotechnology Industries, in* INTELLECTUAL PROPERTY AND BIOLOGICAL RESOURCES 258, 260-64 (Burton Ong ed., 2004).

89. KATHARINE GAMHARTER, ACCESS TO AFFORDABLE MEDICINES: DEVELOPING RESPONSES UNDER THE TRIPS AGREEMENT AND EC LAW 159 (2004).

90. *Id.*

91. *See id.* at 161.

92. *Id.* at 160-61. HIV/AIDS has been listed as an example.

93. *See id.* at 238-46 (discussing procedural requirements for obtaining a compulsory license).

94. *See* Roy, *supra* note 80, at 472; Freeburg, *supra* note 80, at 408; Chien, *supra* note 80, at 853, 896-97.

the market.[95] However, they also believe that compulsory licensing will have no effect on research and development of new pharmaceutical products. Unfortunately, compulsory licensing would result in a decrease in research and development spending, which in turn would lead to a dearth of new pharmaceutical products that the public has come to expect and rely upon.

There are several examples showing the effect of compulsory licensing schemes on various countries. In anticipation for the approval of the Agreement on Trade Related Aspects of Intellectual Property (TRIPS), Indian firms increased their spending on research and development.[96] Indian pharmaceutical companies shifted money from the development of imitative processes to the search for brand new compounds.[97] Another example is that of Canada. After Canada weakened its compulsory licensing regime in 1987 and eliminated the regime in 1993 to comply with TRIPS, Canada experienced an increase in research and development spending from $166 million in 1988 to $900 million in 1999.[98] A study of British companies estimated that compulsory licensing would result in sales declining 68% and spending on research and development would decline 64%.[99] Additionally, a study by economist Edwin Mansfield found that without patent protection, 65% of pharmaceutical products would not have been introduced and 60% would not have been developed.[100] Compulsory licensing and weakening patent protection would have serious negative consequences to the development and introduction of new pharmaceutical products throughout the world.

Compulsory licensing presents four distinct problems for pharmaceutical companies compared to companies in different industries. First, pharmaceutical research is expensive, time consuming, and extremely risky.[101] These high costs and risks increase the fear of diminished profits and impair the incentives to engage in research and development.[102] Combined with the high costs of research and development and the risk

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95. All sides of the debate agree that compulsory licensing will lower the cost of prescription drugs. It is the effect that compulsory licensing has on innovation, research, and development which is at issue.

96. *See* Gillat, *supra* note 82, at 720.

97. *Id.*

98. PHARMACEUTICAL RESEARCH AND MANUFACTURERS OF AMERICA, *supra* note 59, at 10.

99. *See* Gillat, *supra* note 82, at 722.

100. *Id.*

101. *Id.*

102. *Id.* at 723.

involved in the process, the addition of compulsory licensing further weakens any reason for pharmaceutical companies to put their capital at risk. Secondly, the pharmaceutical industry does not have any type of trade secret protection[103] and is highly regulated by the federal government. Since anyone can find out the chemical compound used in any prescription drug, weakening the patent system through compulsory licensing would expose the patent holder to more competition and further impair any motivation for the pharmaceutical company to engage in innovative behavior.

Third, compulsory licensing ignores the significant investment the pharmaceutical company has put into developing the drug. After initial development of the patented compound, it is relatively easy to replicate the compound.[104] Compulsory licensing allows a competitor to profit from a product it did not put any investment of time or capital into. Fourth, royalties from compulsory licensed patents are set by a government entity and not through negotiation with the patent holder.[105] Low royalties will discourage the pharmaceutical company from taking the risk of investing in research and development because of the low probability that it will ever recoup its research and development costs.[106] This instability and inability to project future returns will discourage pharmaceutical companies from developing new products.

Overall, compulsory licensing would negatively impact the pharmaceutical industry and the people who depend on the products the industry produces. The pharmaceutical industry is different from almost every other major industry in that it engages in some of the riskiest research and development in the world. Pharmaceutical companies face extremely high costs to develop products and bring them to the market. Empirical studies show that compulsory licensing significantly lowers the amount of money companies are willing to spend on research and development. While in the short run compulsory licensing will lower prescription drug costs, in the long run consumers will have to deal with the loss of new prescription drugs as pharmaceutical companies no longer spend money on

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103. In other industries, trade secrecy provides effective and potentially lasting protection from the imitations of competitors. However, due to the patent process and the detailed disclosure requirements for drug approval, trade secrecy is not effective in the pharmaceutical industry and potential competitors can easily gain knowledge of the details of the compound in question. *See id.*

104. *Id.* at 724.

105. Gillat, *supra* note 82, at 725.

106. *Id.* at 725-26.

research and development. Today prescription drugs will be cheap; but in the future, there will be far fewer new prescription drugs and people will continue to suffer from the diseases of the past.

III. LITIGATION BETWEEN PHARMACEUTICAL AND GENERIC COMPANIES

In recent years, generic companies have targeted the world's most profitable medicines and tried to gain access to the market with their generic copies before the period of exclusivity on the patent covering the underlying medicine has expired. While the generic companies claim to be doing this to provide cheaper medicines to the public, their true intentions are revealed in that they target the patents of so called "blockbuster" drugs. One of these blockbuster drugs is Lipitor, whose patent holder is Pfizer.

Pfizer has two patents for Lipitor. The first patent is 4,681,893 ('893 patent)[107] and the second is 5,273,995 ('995 patent),[108] both of which cover atorvastatin calcium, the active ingredient in Lipitor.[109] Pfizer's '893 patent expires on September 24, 2009 while the '995 patent expires on December 28, 2010.[110]

Ranbaxy Laboratories is an Indian pharmaceutical manufacturer that specializes in the production and distribution of generic products.[111] Ranbaxy filed an Abbreviated New Drug Application (ANDA No. 76-477)[112] with the FDA, which Pfizer believed infringed upon the '893 patent and the '995 patent.[113] To prevent the generic product from entering the marketplace, Pfizer filed a lawsuit alleging infringement of the '893 and

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107. U.S. Patent No. 4,681,893 (filed May 30, 1986). *See also* Pfizer, Inc. v. Ranbaxy Labs Ltd., 405 F. Supp. 2d 495, 500 (D. Del. 2005).

108. U.S. Patent No. 5,273,995 (filed Feb. 26, 1991). *See also Pfizer*, 405 F. Supp. 2d at 500.

109. *Pfizer*, 405 F. Supp. 2d at 501.

110. *Id.*

111. Ranbaxy Talks, Ranbaxy Laboratories Ltd., http://www.ranbaxy.com/ranbaxytalks.htm (last visited Apr. 14, 2007).

112. *Pfizer*, 405 F. Supp. 2d at 500. The ANDA process allows the FDA to evaluate and approve generic drugs for manufacture and sale in the United States. During the evaluation process, the FDA determines whether the generic product is a bioequivalent to the innovator drug, meaning that it performs in the same manner. *Abbreviated New Drug Application (ANDA) Process for Generic Drugs*, U.S. Food and Drug Administration, Center for Drug Evaluation and Research, http://www.fda.gov/cder/regulatory/applications/ANDA.htm (last visited Apr. 14, 2007). Ranbaxy's application to the FDA sought permission to sell a generic version of Lipitor. *See Pfizer*, 405 F. Supp. 2d at 500.

113. Pfizer, Inc. v. Ranbaxy Labs Ltd., 405 F. Supp. 2d 495, 500 (D. Del. 2005).

'995 patents under 35 U.S.C. § 271(e)(2).[114] In its answer, Ranbaxy alleged that it did not infringe upon either patent, that the term extension on the '893 patent was invalid, that claim 6 of the '995 patent was invalid, and that the '995 patent was unenforceable.[115] The District Court ruled that Ranbaxy had infringed upon both patents and that Ranbaxy had failed to prove any of its defenses.[116] Ranbaxy subsequently appealed to the Federal Circuit.[117]

In the Federal Circuit, Ranbaxy argued that the District Court's decisions were incorrect, specifically regarding the decisions:

> (1) that claim 1 of the '893 patent was infringed; (2) that the '893 patent term extension was not proven invalid; (3) that claim 6 of the '995 patent was infringed; (4) that claim 6 was not proven invalid for failure to comply with § 112, ¶ 4, as anticipated or obvious, or for non-statutory double patenting; and (5) that the '995 patent was not proven unenforceable due to inequitable conduct.[118]

The Federal Circuit affirmed the District Court decision with respect to the '893 patent (the basic patent), but declared the '995 patent to be invalid due to errors in drafting.[119] This decision effectively took patent protection away from Lipitor a year earlier than if the '995 patent was deemed valid. But Ranbaxy is the big loser, since it cannot introduce its generic version of Lipitor until September 2009.[120]

Despite Pfizer having patent protection in many countries around the world, Ranbaxy has tried to gain access to those markets as well.[121] The

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114. *Id.*

115. *Id.*

116. *Id.* at 525-26.

117. Pfizer, Inc. v. Ranbaxy Labs Ltd., 457 F.3d 1284, 1285 (Fed. Cir. 2006), *cert. denied*, 127 S. Ct. 1928 (2007).

118. *Id.* at 1286.

119. *Id.* at 1288-92.

120. The date of September 2009 does not include an additional six month pediatric exclusivity period. *See* Pfizer, Inc., Annual Report (Form 10-K), at 63 (Mar. 1, 2006), *available at* http://www.pfizer.com/pfizer/download/investors/financial/10k_0301_06.pdf. *See also* Pfizer, Inc. v. Ranbaxy Labs Ltd., 405 F. Supp. 2d 495, 501 (D. Del. 2005).

121. *Australian Court Upholds Pfizer's Lipitor Patent*, PHARMA MARKETLETTER, Dec. 22, 2006 (noting that Pfizer's main patent on Lipitor was affirmed by an Australian court); *Austrian Patent Office Rules in Pfizer's Favor*, PHARMA LAW WEEKLY, Nov. 14, 2006, at 450 (reporting the Austrian Patent Office's decision that Pfizer's patent would be infringed by Ranbaxy); *Court in the Netherlands Upholds Basic Lipitor Patent, Delays Launch of*

Chief Executive Officer of Ranbaxy, in his Letter to Shareholders in Ranbaxy's 2005 Annual Report, discusses his company's strategy to challenge patents that Ranbaxy feels it can defeat in court.[122] While Ranbaxy has been defeated in court after court, it continues to attack Pfizer's patent in country after country. Ranbaxy has lost in the United States, the United Kingdom, Australia, Austria, the Netherlands, Finland, and elsewhere but continues to challenge the Lipitor patent. So why does Ranbaxy keep trying to get Lipitor invalidated? One reason is that Lipitor is the best selling drug in the world, garnering sales of over $12.1 billion

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Ranbaxy Generic, PHARMA LAW WEEKLY, Oct. 10, 2006, at 288 (reporting a decision by a court in the Netherlands that Pfizer's patent would be infringed upon by Ranbaxy); *EPO Upholds Pfizer's Lipitor Patent*, PHARMA MARKETLETTER, Oct. 20, 2006 (noting the decision of the European Patent Office upholding Pfizer's patent); *Pfizer Prevails in Important US Lipitor Patent Fight with Ranbaxy*, PHARMA MARKETLETTER, Dec. 19, 2005 (reporting Pfizer's victory at the District Court level affirming the validity of its patents); *Pfizer Secures Commercial Rights to Blockbuster Statin Lipitor Until 2011*, PHARMA MARKETLETTER, July 3, 2006 (noting Pfizer's victory in the United Kingdom's Court of Appeal); *Pfizer to Appeal Lipitor Patent Loss in Norway*, PHARMA MARKETLETTER, Aug. 31, 2006 (reporting the decision by a Norwegian court invalidating Pfizer's patents, but noting that Pfizer is appealing and that despite the ruling, Pfizer still has exclusivity in Norway until 2009); *Ranbaxy Enjoined by Finnish Court from Marketing Generic Lipitor*, PHARMA BUSINESS WEEK, Mar. 20, 2006, at 176 (reporting a Finnish court's decision to enjoin Ranbaxy from producing generic Lipitor in Finland); *Ranbaxy Successfully Invalidates Atorvastatin Patent in Austria*, PHARMA BUSINESS WEEK, May 24, 2006, at 258 (reporting an Austrian court's decision to invalidate Pfizer's patent on Lipitor); *UK Appeals Court Affirms Earlier Ruling*, PHARMA MARKETLETTER, July 3, 2006 (noting the United Kingdom's Appeals Court affirmed its prior decisions on Pfizer patents); *UK Court Rules in Key European Patent Cases on Cholesterol Drug Atorvastatin*, PHARMA BUSINESS WEEK, Nov. 14, 2005, at 171 (noting the United Kingdom's High Court of Justice decision affirming Ranbaxy's infringement of the basic Lipitor patent); *U.S. Appeals Court Denies Ranbaxy Petition to Rehear Decision on Main Patent in Lipitor Case*, PHARMA LAW WEEKLY, Nov. 21, 2006, at 369 (reporting the Federal Circuit's denial of Ranbaxy's petition for rehearing); *U.S. Appeals Court Upholds Basic Patent for Atorvastatin, Exclusivity in U.S. to March 2010*, PHARMA BUSINESS WEEK, Aug. 28, 2006, at 190 (reporting the Federal Circuit's decision upholding one of Pfizer's patents); *U.S. Trademark Office to Confirm Validity of Patent of Key Ingredient in Lipitor*, PHARMA BUSINESS WEEK, Jan. 2, 2006, at 177 (noting the Patent Office's decision to confirm the validity of Pfizer's patent).

122. *See* RANBAXY, RANBAXY LABORATORIES ANNUAL REPORT 2005 8 (2005), *available at* http://www.ranbaxy.com/ar2005/ar2005.pdf (CEO Malvinder M. Singh remarking that "Our Company is confident of the strength of its scientific and legal rationale and corresponding intellectual property strategies, and has challenged patents where we are confident of the merits of the case. . . .Ranbaxy follows a balanced business strategy and continuously evaluates risk-reward options to choose a course of action that is in the best interests of the Company and its shareholders.").

dollars in 2005.[123] Lipitor's market is huge and Ranbaxy wants access to that lucrative market.

Keep in mind that Ranbaxy did not spend any money developing Lipitor as a product. Ranbaxy acquired the formula for atorvastatin calcium by looking at a patent published by the Patent Office. Critics of the pharmaceutical industry claim that the pharmaceutical companies are the greedy ones, but the pharmaceutical companies are not trying to invalidate others intellectual property and take the resulting sales. In fact, Ranbaxy is a significant part of the reason why the cost of prescription drugs are as high as they are. Ranbaxy and other companies like it, are benefiting from the patent regime by learning of a compound of which they would otherwise have no knowledge and then using that knowledge to hurt the innovators who developed the technology by seeking to steal their market and intellectual property. While Ranbaxy has failed to win a victory in any major market against Pfizer, Ranbaxy continues its destructive practice. With no significant decision in Ranbaxy's favor, one must conclude that Ranbaxy is taking advantage of the court system and has no reasonable basis to believe that the Lipitor patent is invalid.

Without a drug like Lipitor, Pfizer could not afford to keep spending as much as it does on research and development. For Pfizer's business model to be effective, Pfizer must engage and defeat any attempt to steal its intellectual property. In its 2005 Annual Report, Pfizer discusses the increasing willingness of generic companies to challenge Pfizer's patent rights.[124] Pfizer faces legal challenges to a number of its patents and is committed to defending its patent rights.[125] The legal costs involved in this fight are substantial, and the American public is paying the price in higher prescription medication costs.

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123. *See*, PFIZER, PFIZER INC. 2005 FINANCIAL REPORT 13 (2005), *available at* http://www.pfizer.com/pfizer/annualreport/2005/financial/p2005fin13.jsp.

124. *Id.* at 4.

125. *Id.* at 6 ("We are involved in a number of patent suits, the majority of which involve claims by generic drug manufacturers that patents covering our products, processes or dosage forms are invalid and/or do not cover the product of the generic manufacturer. Pending suits include generic challenges to patents covering, among other products, amlodipine (Norvasc), atorvastatin (Lipitor), tolterodine (Detrol) and celecoxib (Celebrex). Also, counterclaims as well as various independent actions have been filed claiming that our assertions of, or attempts to enforce, our patent rights with respect to certain products constitute unfair competition and/or violations of the antitrust laws. In addition to the challenges to the U.S. patents on a number of our products that are discussed below, we note that the patent rights to certain of our products, including without limitation Lipitor, are being challenged in various other countries.").

Lipitor is not the only pharmaceutical product under attack from generic companies. Eli Lilly successfully defended its patent for Zyprexa when Zenith Goldline Pharmaceuticals, Dr. Reddy's Laboratories, and Teva Pharmaceuticals filed an ANDA to get their respective generic products on the market.[126] Pfizer successfully proved that Dr. Reddy's Laboratories had infringed upon its Norvasc patent.[127] Pfizer won an injunction against Teva Pharmaceuticals and Ranbaxy when they infringed on Pfizer's Accupril patent.[128] Glaxo Group (now GlaxoSmithKline) won an infringement action against Apotex over its Ceftin patent.[129] Glaxo won a reversal of a decision by the Southern District of Florida that its Wellbutrin and Zyban patents were not infringed upon by Andrx Pharmaceuticals.[130] Merck also won a judgment that its patent for Fosamax was valid after Teva and Goldline sued to invalidate the patent.[131] Sanofi and Bristol-Myers Squibb won a preliminary injunction against Apotex for infringing upon their patent for Plavix, another blockbuster drug like Lipitor, which helps to reduce heart attacks and strokes.[132] As one final example, Janssen Pharmaceutica won an infringement case against Mylan Pharmaceuticals and Dr. Reddy's over its Risperdal patent.[133] The list of examples goes on and the pattern is quite clear. Generic companies are engaged in a systematic strategy of attacking the intellectual property of the pharmaceutical innovators. The legal costs incurred by the pharmaceutical companies in defending their patents is quite large and leads to more expensive prescription medications for the American people. The American consumer pays the price for this attempted theft of intellectual property which takes place in courtrooms around the world on an ever increasing basis.

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126. *See* Eli Lilly & Co. v. Zenith Goldline Pharms., 471 F.3d 1369 (Fed. Cir. 2006).

127. Pfizer, Inc. v. Dr. Reddy's Labs., Ltd., 359 F.3d 1361, 1367 (Fed. Cir. 2004).

128. Pfizer, Inc. v. Teva Pharms. USA, Inc., 429 F.3d 1364, 1383 (Fed. Cir. 2005).

129. Glaxo Group, Ltd. v. Apotex, Inc., 376 F.3d 1339, 1351 (Fed. Cir. 2004).

130. Glaxo Wellcome, Inc. v. Andrx Pharms., Inc., 344 F.3d 1226, 1234 (Fed. Cir. 2003).

131. Merck & Co. v. Teva Pharms. USA, Inc., 347 F.3d 1367, 1374 (Fed. Cir. 2003).

132. Sanofi-Synthelabo v. Apotex, Inc., 470 F.3d 1368, 1385 (Fed. Cir. 2006).

133. Janssen Pharmaceutica N.V. v. Mylan Pharms., Inc., 456 F. Supp. 2d 647-48 (D. N.J. 2006), *aff'd by*, 2007 U.S. App. LEXIS 11686 (Fed. Cir. May 11, 2007).

IV. POSSIBLE SOLUTIONS TO DECREASING LITIGATION AND REDUCING THE COST OF PRESCRIPTION MEDICATIONS

A. INTELLECTUAL PROPERTY INSURANCE

The consumer is adversely affected by the massive amounts of money pharmaceutical companies spend defending their intellectual property. One intriguing solution for the pharmaceutical industry in dealing with this rampant patent litigation is to buy intellectual property insurance coverage. There are three types of insurance coverage that cover a company's intellectual property: (1) commercial or comprehensive general liability (CGL) insurance, (2) patent infringement insurance, and (3) patent enforcement insurance.[134] Recent revisions to the CGL have excluded coverage for intellectual property claims pertaining to infringement on patents.[135] So while CGL policies will no longer cover patent claims, patent infringement and patent enforcement insurance coverage are both available to pharmaceutical companies.

Due to the increase in patent litigation over the last several decades, insurance companies created patent infringement insurance.[136] Patent infringement policies will generally cover infringement stemming from the use, distribution, sale, and advertising of the patent.[137] A policy will cover the insured for attorney's fees defending the patent, settlement payments, prejudgment interest and damage awards.[138] These expenses contribute to the overall limits of the policy, so the insured might have to pay out of pocket if there is insufficient coverage to satisfy an adverse judgment.[139] Patent infringement coverage was designed to defend against infringement claims, however, and cannot be used to pursue an action alleging that another entity has infringed on the policyholder's patent.[140] Additionally, unless there is an endorsement, patent infringement coverage extends only

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134. Jason A. Reyes, *Note: Patents and Insurance: Who Will Pay for Infringement?*, 1 B.U. J. SCI. & TECH. L. 95, 96 (1995).

135. Robert H. Jerry, II & Michele L. Mekel, *Cybercoverage for Cyber-Risks: An Overview of Insurers' Responses to the Perils of E-Commerce*, 8 CONN. INS. L.J. 7, 22-23 (2001).

136. Melvin Simensky & Eric C. Osterberg, *The Insurance and Management of Intellectual Property Risks*, 17 CARDOZO ARTS & ENT. L.J. 321, 329 (1999).

137. *Id.*

138. *Id.*

139. *Id.*

140. *Id.*

to the United States.[141] As one would expect, the cost of patent infringement coverage is expensive and some policies will not reimburse expenses until the litigation is concluded.[142] Patent infringement coverage is expensive because there is no big pay day for insurers when they win a defensive patent action.

Patent infringement coverage is not a beneficial investment for pharmaceutical companies to make. Pharmaceutical companies are not worried that they are infringing the patents of others because they own the intellectual property. Rather they are concerned with infringement of their patents by generic companies.

A second insurance option for pharmaceutical companies is patent enforcement insurance. Patent enforcement insurance is an offensive type of insurance for attacking entities infringing upon the policyholder's patent.[143] Patent enforcement insurance protects the policyholder up to a limit for legal actions taken to enforce patent rights.[144] Patent enforcement insurance generally contains terms such that: (1) the action must be taken during the period of coverage; (2) the patent covered must be specified; and (3) coverage does not extend to those licensed to use the patent.[145] There are several benefits to having a patent enforcement policy. First, holding the policy may deter the potential infringer from infringing knowing that the patent holder is prepared to litigate.[146] Second, premiums for patent enforcement insurance are much lower than for patent infringement insurance.[147] Finally, the market for patent enforcement insurance is large and many insurance companies seek this very lucrative area of operations.[148]

Patent enforcement insurance would appear to benefit pharmaceutical companies. Pharmaceutical companies need protection, especially overseas, from companies taking their patents and producing infringing products without a license. As the Lipitor case illustrates, pharmaceutical companies often engage in offensive patent enforcement actions. However insurance companies do not win big pay days in these actions; since

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141. *Id.* at 330.

142. Simensky & Osterberg, *supra* note 136, at 330.

143. Mark C. Vallone, *Note: System and Method of Funding SMES Commencing Patent Infringement Disputes*, 56 SYRACUSE L. REV. 181, 187-88 (2005).

144. *Id.*

145. *Id.* at 188.

146. *Id.*

147. Reyes, *supra* note 134, at 96-97.

148. *Id.* at 97.

infringement has technically not taken place yet, pharmaceutical companies usually win an injunction and do not win monetary damages.[149]

Currently no insurance product exists that would lower the cost of patent litigation for pharmaceutical companies and would effectively shift risk to an insurer. Premiums for patent infringement insurance are expensive, the policies are filled with limitations, and it is doubtful that the insurance would save the companies money since there is a near certainty of litigation occurring.[150] While the premiums for patent enforcement insurance are more reasonable, this coverage probably is also not a viable option for pharmaceutical companies because the likelihood of obtaining damages is quite low. Until a new insurance product is developed to cover this area, it is unlikely that insurance will cut the costs of litigation and save the consumer money.

B. REFORMING PATENT LAWSUIT ABUSE

In the last decade, many groups have pushed for tort reform to reign in excessive litigation costs that threaten to kill American competitiveness in the world wide marketplace.[151] In 2004, the United States Department of Commerce Subcommittee on U.S. Competitiveness estimated that the tort system is costing the average American $800 per year.[152] Similarly, wasteful patent infringement lawsuits cost Americans money through taxes to operate the legal system and also because these lawsuits lead to higher prescription drug costs.

In the American legal system, each party is obligated to cover its own litigation costs.[153] Absent statutory authority, courts will generally not award attorney's fees to the prevailing party.[154] So when a pharmaceutical company is sued over its patent, the company bears all of its costs in defending against the lawsuit. But why is it just for pharmaceutical companies to cover their own litigation costs in lawsuits where they are

149. *See* cases cited *supra* notes 126-133.

150. *See* sources cited *supra* note 121.

151. *See generally* Deborah J. La Ferta, *Freedom, Responsibility, and Risk: Fundamental Principles Supporting Tort Reform*, 36 IND. L. REV. 645 (2003); Liam Pleven, *Math Divides Critics as Startling Toll of Torts Is Added Up*, WALL ST. J., Mar. 13, 2006, at A2; Steven B. Hantler, *States Compete to Clear the Tort Bar*, WALL ST. J., July 19, 2005, at B2.

152. *See* Hantler, *supra* note 151.

153. Buckhannon Bd. & Care Home, Inc. v. W. Va. Dep't of Health & Human Res., 532 U.S. 598, 602 (2003).

154. *Id.*

forced to sue to prevent the theft of their intellectual property from generic companies? Furthermore, since costs are passed on to the American consumer, why is it just for the American consumer to pay the cost of defending against these illegitimate attempts to take intellectual property? Why should the American consumer have to pay when a generic company has no legitimate reason to believe that a patent is invalid?

Statutory authority exists for judges to award attorney's fees and triple damages to the prevailing party in patent infringement litigation.[155] But an award of attorney's fees can only be made after a specific finding of exceptional circumstances.[156] The Federal Circuit discussed a finding of exceptional circumstances: "Exceptional cases usually feature some material, inappropriate conduct related to the matter in litigation, such as willful infringement, fraud or inequitable conduct in procuring the patent, misconduct during litigation, vexatious or unjustified litigation, conduct that violates Federal Rule of Civil Procedure 11, or like infractions."[157] The conduct of generic companies falls within the exceptional cases standard.

But in actual application, the Federal Circuit has significantly limited the awarding of attorney's fees in most actions involving pharmaceutical patents. As evidenced by the Pfizer and Ranbaxy Lipitor litigation, most patent disputes arise when a generic company files an ANDA to gain approval for a generic drug to enter the market. As long as the patent is deemed valid, the generic company will have infringed upon the pharmaceutical company's patent.[158] Damages will only be awarded where the infringer has actually manufactured, used, sold, or offered to sell an approved drug in the United States.[159] Since the pharmaceutical company cannot win any damages, it likewise cannot win triple damages on a finding of willful infringement. Also following from this, the Federal Circuit has concluded that, "the mere fact that a company has filed an ANDA

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155. 35 U.S.C. § 284-85 (2000).

156. 7 DONALD S. CHISUM, CHISUM ON PATENTS § 20.03(4)(c) (2007).

157. Serio-US Indus. v. Plastic Recovery Techs. Corp., 459 F.3d 1311, 1321-22 (Fed. Cir. 2006).

158. *See* 35 U.S.C. § 271(e)(2)(A) (2000) ("It shall be an act of infringement to submit...an application under section 505(j) of the Federal Food, Drug, and Cosmetic Act or described in section 505(b)(2) of such Act for a drug claimed in a patent or the use of which is claimed in a patent . . .").

159. *Id.* § 271(e)(4)(C) ("For an act of infringement described in paragraph (2)...damages or other monetary relief may be awarded against an infringer.only if there has been commercial manufacture, use, offer to sell, or sale within the United States or importation into the United States of an approved drug or veterinary biological product.").

application or certification cannot support a finding of willful infringement for purposes of awarding attorney's fees pursuant to 35 U.S.C. § 271(e)(4)."[160] This decision essentially prevents the pharmaceutical companies from recovering attorney's fees or any type of punitive award when generic companies seek to steal their intellectual property in an American courtroom.

There are several other possible methods for pharmaceutical companies to recover legal expenses. One method is to seek redress under Rule 11 of the Federal Rules of Civil Procedure.[161] If the pharmaceutical company could show that a written motion or pleading of the generic company was (1) for an improper purpose, (2) the legal contentions are not warranted by existing law, or (3) the denial of factual contentions are not warranted by the circumstances.[162] The second method is under Rule 38 of the Federal Rules of Appellate Procedure.[163] The final method would be to seek redress under a statute authorizing recovery where opposing counsel "unreasonably and vexatiously" multiplies the cost of proceedings.[164] To recover under this theory, the court must make a determination that the infringer is a culpable infringer who acted willfully in the light of the totality of the circumstances.[165] More specifically, the court needs to make

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160. Glaxo Group Ltd. v. Apotex, Inc., 376 F.3d 1339, 1350-51 (Fed. Cir. 2004).

161. FED. R. CIV. P. 11(c) ("Sanctions. If, after notice and a reasonable opportunity to respond, the court determines that subdivision (b) has been violated, the court may, subject to the conditions stated below, impose an appropriate sanction upon the attorneys, law firms, or parties that have violated subdivision (b) or are responsible for the violation").

162. *See* FED. R. CIV. P. 11(b) ("Representations to Court. By presenting to the court (whether by signing, filing, submitting, or later advocating) a pleading, written motion, or other paper, an attorney or unrepresented party is certifying that to the best of the person's knowledge, information, and belief, formed after an inquiry reasonable under the circumstances, (1) it is not being presented for any improper purpose, such as to harass or to cause unnecessary delay or needless increase in the cost of litigation; (2) the claims, defenses, and other legal contentions therein are warranted by existing law or by a nonfrivolous argument for the extension, modification, or reversal of existing law or the establishment of new law; (3) the allegations and other factual contentions have evidentiary support or, if specifically so identified, are likely to have evidentiary support after a reasonable opportunity for further investigation or discovery; and (4) the denials of factual contentions are warranted on the evidence or, if specifically so identified, are reasonably based on a lack of information or belief.").

163. FED. R. APP. P. 38 ("Frivolous Appeal - Damages and Costs. If a court of appeals determines that an appeal is frivolous, it may, after a separately filed motion or notice from the court and reasonable opportunity to respond, award just damages and single or double costs to the appellee.").

164. 28 U.S.C. § 1927 (2000).

165. *See* CHISUM, *supra* note 156, § 20.03.

a finding that the infringer acted in bad faith.[166] Certainly there is a valid argument that the generic companies have engaged in "bad faith infringement." Currently, courts do not use these provisions to punish the actions of the generic companies, and thereby make the pharmaceutical companies whole, which only punishes the American consumer.[167]

There are two possible ways to correct this problem. First, courts should find willful infringement and bad faith infringement where generic companies knowingly pursue a strategy to invalidate patents which they should suspect are valid. Courts need to consider that lawsuits are going on around the world as generic companies attempt to steal intellectual property with no basis for believing the patent is invalid. Courts should look at the totality of the circumstances, where generic companies lose case after case and continue to waste the time of courts in pursuing this destructive activity. This reckless behavior harms the American consumer and will not stop unless the generic companies are punished. At a minimum, the pharmaceutical companies should be able to recover attorney's fees and courts should consider punitive damages to terminate this irresponsible conduct. Judges should not have their hands tied in awarding fees and punitive damages because the generic company filed an ANDA and did not actually begin manufacturing, use, or sale of the patent in the United States.

Similarly, Congress should pass legislation to curtail this activity. This nation believes in rewarding entrepreneurs and innovators which is why Congress established a patent system. Perhaps, there are instances where a

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166. Jurgens v. CBK, Ltd., 80 F.3d 1566, 1571 (Fed. Cir. 1996) ("Instead, in the initial determination of culpability, and thus liability for increased damages, 'bad faith' properly refers to an infringer's failure to meet his affirmative duty to use due care in avoiding infringement of another's patent rights. If an infringer adequately performs this duty by determining that, for example, an asserted patent is invalid, that there is no infringement, or that his conduct is covered by licensing agreements, he will not be held liable for increased damages. Even if a party is subsequently found to be infringing another's patent despite its investigations, it will be liable only for compensatory damages, not increased damages, if it performed its affirmative duty in good faith. On the other hand, where one continues his infringing activity, and fails to investigate and determine, in good faith, that he possesses reasonable defenses to an accusation of patent infringement, the infringement is in bad faith. Such conduct occurs when an infringer merely copies a patented invention, or where he obtains incompetent, conclusory opinions of counsel only to use as a shield against a later charge of willful infringement, rather than in a good faith attempt to avoid infringing another's patent. Thus, 'bad faith' is more correctly called 'bad faith infringement,' and it is merely a type of willful infringement.") (citation omitted).

167. *See* Glaxo Group, Ltd. v. Apotex, Inc., 376 F.3d 1339 (Fed. Cir. 2004) (refusing to find willful infringement where generic company filed an ANDA despite finding patent valid).

generic company has a valid challenge to a patent. The legislation should not preclude valid activity, but should allow a judge to determine that a generic company is acting in bad faith and willfully infringing upon a valid patent based on the totality of the circumstances. The totality of the circumstances should include such considerations as: (1) the number of countries in which the patent is challenged and how many of those cases the generic company loses; (2) a determination of whether the generic company's claim has any validity; (3) other patterns of abuse by the generic company; and (4) other evidence that either establishes or denies that willful infringement is taking place. When the court finds that willful infringement took place, it should award attorney's fees and consider punitive damages as well.

These two methods would help curtail the generic companies' abuses. By giving judges discretion to award or deny fees and damages, valid claims by generic companies will not be penalized. But when abusive action by generic companies continues to threaten innovation in the pharmaceutical industry and cost the American consumer more and more money every year, Congress and the courts must react to correct this situation. Awarding attorney's fees and monetary damages will remove the incentive that generic companies currently have to infringe valid patents.

CONCLUSION

There are many reasons why prescription drugs are expensive, but the patent system is not at fault. The patent system was created to encourage and stimulate innovation in the United States. The period of exclusivity granted to the patent offsets the enormous financial investment in the research and development of new drugs by preventing competition in the market. Although the cost of research and development is a contributor to the high cost of pharmaceuticals, the cost of patent litigation is another substantial factor. After all, there is no guarantee that any new compound will become a blockbuster drug, and it is the rare exception when a discovered product makes it to the marketplace.

Consumer advocates have proposed compulsory licensing as a way to reduce prescription drug costs. This is a direct attack on the patent system of the United States and the intellectual property rights of the pharmaceutical industry. Compulsory licensing would make pharmaceutical companies less willing to risk capital in the search for new medicines. The resulting decrease in research and development spending would lead to the end of the development of new products. Limiting the patent rights of the pharmaceutical industry would result in a number of

harmful effects and is not an appropriate solution to reducing the price of prescription medicines.

On the contrary, strengthening the pharmaceutical companies' patent rights would decrease prescription drug costs. Pharmaceutical products litigation costs have boomed over the years. This cost of litigation is passed on to the consumer in the form of higher prescription drug costs. Reducing the cost of litigation will result in lower costs for the pharmaceutical company and lower costs for the consumer. Patent infringement lawsuits are not the sole reason for the rising cost of prescription drugs, but they are undoubtedly a contributor. Most litigation over patents in the pharmaceutical industry occurs when generic competitors enter a market and infringe the pharmaceutical company's patent. These generic companies, in country after country, seek to invalidate the patent with no legitimate basis for believing the patent is invalid. Despite losing in country after country and jurisdiction after jurisdiction, these companies continue to pursue this reckless strategy. This costs pharmaceutical companies a great deal of money and raises the price of prescription drugs on American consumers.

Unfortunately, current insurance products for intellectual property, while helpful, are costly and ultimately ineffective in transferring risk from the insured to the insurer. Instead, Congress and the court need to take action and enforce rules that strengthen the rights of pharmaceutical patent holders by awarding attorney's fees and punitive damages in cases with clear abuse and willful infringement. Generic companies must be held to account. They cannot be allowed to punish prescription drug customers because of their greed. Additionally, they cannot be allowed to take advantage of the court system in an attempt to steal valid intellectual property from some of the world's top innovators. Innovators' intellectual property rights must be defended, and the American consumer should not have to foot the bill for this waste and abuse of the American legal system.

CASE NOTE: *HOWARD DELIVERY SERVICE, INC. V. ZURICH AMERICAN INSURANCE CO.*: THE U.S. SUPREME COURT RESOLVES THE SPLIT AMONG CIRCUITS REGARDING WHETHER WORKERS' COMPENSATION PREMIUMS MAY BE ELIGIBLE FOR PRIORITY TREATMENT IN BANKRUPTCY PROCEEDINGS

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INTRODUCTION

The aim of this Note is to explain and explore the rationale and potential ramifications of the United States Supreme Court's decision in *Howard Delivery Service, Inc. v. Zurich American Ins. Company*[1], where the Court resolved the split among circuits concerning the treatment in bankruptcy proceedings of insurers seeking fifth-level priority status under section 507(a)(5)[2] of the Bankruptcy Code for unpaid workers' compensation premiums. Providers of fringe benefits to a debtor's employees are now less likely to recover from a bankrupt employer's estate following the Court's decision. As a result, at least one type of third party insurer has been excluded from priority status altogether.[3] In addition to its impact on insurers, the *Howard* holding likely has implications for both employers and employees as well.

I. BACKGROUND

Creditors of an employer that has filed Chapter 11 bankruptcy[4] face a high likelihood that the debtor will have inadequate funds to repay all of the unsecured claims against the company.[5] In order to obtain repayment of debts, creditors most often rely on a policy that ranks them equally and places all debts on equal footing.[6] The general rule with this policy is that creditors receive a pro-rata distribution of available funds.[7] In addition to

1. 126 S. Ct. 2105, 2109 (2006).

2. *See* 11 U.S.C. § 507(a)(5) (2000 & Supp. 2006). Section 507(a) sets forth levels of priority for expenses and unsecured claims. Creditors of equal priority are treated equally and each creditor of highest priority is paid before any creditor in a lower priority.

3. *Howard*, 126 S. Ct. at 2116.

4. Chapter 11 is one of five debtor relief chapters for filing bankruptcy: Chapter 7 (Liquidation), Chapter 9 (Adjustment of debts of a municipality), Chapter 11 (Reorganization), Chapter 12 (Adjustment of debts of a family farmer with regular annual income), and Chapter 13 (Adjustment of debts of an individual with regular income).

5. *See generally* 1 COLLIER BANKRUPTCY MANUAL ¶ 103.01 (3d ed. 1997) (explaining the structure of the bankruptcy code).

6. *See id.*

7. *See generally* 4 ALAN N. RESNICK & HENRY J. SOMMER, COLLIER ON BANKRUPTCY § 507 (15th ed. 2006) (explaining the "priorities" section of the bankruptcy code).

this general rule of apportionment, Congress has recognized special instances where exceptions are appropriate.[8]

A. THE PRIORITY SYSTEM OF DISTRIBUTION IN BANKRUPTCY PROCEEDINGS

The Bankruptcy Code favors certain types of claims, giving them priority in distribution over other unsecured claims.[9] Section 507 of the Code[10] lays out the various debts and claims which enjoy priority treatment in bankruptcy.[11] Section 507 grants priority successively, so that each category of priority must be fully satisfied before any junior claim will receive payment.[12] In addition, unsecured priority claims do not supersede legal pre-petition liens on the assets of the debtor, so that "only after the discharge of valid liens and encumbrances are assets available for distribution to priority claimants."[13]

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8. *See* H.R. REP. NO. 95-595, at 186 (1978).

9. W. HOMER DRAKE & CHRISTOPHER S. STRICKLAND, CHAPTER 11 REORGANIZATIONS, § 10:8 (2d ed. 2006) (explaining the various types of priority claims).

10. 11 U.S.C. § 507(a) (2000 & Supp. 2006).

11. For a general discussion about the Bankruptcy Code's section 507 priority regime, see David A. Foster, *What's So Super About Bankruptcy Code Section 1113 - Harmonizing the Disbursement of Benefits Under a Chapter 11 Debtor's Collective Bargaining Agreement with 11 U.S.C. § 507*, 1994 DET. C.L. REV. 1247 (1994); Craig B. Cooper, *Priority of Postpetition Retainers, Carve-Outs, and Interim Compensation Under the Bankruptcy Code*, 15 CARDOZO L. REV. 2337 (1994); Daniel Keating, *Fruits of Labor: Worker Priorities in Bankruptcy*, 35 ARIZ. L. REV. 905 (1993); Patrick M. Castleberry, *Individual Tax Claims in Chapter 7 and 13 Bankruptcies: Administrative Priorities and Dischargeability*, 47 CONSUMER FIN. L. Q. REP. 433 (1993); Daniel Keating, *Pension Insurance, Bankruptcy and Moral Hazard*, 1991 WIS. L. REV. 65 (1991); *In re* Commercial Fin. Servs., Inc., 246 F.3d 1291 (10th Cir. 2001) (administrative expense priorities are strictly construed because the presumption in bankruptcy cases is that the debtor's limited resources will be equally distributed among creditors). *See also* DRAKE & STRICKLAND, *supra* note 9, § 10:8.

12. *See In re* Great Ne. Lumber & Millwork Corp., 64 B.R. 426, 427-28 (Bankr. E.D. Pa. 1986) (holding that a claim should be preferred over others only where the Bankruptcy Code clearly indicates that it should be afforded priority status).

13. Priority, within the meaning of section 507, denotes a claim that is satisfied from the "general assets" of the bankrupt's estate after the satisfaction of secured liens but before the debts of general creditors. *In re* Federal's Inc., 553 F.2d 509, 518 (6th Cir. 1977). *See also In re* HLM Corp., 62 F.3d 224, 226 (8th Cir. 1995) (stating that unless the Bankruptcy Code specifically creates an exception, secured claims are given priority and satisfied before any payments for unsecured claims); DRAKE & STRICKLAND, *supra* note 9, § 10:8.

The Bankruptcy Code grants special priority treatment to ten major categories of debts, in order to meet various policy objectives.[14] Included in the 11 U.S.C. § 507(a) prescription for priority claims, in the following order, are: first, "allowed unsecured claims for domestic support obligations that, as of the date of filing of the petition...are owed or recoverable by a spouse, former spouse, or child of the debtor...."[15] Second-level priority is afforded to administrative expenses allowed under § 503(b),[16] and third priority goes, under § 507(a), to involuntary gap claims, which are unsecured claims arising in involuntary cases.[17]

Two main levels of priority claims are assigned to debts owed to employees.[18] Fourth priority is assigned to unsecured wage claims such as wages, salaries, and commissions earned by an employee within ninety

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14. *See* 11 U.S.C. § 507 (2000 & Supp. 2006). Policy objectives of the various levels of priority are explained throughout the Historical and Statutory Notes. The Revision Notes and Legislative Reports explain permutations and compromises that were considered or adopted in the history of the Bankruptcy Act of 1978.

15. *Id.* § 507(a)(1)(A). The new priority was added by a 2005 amendment. This addition resulted in a renumbering of the paragraphs of the priority section, and it is helpful to keep this in mind when reading to avoid confusion when comparing new cases with older cases.

16. Section 507(a)(2) grants second priority to "administrative expenses allowed under section 503(b) of this title, and any fees and charges assessed against the estate under chapter 123 of title 28." *Id.* § 507(a)(2). Administrative expenses are payable under section 503 only if they accrue subsequent to filing. While administrative expense claims may arise from an ongoing relationship that began before the filing of the petition, the existence of an ongoing relationship cannot be used to recover pre-filing debts. *See In re* Pacific Far E. Line, Inc., 713 F.2d 476 (9th Cir. 1983). While the recently enacted Bankruptcy Abuse Prevention and Consumer Protection Act, Pub. L. 109-8, § 101, 119 Stat. 23, significantly alters the priority distribution scheme in bankruptcy, including changes to section 503 (b). Those changes are not relevant in discussing *Howard*, and will therefore not be discussed in this note. For a more thorough explanation of the impact of those changes, see DRAKE & STRICKLAND, *supra* note 9, § 10:8, n.5.

17. Section 507(a)(3) grants third priority to "unsecured claims allowed under section 502(f) of this title." U.S.C. § 507(a)(3) (2000 & Supp. 2006). *See also In re* CSVA, Inc., 140 B.R. 116, 118 (Bankr. W.D.N.C 1992) (stating that administrative claims arising after order for relief has been entered have priority over claims arising during gap period between filing of involuntary petition and entry of order for relief); *In re* Hanson Ind., Inc., 90 B.R. 405, 413 (Bankr. D. Minn. 1988) (stating that the Bankruptcy Code protects administrative expenses incurred during the course of bankruptcy proceedings by grant of first priority status in distribution of the estate, however, involuntary gap creditors are specifically excepted from this first priority status and instead relegated to a second tier of priority); DRAKE & STRICKLAND, *supra* note 9, § 10:8.

18. 11 U.S.C. § 507(a)(4)-(5) (2000 & Supp. 2006).

days of filing.[19] Such fourth-level priority claims must relate to wages salaries or commissions, including vacation, severance, and sick leave pay, and specifically do not include other expected debts for contributions to employee benefit plans.[20] Fifth priority is provided for contributions to employee benefit plans which are unsecured claims for contributions to employee benefit plans arising within 180 days before filing the bankruptcy petition or the date of cessation of debtor's business.[21] The amount that can be claimed under this priority is limited to $10,000[22] per employee, minus the entire amount paid by the employer under fourth priority to all debtors.[23] Due to the fact that the key term "employee benefit plan" is not specifically defined by the Code, extensive litigation has taken place in an effort by creditors to obtain priority status for amounts owed to them by employers. Until 2006, when the U.S. Supreme Court decided *Howard,* a split among circuits made this question difficult to answer with much certainty.[24]

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19. *Id.* § 507(a)(4). In order to qualify under this section, the claimant must first be an individual or corporation employed by the debtor. *See In re* Saint Joseph's Hosp., 126 B.R. 37, 38 (Bankr. E.D. Pa. 1991) (holding that dentist who operated practice for which debtor hospital paid expenses, provided malpractice insurance and health insurance, and paid sixty percent of collections, but who himself supplied equipment and machinery and used and engaged personnel to assist him, did not qualify as "employee" entitled to wage priority in hospital's bankruptcy case, although communications by hospital to dentist referred to his salary and employment).

20. *See In re* Webster, 126 B.R. 4, 5 (Bankr. D. Me. 1991) (holding that a claim for unpaid workers' compensation benefits accrued pre-petition did not come within the Bankruptcy Code provision granting priority to wages earned within ninety days before bankruptcy filing or cessation of debtor's business, notwithstanding the state law provision indicating that workers' compensation claims were entitled to preference over unsecured debts of employer; the plain meaning of Bankruptcy Code provision did not include workers' compensation benefits, and if the state had attempted to broaden priority by statute, the effort would run afoul of the Supremacy Clause).

21. 11 U.S.C. § 507(a)(5) (2000 & Supp. 2006). Congress included the "cessation of business" requirement in order to ensure that the debtor does not strategically choose its petition date as a method of defeating priority wage and benefit claims. This cessation must be interpreted to facilitate the congressional policy of protecting employees. *See* 2 WILLIAM L. NORTON, JR., NORTON BANKRUPTCY LAW AND PRACTICE § 42:39 (2d ed. 2007) (discussing priority claims for contributions to employee benefit plans); *In re* Bodin Apparel, Inc., 56 B.R. 728, 730-31 (S.D.N.Y. 1985).

22. This limitation was increased from an aggregate of $4,000 per employee to the current amount of $10,000 by the Bankruptcy Abuse Prevention and Consumer Protection Act.

23. 11 U.S.C. § 507(a)(5)(B) (2000 & Supp. 2006).

24. Howard Delivery Serv., Inc. v. Zurich Am. Ins. Co., 126 S. Ct. 2105, 2110 (2006).

Other levels of protection in bankruptcy, not related to the employment context, include sixth priority for claims against a grain storage facility or fish storage or processing facility.[25] Seventh priority is assigned to consumer deposits that are unsecured claims of individuals, to a maximum of $2,225[26] for each such individual, arising from the deposit before the commencement of the bankruptcy case of money in connection with the purchase, lease, or rental of property, or the purchase of services, for the personal, family, or household use of such individuals, that were not delivered or provided.[27] Eighth priority is assessed for the unsecured claims by units of government for certain unpaid taxes.[28] These claims may include income tax,[29] property tax,[30] excise taxes,[31] duties stemming from

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25. 11 U.S.C. § 507(a)(6) (2000 & Supp. 2006). The aggregate amount allowable under this section is limited to $4,925 per person qualified as either a producer of grain under section 557(b), or as a United States fisherman. This priority concerning grain producers is applied only when there is insufficient grain or proceeds of grain as a result of the storage facility's sale of grain for immediate distribution back to the producer. The intention of this portion of the code is to ensure that title to grain stored under section 557 remains in the producers of such grain when deposited for storage with such a facility. *See In re* Mickelson, 192 B.R. 516, 521 (Bankr. D. N.D. 1996) (explaining that, to the extent that a producer has not recovered the full amount of his or her grain pursuant to section 557, he or she is entitled to priority under section 507(a)(5) [now renumbered as § 506(a)(6)]).

26. This amount has been increased from $1,800 to $2,225 per individual in the most recent amendment of section 507(a).

27. *See* 11 U.S.C. § 507(a)(7) (2000 & Supp. 2006). For purposes of this subsection, "'deposit' means the tendering of consideration to purchase or rent specific property or services with the expectation that such consideration will be applied toward the purchase or rental of such property or service, and that it will be returned if either the property or service is not delivered, or if a condition precedent for the return of the consideration is fulfilled by the depositor." *See In re* Glass, 203 B.R. 61, 64 (Bankr. W.D. Va. 1996) (holding advance of money from a purchaser of property to a debtor-vendor to enable completion of the transaction was not a deposit within the meaning of section 507(a)(6) [renumbered to section 507(a)(7)]); *In re* Smith, 206 B.R. 113, 115 (Bankr. D. Md. 1997) (holding that reasonable attorney's fees and costs that were incurred pre-petition by creditor-homeowner association in connection with its attempts to collect or obtain lien for Chapter 13 debtor's homeowner association assessments would be allowed as part of creditor's general unsecured claim for assessments).

28. *See* 11 U.S.C. § 507(a)(8) (2000 & Supp. 2006).

29. *Id.* § 507(a)(8)(A). In order for a federal tax claim to receive priority under this subsection, it must only relate to a tax that came due either in three years before the petition date, or as a tax assessed within the 240-day period prior to filing of the petition, though it is not required that the tax possess both of these requirements. *In re* Easton, 59 B.R. 714, 718 (Bankr. C.D. Ill. 1986). *See generally In re* Pacific-Atlantic Trading Co., 64 F.3d 1292 (9th Cir. 1995) (Chapter 7 corporate debtor's income tax liability for fiscal year ending two months post-petition was not an administrative expense, but was entitled only to seventh

importation of merchandise,[32] or penalties related to nonpayment of taxes.[33] Ninth priority is allowed for unsecured claims based on any commitment by the debtor to a FDIC regulatory agency (or predecessor to such agency) to maintain the capital of an insured depository institution.[34] Finally, tenth priority has been assigned to claims for death or personal injury resulting

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priority, even though tax liability was incurred by the estate, where tax was not assessed pre-petition, but was assessable post-petition).

30. 11 U.S.C. § 507(a)(8)(B) (2000 & Supp. 2006). As with many of section 507(a)(8)'s provisions, timing is essential in the application of this subsection. *See In re* Terminals Unlimited, Inc., 63 B.R. 419, 421 (Bankr. D. Md. 1986) (holding that a county's claim for personal property taxes would constitute a priority claim and not an administrative expense if the due date for repayment occurred prior to filing of debtor's Chapter 11 petition). Courts have almost uniformly applied the timing requirements of this section formalistically. *See In re* Becker, 169 B.R. 725, 730-31 (Bankr. D. Kan. 1994) (holding that unpaid property taxes of Chapter 12 debtors for 1983 and 1984 tax years were entitled to treatment as general unsecured claims, and not as priority claims, where taxes from 1983 and 1984 were not payable, without penalty, in the one year period before filing the bankruptcy petition).

31. 11 U.S.C. § 507(a)(8)(E) (2000 & Supp. 2006). In order to qualify as an excise tax, an obligation must be, at a minimum, "an involuntary, pecuniary burden imposed by a state legislature for some public purpose under its police or taxing power". *See* DRAKE & STRICKLAND, *supra* note 9, § 10:8. However, even if these requirements are satisfied, it does not necessarily follow that a claim will receive eighth priority as an excise tax. *See In re* Suburban Motor Freight, Inc., 36 F.3d 484, 489-90 (6th Cir. 1994) ("tax" imposed on Chapter 11 debtor under Internal Revenue Code provision imposing 10% penalty on any accumulating funding deficiency of certain pension plans was not entitled to priority as an excise tax, but instead was to be dealt with, for bankruptcy purposes, as a penalty - an ordinary unsecured claim, and its exaction was punishment for unlawful omission). Generally speaking, an excise tax within this section is a tax imposed for the performance of an act, on engaging in occupation, or on enjoyment of a privilege, that is, a tax on manufacture, sale, or use of goods, or on the carrying on of an occupation or activity or transfer of property. *See In re* Templar, 170 B.R. 562 (Bankr. M.D. Pa. 1994).

32. 11 U.S.C. § 507(a)(8)(F) (2000 & Supp. 2006).

33. *Id.* § 507(a)(8)(G). In applying this subsection, an important distinction is drawn between penalties which compensate for "actual pecuniary loss" and those which merely punish. *See In re* Hovan, Inc., 96 F.3d 1254 (9th Cir. 1996) (penalty portions of Chapter 11 debtor's state tax obligations were punitive, not compensatory, and therefore not entitled to priority statute even though the state claimed penalties compensated for actual pecuniary loss associated with collecting unpaid taxes; the state's escalating percentage–based penalty provisions had no direct relation to any specific costs incurred by the state, indicating an intent to punish, and were imposed in addition to interest that compensated the state for losses related to the time value of money). *See also* DRAKE & STRICKLAND, *supra* note 9, § 10:8.

34. 11 U.S.C. § 507(a)(9) (2000 & Supp. 2006).

from the operation of a motor vehicle or vessel if such operation was unlawful because the debtor was intoxicated from using alcohol or drugs.[35]

It is also worth mentioning that § 507(b) grants a super-priority claim for secured creditors who receive inadequate protection of their claim and sustain damages arising from the automatic stay of their action under section 362 of Title 11.[36] Through this allowance, section 507(b) bolsters the impact of adequate protection under sections 362, 363, and 364(d),[37] by mandating that damages sustained by inadequately protected creditors shall be given priority over all other priority claims.[38] Affording super-priority status for administrative claims to creditors, for whom adequate protection payments prove insufficient, finds its justification in the goal of encouraging the provision of goods and services to a bankruptcy estate, and of "compensating those who expend new resources attempting to rehabilitate the debtor."[39]

B. EMPLOYEE PRIORITY CLAIMS

Claims involving debtors specifically in their role as employers must fall within two possible categories in order to receive priority treatment in the bankruptcy context.[40] These claims must be made for either "wages,

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35. *Id.* § 507(a)(10).

36. *Id.* § 507(b). Generally a creditor must pass a three-tiered test before receiving this super-priority: First, adequate protection must have been provided prior to the request, and such protection must have ultimately failed or been inadequate to meet the creditor's needs. Second, the creditor must have a claim that is allowable and that incorporates administrative expenses. Third, the claim must have arisen under an automatic stay, from use, sale, or lease of collateral, or from the granting of a lien for post-petition credit. *In re* Cason, 190 B.R. 917, 923 (Bankr. N.D. Ala. 1995); *In re* Willingham Investments, Inc., 203 B.R. 75, 79 (Bankr. M.D. Tenn. 1996) (bargained-for language in cash collateral order did not entitle creditor to super-priority where creditor did not otherwise meet the criteria established in section 507(b)).

37. *See generally* 11 U.S.C. §§ 362-364 (2000 & Supp. 2006). For a detailed analysis of the Code's system for providing adequate protection, see DRAKE & STRICKLAND, *supra* note 9, § 9:6.

38. *See* DRAKE & STRICKLAND, *supra* note 9, § 10:8.

39. *See generally In re* J.F.K. Acquisitions Group, 166 B.R. 207, 211 (Bankr. E.D. N.Y. 1994) (quoting 11 U.S.C. § 507(b) (2000 & Supp. 2006)). *See also* Baybank-Middlesex v. Ralar Distr., Inc., 69 F.3d 1200, 1204 (1st Cir. 1995) (Chapter 11 debtor's use of collateral subject to lien of unsecured creditor caused no loss, given that creditor ultimately recovered its pre-petition claim in full, thus, creditor was not entitled to administrative expense claim or super-priority administrative expense treatment).

40. *See* 11 U.S.C. § 507(a)(4)-(5) (2000 & Supp. 2006).

salaries, or commissions," as allowed under 11 U.S.C. § 507(a)(4),[41] or for "contributions to an employee benefit plan," as discussed in section 507(a)(5).[42] Those claims which qualify under § 507(a)(4) are assigned fourth level priority under the Bankruptcy Code, and claims under § 507(a)(5) receive fifth priority.[43] The total amount allowed under the Code between these two levels of priority is limited to $10,000 per employee. Claims under level four will be paid in full before any fifth priority claims are paid.[44]

1. Wage Priority

As most would understand, the terms "wages, salaries, or commissions"[45] are the payments to employees which come via a regular paycheck.[46] Section 507(a)(3) of the Bankruptcy Act of 1978 (now renumbered to 507(a)(4)) expanded the protection employees received under the former act, enacted in 1938.[47] Under the Code, wages may include payments by the hour, the week, or monthly, as well as bonuses and payment for individual tasks.[48] Over time, the amount allowed under this subsection has been increased by amendments to the Code.[49] The aggregate amount now allowed between fourth and fifth level priority for employee claims is $10,000 per individual employee.[50]

In addition to wages and salaries, section 507(a)(4) allows for compensation claims to include vacation, severance packages, and sick leave pay due an employee.[51] As a policy matter, these additional forms of compensation were added by Congress in recognition that employees may

41. *Id.* § 507(a)(4).
42. *Id.* § 507(a)(5).
43. *See generally id.* § 507(a)(4)-(5).
44. *See id.* § 507(a).
45. *See id.* § 507(a)(4)(A).
46. The Code also expressly includes vacation, severance, and sick leave pay, as well as sales commissions earned by an individual under certain circumstances that are not germane to this discussion. *See* 11 U.S.C. § 507(a)(4)(A) (2000 & Supp. 2006).
47. The Act of 1978 formally repealed the Act of 1938, where wages received second-level priority, but were limited to wages and commissions. *See* Bankruptcy Act of 1938.
48. *See In re* Cardinal Indus., 160 B.R. 83 (Bankr. S.D. Ohio 1993).
49. *Compare* Bankruptcy Act of 1938 § 64 ($600), *with* Act of 1978 ($2,000) this amount was raised in 1994 to $4,000, and most recently to $10,000 per employee in the current edition of 11 U.S.C. § 507(a)(4) (2000 & Supp. 2006).
50. *See* 11 U.S.C. § 507(a)(4)-(5)(B)(i) (2000 & Supp. 2006).
51. *See id.* § 507(a)(4)(A).

negotiate for additional benefits in lieu of higher wages.[52] Although Congress did amend the Code to recognize these bargained-for benefits as protected by fourth level priority status, not all job-related services performed by the employee produce benefits that the Code equates to wages. These unprotected wage substitutes include employee expenses[53] that are normally reimbursed by the employer, and stock options ordinarily deducted from the employee's paycheck.[54] According to past holdings, wages and other forms of compensation, for purposes of section 507(a)(4), appear to be directly related to payment for an employee's past service, and do not include fringe benefits, or other benefits received automatically as a result of employment.[55]

2. Priority for Contributions to Employee Benefit Plans

As explained above, section 507(a)(5) of the Code grants priority status to unsecured claims for contributions to an employee benefit plan.[56] Congress enacted section 507(a)(5) in response to two Supreme Court cases[57] decided under the Bankruptcy Act of 1898.[58] In those cases, the Court ruled that the Act's wage priority under section 64(a)(2) "did not cover employer contributions to union-operated welfare and annuity funds."[59] The legislative history of section 507(a)(5) expressly describes that the provision was enacted to overrule those Supreme Court decisions.[60] By doing this, Congress gave recognition to the fact that collective

52. *See* S. REP. No. 95-989, at 69 (1978).

53. *See In re* Grower's Seed Ass'n, 49 B.R. 17 (Bankr. N.D. Tex. 1985) (moving expenses that the employer promised to reimburse do not fall within the wage priority).

54. *See In re* Baldwin-United Corp., 52 B.R. 549, 551 (Bankr. S.D. Ohio 1985) (holding that stock options may not be included under the wage priority, and may not be considered either wages or severance pay).

55. *See* Deborah Gille, *Tenth Circuit Bankruptcy Appellate Panel Hold's Worker's Compensation Premiums Are Not Entitled to Fringe Benefit Priority Status - In re* Southern Star Foods, Inc., 28 N.M. L. REV. 487, 490 (1998) (discussing the implications of the 10th Circuit holding that an insurer's claim for workers' compensation premiums are not entitled to priority status under section 507(a)).

56. 11 U.S.C. § 507(a)(5) (2000 & Supp. 2006). As with wage claims under section 507(a)(4), employee benefit claims may be aggregated into a class having the option of accepting a proposed payout scheme in a reorganization plan. *See id.* § 1129(a)(9)(B).

57. The two cases were *Joint Industry Board of Electrical Industry v. United States*, 391 U.S. 224 (1968) and *United States v. Embassy Restaurant, Inc.*, 359 U.S. 29 (1959).

58. 11 U.S.C. § 104(a)(2) (repealed 1978).

59. *See In re* Saco Local Dev. Corp., 711 F.2d 441, 448 (1st Cir. 1983).

60. *See* H.R. REP. No. 95-595 (1977); S. REP. No. 95-989 (1978).

bargaining agreements often substitute employee fringe benefits for wage demands.[61]

Although the Court decisions that inspired this change to the Code addressed only collective bargaining agreements, "employee benefit plans" that receive priority under section 507(a)(5) are not limited to those that arise from collective bargaining agreements. Since Congress's intent "in enacting the section was to expand wage priority to new forms of compensation," the preference applies equally to fringe benefits paid unilaterally by the employer, without specifically being bargained-for as a true wage substitute.[62]

Although the Code does not define the term "employee benefit plan," the legislative history indicates that Congress intended that "pension plans, and health or life insurance plans ... arising from services rendered" would be included.[63] Some courts[64] defer to the definition of "employee benefit plan" used by the Employee Retirement Income Security Act of 1974 (ERISA).[65] Included expressly in the ERISA definition of "employee benefit plan" is that it includes coverage for the employee or their beneficiary, "through the purchase of insurance or otherwise, benefits in the

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61. *See id.*; Matter of Lummus Ind., Inc., 193 B.R. 615, 618 (Bankr. M.D. Ga. 1996) (stating that the "theory behind [section 507(a)(5)] is that, in the realities of collective bargaining agreement negotiations, employees may give up certain claims for wages in exchange for fringe benefits. As a result, the fringe benefits earned 180 days before the filing of a bankruptcy petition should be entitled to priority in the same way for the same reason that wages are entitled to priority").

62. *See In re* Saco Local Dev. Corp., 711 F.2d 441, 449 (1st Cir. 1983).

63. *See* H.R. REP. No. 95-595 (1977); S. REP. No. 95-989 (1978).

64. *See, e.g.*, Allegheny Int'l, Inc. v. Metro. Life Ins. Co., 145 B.R. 820 (W.D. Pa. 1992); *In re* AOV Indus., Inc., 85 B.R. 183 (Bankr. D.C. 1988); *In re* Cardinal Indus., Inc., 164 B.R. 76 (Bankr. S.D. Ohio 1993); *In re* HLM Corp., 62 F.3d 224, 227 (8th Cir. 1995) (unpaid prepetition workers' compensation premiums are not "contributions to an employee benefit plan" and are therefore not entitled to fifth priority status). *But see In re* Gerald T. Fenton, Inc., 178 B.R. 582 (Bankr. D.C. 1995) (holding that workers' compensation premiums owed to an insurance company where the coverage was mandated by statute were entitled under section 507(a)(5) to priority status as "contributions to an employee benefit plan").

65. *See* 29 U.S.C. § 1002 (2000). ERISA defines an "employee welfare benefit plan" as "any plan, fund, or program ... established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchases of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services..." *Id.*

event of sickness, disability, accident, [or] death."[66] Such a definition appears to almost explicitly include workers' compensation insurance coverage.

In order to receive priority treatment, the claim for contributions to an employee benefit plan must arise from services rendered within 180 days of the first to occur of either the date of filing for bankruptcy, or the date of cessation of the debtor's business.[67] The "cessation of business" requirement was included by Congress to prevent the employer from opportunistically choosing the date of filing so that employee's claim will be defeated by the 180 day requirement.[68] Courts must interpret this cessation with the legislative intent in mind, to facilitate the policy of protecting employees.[69] The companion fourth priority also includes an identical cessation of business requirement and is likewise interpreted.[70]

The Code provides that a claim brought under section 507(a)(5) for contributions to an employee benefit plan is subject to an established cap.[71] The aggregate amount which can be recovered under this section is $10,000 per individual employee, reduced by the total amount of payments to employees as priority wage payments under section 507(a)(4).[72] Since both sections share the cap, section 507(a)(4) and section 507(a)(5) must be dealt with as a package.[73] This treatment reflects the reality that wages and fringe benefits are treated as complementary in labor agreements. Claims not falling within these statutory limitations are treated as general unsecured claims.[74]

By identifying specific debts, which are to be paid outside the principle of *pro rata* or equality of distribution among creditors, Congress created exceptions for certain classes of creditors. Due to the "special, policy-

66. *See id.*

67. 11 U.S.C. § 507(a)(5)(A) (2000 & Supp. 2006).

68. *See In re* Bodin Apparel, Inc., 56 B.R. 728, 731 (S.D.N.Y. 1985).

69. *See In re* Davidson Transfer & Storage Co., 41 B.R. 805, 807-08 (Bankr. D. Md. 1984).

70. 11 U.S.C. § 507(a)(4) (2000 & Supp. 2006).

71. *See id.* § 507(a)(5).

72. *Id.* § 507(a)(5)(B).

73. *Id.*

74. *See In re* Sunarhauserman, Inc., 184 B.R. 279, 283 (Bankr. N.D. Ohio 1995) (adjusting a claim for contributions to an employee pension plan based on reductions in the work force and a freeze on plan benefits that occurred within the 180 day window before the petition was filed).

based" nature of these rights, a claimant must fit clearly within explicated requirements in order to be granted priority status.[75]

II. STATEMENT OF THE CASE

Zurich American Insurance Company ("Zurich") contracted with Howard Delivery Service, Inc. ("Howard") to provide workers' compensation coverage for Howard's employees in ten states.[76] Each of the states in which Howard operated required the employer to maintain this coverage to ensure "it's employees' receipt of health, disability, and death benefits in the event of on-the-job accidents."[77]

Howard had been a freight trucking business, operating terminals in Michigan, Ohio, Illinois, and West Virginia,[78] with other operations in a total of twelve states.[79] Howard had contracted with Zurich, through two separate policies, to provide workers' compensation coverage for its workers in only ten of those states because West Virgina[80] and Ohio[81] do not permit private insurers to provide workers' compensation insurance.[82] Under the policies it provided, Zurich was to receive payments from Howard, both for the initial premiums required under the policies, as well as retrospective adjustments to the premiums, either as an increase or decrease in future payments, depending on Howard's employees' actual loss experiences.[83] According to these policies, although Zurich maintained the right to cancel the policies in the event of nonpayment of premiums, the insurer was required to continue to pay all workers' compensation benefits arising from claims related to on-the-job accidents occurring while the policy was in effect, irrespective of whether Howard later defaulted on payment of premiums.[84]

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75. *See* 4 COLLIER ON BANKRUPTCY ¶ 507.01 (3rd ed. 1997).

76. Howard Delivery Serv., Inc. v. Zurich Am. Ins. Co., 126 S. Ct. 2105, 2109 (2006).

77. *Id.*

78. *See* Brief for the Respondent at *2, *Howard*, 126 S. Ct. 2105 (No. 05-128), 2006 WL 218965 (citing Howard's First Amended Disclosure Statement for Chapter 11 Plan of Reorganization of Official Committee of Unsecured Creditors (Dkt. #297, filed Dec. 23, 2002)).

79. *See Howard*, 126 S. Ct. at 2109.

80. *See* W. VA. CODE § 23-3-1 (2005).

81. *See* OHIO REV. CODE ANN. §§ 4123.30-4123.35 (West 2005).

82. *See* Brief for the Respondent, *supra* note 78, at *2.

83. *Id.* at *2-3.

84. *See id.* at *3 (such an agreement is required under various state statutes in order to ensure that employees' losses related to on-the-job injuries are compensated, even in the

When Howard lost its main customer in 2001, it was no longer able to maintain profitability.[85] Instead of immediately filing for bankruptcy, Howard attempted to minimize the disruption of its workforce by an orderly wind-down of its business, but because of lost revenues, stopped paying workers' compensation insurance premiums to Zurich roughly six months before filing for bankruptcy.[86] Had Zurich immediately canceled the policies, Howard would have been unable to continue to operate its remaining business in those states requiring such coverage without either finding another carrier to assume the policies or meeting strict self-insurance requirements.[87] Neither of these options would have been feasible for a firm in such financial difficulty as that of Howard.[88] If Zurich had sought to cancel the policies, the carrier would have first needed to give advance notice to state regulators and to Howard before the actual cancellation, the length of such notice varying from state to state.[89]

On January 30, 2002, Howard formally filed for Chapter 11 bankruptcy.[90] After this filing, Howard began liquidation under a Chapter 11 plan confirmed by the bankruptcy court.[91] Due to the fact that the company's assets were insufficient to pay all of the claims, it was established that none of the non-priority unsecured claims would be paid and that funds would also be inadequate to cover the unsecured debts which were entitled to priority status.[92]

After Howard filed for Chapter 11 bankruptcy, Zurich sought priority status for $400,000 in unpaid workers' compensation premiums, which it asserted were entitled to priority status under section 507(a)(5)[93] as

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event that the employer later becomes insolvent or otherwise fails to maintain workers' compensation coverage.) One exemplary statute can be seen in N.Y. WORKERS' COMP. LAW § 54(3) (Gould 2005).

85. Brief for the Respondent, *supra* note 78, at *3.

86. *Id.*

87. *Id.* at *3-4.

88. *Id.* at *4.

89. For example, according to 820 ILL. COMP. STAT. 305/4-4 (2005) ten days notice would be required, while under VA. CODE ANN. § 652-804(B) (2005) thirty days notice must be given. *See* Brief for the Respondent, *supra* note 78, at *4.

90. Howard Delivery Serv., Inc. v. Zurich Am. Ins. Co., 126 S. Ct. 2105, 2109 (2006).

91. Brief for the Respondent, *supra* note 78, at *4.

92. *Id.*

93. In their briefs, the parties referred to section 507(a)(4), but the provision was renumbered after Howard's filing for Chapter 11 bankruptcy. The change to the Code was part of the Bankruptcy Abuse Prevention and Consumer Protection Act of 2005. Aside from the renumbering, this act is not applicable to the case at issue here. For clarity, the updated numbering is used throughout the discussion of *Howard* within this Case Comment.

"contributions to an employee benefit plan."[94] Both the Bankruptcy Court and the District Court for the Northern District of West Virginia denied priority status for Zurich's claim, reasoning that the premiums did not qualify as bargained-for benefits in lieu of additional wages, and therefore were outside Congress's intent for section 507(a)(5) protection.[95] The courts determined that, unlike contributions to employee pension and health plans, where such priority status has been granted,[96] unpaid workers' compensation premiums do not qualify under this theory.[97]

The case was appealed to the Fourth Circuit, where the court reversed the lower courts' decisions in a *per curiam* opinion.[98] In their decision, the two judges comprising the majority disagreed in their reasoning for the holding.[99] One judge held that section 507(a)(5) unambiguously accorded priority status to claims for unpaid workers' compensation premiums.[100] The other judge held that the phrase "employee benefit plan" in section 507(a)(5) of the Bankruptcy Code was ambiguous.[101] After considering the legislative history, he concluded that it was most likely that Congress did intend to give priority status to unpaid workers' compensation premiums.[102] In contrast, the one dissenting judge found that the plain meaning of section 507(a)(5) clearly denied priority status for such a claim by an insurer.[103]

Upon further appeal, the United States Supreme Court granted certiorari in order to resolve the existing disagreement among circuits on the treatment of unpaid workers' compensation premiums when insurers seek priority status.[104] This disagreement is mainly attributable to the fact

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94. *Howard*, 126 S. Ct. at 2109.

95. *Id.* at 2109-10.

96. *See generally* Aetna Life Ins. Co. v. Montaldo Corp., 232 B.R. 853 (M.D.N.C. 1997) (reversing Bankruptcy Court decision and holding that unpaid group health and life insurance premiums do qualify for fourth-level priority as "contributions to an employee benefit plan").

97. Howard Delivery Serv., Inc. v. Zurich Am. Ins. Co., 126 S. Ct. 2105, 2110 (2006).

98. Howard Delivery Serv., Inc. v. Zurich Am. Ins. Co., 403 F.3d 228 (4th Cir. 2005).

99. *Id.*

100. *Id.* at 237.

101. *Id.* at 238-39.

102. *Id.* at 239-41.

103. *Id.* at 241-44.

104. Howard Delivery Serv., Inc. v. Zurich Am. Ins. Co., 126 S. Ct. 621 (2006) (granting certiorari). *See also* Travelers Prop. Cas. v. Birmingham-Nashville Express, 224 F.3d 511, 517 (6th Cir. 2000) (denying priority status to unpaid workers' compensation premiums); State Ins. Fund v. S. Star Foods, 144 F.3d 712, 717 (10th Cir. 1998) (also denying priority status); *In re* Arrow Carrier Corp., 154 B.R. 642, (Bankr. D.N.J. 1993) (holding that claims for unpaid workers' compensation premiums are not entitled to priority

that when Congress added the provision for priority status accorded by section 507(a)(5) to the Bankruptcy Code, they left the key terms, "contributions to an employee benefit plan ... arising from services rendered within 180 days before the date of the filing of the petition," largely undefined.[105]

In arguing its case, Zurich asserted that the Court should join the circuits which to followed the definition of an employee benefit plan used in the Employee Retirement Income Security Act of 1974 ("ERISA"), which includes "any plan, fund, or program [providing] its participants ..., through the purchase of insurance or otherwise, ... benefits in the event of sickness, accident, disability, [or] death."[106] Zurich argued that giving its claim for unpaid workers' compensation premiums § 507(a)(5) priority would promote the goals of the priority regime by providing to employers and employees the benefit of aiding in the rehabilitation of ailing businesses through incentivizing workers' compensation insurance carriers to continue coverage for failing enterprises.[107] In its brief to the Court, Zurich pointed out that the very reason why workers' compensation benefits are required by most states is that they provide a vitally important benefit to workers and their families.[108] Zurich asserted that if states had not chosen to mandate such protection by statute, "workers' compensation would surely be a common feature of bargained-for employee benefit packages today."[109] Zurich claimed that the "bargained-for wage substitute" test promoted by Howard would bring the perverse result of denying statutory protection to the forms of employee benefits that states have found to be most important.[110]

In appealing the Fourth Circuit holding, Howard Delivery Service argued that in order for contributions to be eligible for priority status, they must be voluntary.[111] If accurate, that position would disallow the contribution considered in that case due to the fact that providing its

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treatment). *But see In re* Gerald T. Fenton, Inc., 178 B.R. 582 (Bankr. D.C. 1995) (holding that an insurance company's claim for statutorily mandated workers' compensation insurance was entitled to fifth priority status under section 507(a)(5) as contributions to an employee benefit plan); Employers Ins. of Wausau v. Plaid Pantries, Inc., 10 F.3d 605, 607 (9th Cir. 1993) (also according priority status to such claims).

105. *See* 11 U.S.C. § 507(a)(5) (2000 & Supp. 2006).

106. *Howard*, 126 S. Ct. at 2112. *See also* 29 U.S.C. § 1002(1) (2000 & Supp. 2006).

107. *Howard*, 126 S. Ct. at 2115.

108. *See* Brief for the Respondent, *supra* note 78, at *1.

109. *Id.*

110. *Id.*

111. Howard Delivery Serv., Inc. v. Zurich Am. Ins. Co., 126 S. Ct. 621, 2117 (2006).

workers with workers' compensation coverage was statutorily mandated by the various states in which Howard operated.[112] Howard argued that because these payments were mandatory, they could not be considered contributions at all.[113] Howard asserted that because the payments were mandated by statute, they did not "arise from services rendered,"[114] as required by the statute under which Zurich sought priority status.[115] According to Howard, this phrase excludes payments to insurance companies altogether, due to the fact that those payments result from the services of the insurance company, rather than from the services of the employees of the distressed employer.[116]

III. THE SUPREME COURT'S RATIONALE

A. OPINION OF THE MAJORITY

The majority opinion of the Court, delivered by Justice Ginsburg, and joined by Chief Justice Roberts, and Justices Scalia, Stevens, Thomas, and Breyer,[117] reversed the holding of the Fourth Circuit[118] and denied priority status to Zurich American Insurance Company for the unpaid workers' compensation premiums it was owed by Howard Delivery Service.[119] In their opinion, the Court pointed out that workers' compensation plans differed from the "employee benefit plans" protected by priority under section 507(a)(5), because they "do not run exclusively to the employees' benefit."[120] The court explained that not only do employees gain assurance of compensation for on the job injuries, without having to show negligence on the part of the employer, but employers also gain immunity from tort actions that might yield damaging rewards.[121] For this reason, the majority considers workers' compensation premiums as more of a liability insurance payment than a contribution to an "employee benefit plan."[122]

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112. *Id.* at 2109.
113. *Id.* at 2117.
114. 11 U.S.C. § 507(a)(5) (2000 & Supp. 2006).
115. *Howard,* 126 S. Ct. at 2118.
116. *Id.* at 2118.
117. *See* Howard Delivery Serv., Inc. v. Zurich Am. Ins. Co., 126 S. Ct. 2105, 2108 (2006).
118. *See id.* at 2116.
119. *Id.*
120. *Id.* at 2109.
121. *See id.* at 2109.
122. *Id.*

In its opinion the Court pointed out that the main purpose of the statutory section at issue in that case was to capture portions of employee compensation, for services rendered, not covered under section 507(a)(4).[123] With this in mind, the Court framed the main issue in the case as whether workers' compensation premiums should be included under section 507(a)(5) priority because they are "contributions to an employee benefit plan."[124] In assessing the correct definition of the term "employee benefit plan," the Court found Zurich's argument,[125] that the correct interpretation is the one provided by ERISA,[126] unappealing.[127] Instead, the Court held that because the Bankruptcy Code provides no specific directions that establish the validity of the interpretation used in ERISA, no warrant existed to "write them into the text."[128]

In denying fifth level priority to workers' compensation premiums, the Court stated that unlike pension plans or life, health, or disability insurance, which are granted as substitutions for increased wages, workers' compensation benefits are provided as much for the benefit of the employer as they are for the employee.[129] The Court explained that due to the trade off in workers' compensation providing benefits to both employers and employees, they hesitate to consider such coverage a fringe benefit.[130] They argue that pension plans and group health or life insurance plans provided by employers insure the employee only, but workers' compensation insurance provides both accident compensation coverage for employees and a liability insurance component for employers.[131]

Another distinction made by the Court between workers' compensation programs and other fringe benefits is that, unlike other coverage, most states require employers to provide workers' compensation coverage.[132] Because workers' compensation premiums owed to a state fund were

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123. Howard Delivery Serv., Inc. v. Zurich Am. Ins. Co., 126 S. Ct. 2105, 2111 (2006).

124. *Id.* at 2113.

125. *Id.* at 2112.

126. *See* 29 U.S.C. § 1001 (2000).

127. *See* United States v. Reorganized CF & I Fabricators of Utah, Inc., 518 U.S. 213, 219 (1996).

128. *Howard*, 126 S.Ct. at 2113.

129. Howard Delivery Serv., Inc. v. Zurich Am. Ins. Co., 126 S. Ct. 621, 2113 (2006) (citing 6A LARSON & L. LARSON, WORKERS COMPENSATION LAW § 100.01[1] (2005)).

130. *Id.* at 2114.

131. *Id.*

132. *Id.*

ranked, by the Fourth Circuit,[133] as excise taxes having eighth priority, the Court found that it would be anomalous to allow such debts owed to a private creditor to receive fifth priority, given that Congress commonly prefers government creditors over private creditors.[134]

In response to Zurich's argument that giving workers' compensation claims fifth level priority will give carriers an incentive to continue coverage of a failing enterprise and help to provide rehabilitation of the business, the Court stated that such an outcome is doubtful.[135] The Court states that such protection in the bankruptcy context would likely not weigh as heavy in the hypothetical insurers mind, when deciding whether to cancel coverage, as would the exposure to liability for compensation of injured workers without payment of premiums by the distressed employer.[136] The Court found that consideration to be a stronger motivating factor for carriers than an assurance of priority status, which still carries no guarantee of payment.[137]

The Court explicated that "[r]ather than speculating on how workers' compensation insurers might react were they granted an (a)(5) priority, we are guided in reaching our decision by the equal distribution objective underlying the Bankruptcy Code."[138] In order to pursue this objective, the Court stated its intent to "tightly" construe provisions allowing preferences, so that if "one claimant is preferred over others, the purpose should be clear from the statute."[139] Because every claim given priority status effectively reduces the amount recoverable by all creditors of equal or lower priority, the Court finds it necessary to strictly limit the availability of 507(a) priorities to those expressly allowed by the statute.[140] According to the Court, "[o]pening the (a)(5) priority to workers' compensation carriers could shrink the amount available to cover unpaid contributions to plans paradigmatically qualifying as wage surrogates, prime among them, pension and health benefit plans."[141] For these reasons, the majority found

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133. *See* New Neighborhoods, Inc. v. W. Va. Workers' Comp. Fund, 886 F.2d 714, 718-20 (4th Cir. 1989).

134. *See Howard*, 126 S.Ct. at 2114-15 (citing *In re* Birmingham-Nashville Exp., Inc., 224 F.3d 511, 517-18 (6th Cir. 2001)).

135. Howard Delivery Serv., Inc. v. Zurich Am. Ins. Co., 126 S. Ct. 621, 2115 (2006).

136. *See id.*

137. *See id.*

138. *Id.* at 2116.

139. *Id.* (quoting Sampsell v. Imperial Paper & Color Corp., 313 U.S. 215, 219 (1941)).

140. *Id.*

141. Howard Delivery Serv., Inc. v. Zurich Am. Ins. Co., 126 S. Ct. 2105, 2116 (2006).

that claims for unpaid workers' compensation premiums do not fall within the intent of Congress in drafting section 507(a)(5).[142]

B. OPINION OF THE DISSENT

The minority opinion of the Court was delivered by Justice Kennedy, and joined by Justices Souter and Justice Alito.[143] These Justices agreed with the holding of the Fourth Circuit that payments for workers' compensation coverage are "contributions to an employee benefit plan ... arising from services rendered."[144]

In opposing the holding of the majority, the dissenters explained their disagreement with the assertion that "statutorily prescribed workers' compensation regimes do not run exclusively to the employees' benefit," and stated that such a rationale cannot adequately serve as justification for the Court's ruling.[145] The minority also argued that the holding of the majority was neither in accordance with Congress's intent in forming section 507(a)(5), nor with the plain meaning of the text of that section.[146] Instead of reading the bankruptcy priorities simply in the way which gives protection to as few creditors as possible, as was done by the opinion of the majority when they stated that the Bankruptcy Code "provisions allowing preferences must be tightly construed,"[147] the minority opinion emphasizes that the provisions should be interpreted "in accord with the principle of equal treatment of like claims."[148]

Although Howard sought an interpretation of the term "contributions to an employee benefit plan" to require a "voluntariness" component to qualify as a contribution, pointing to counter-examples where the Court's past opinions expressly refer to "mandatory contributions" when discussing payments by employers to employees, the dissent explained that "in the context of employer payments" such a requirement is not a reasonable use of the word contribution.[149] Even contributions to pension and health plans,

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142. *See* 11 U.S.C. § 507(a)(5) (2000 & Supp. 2006). *See also Howard*, 126 S. Ct. at 2116.

143. *Howard*, 126 S. Ct. at 2117.

144. *See* 11 U.S.C. § 507(a)(5) (2000 & Supp. 2006).

145. *See Howard*, 126 S. Ct. at 2117.

146. *Id.*

147. Howard Delivery Serv., Inc. v. Zurich Am. Ins. Co., 126 S. Ct. 2105, 2116 (2006).

148. *Id.* at 2117.

149. *Id. See also* Hughes Aircraft Co. v. Jacobson, 525 U.S. 432, 435 (1999) (where the Court used the term "mandatory contributions" in referring to payments to employees in

which are expressly within the ambit of section 507(a)(5), are rarely made, if ever, voluntarily in the charitable sense that Howard's position advocates.[150] With this in mind, Justice Kennedy explained that "the mandatory nature of most workers' compensation coverage, then, fails to establish that the payments are not 'contributions.'"[151]

The dissent found Howard's argument that the workers' compensation premiums at issue here did not "arise from services rendered,"[152] equally unpersuasive.[153] Although Howard argued that insurance payments are automatically excluded by that section because they are made in exchange for the services of the insurance company instead of the services of the employee, the payments are nonetheless predicated upon the employees' performance of services for the employer.[154] Howard's interpretation would run counter to the goal of protecting employees, because "to allow the insurer to obtain its premiums through the priority would seem the surest way to provide the employees with the policy benefits to which they are entitled."[155]

The dissent's main point of disagreement with the majority opinion lies with the majority's determination that workers' compensation insurance does not qualify as an "employee benefit plan."[156] Citing the obvious benefits provided to employees by workers' compensation coverage, even in light of the possible tort claims relinquished under the system, Justice Kennedy explained that even where an employee might have received a greater payment in a tort suit, the speed and certainty of payment, along with avoidance of suing one's own employer, is often worth the trade-off.[157] While the majority opinion chose not to categorize workers' compensation as an employee benefit plan largely due to the fact that it also benefits employers,[158] the dissent found such logic counterproductive.[159]

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the context of 26 U.S.C. § 411(a)(3)(D) (2000 & Supp. 2006). *See also* Gen. Bldg. Contr. Assn., Inc. v. Pennsylvania, 458 U.S. 375, 394 (1982) (also referring to "mandatory contributions").

150. *Howard*, 126 S. Ct. at 2118.

151. *Id.*

152. *See* 11 U.S.C. § 507(a)(5) (2000 & Supp. 2006).

153. Howard Delivery Serv., Inc. v. Zurich Am. Ins. Co., 126 S. Ct. 2105, 2118 (2006).

154. *Id.* at 2118.

155. *See id.* (citing *In re* Saco Local Development Corp., 711 F.2d 441, 449 (1st Cir. 1983) (majority opinion written by Jusitce Breyer)).

156. 11 U.S.C. § 507(a)(5) (2000 & Supp. 2006). *See Howard,* 126 S. Ct. at 2118.

157. *Howard,* 126 S. Ct. at 2118.

158. *See id.* at 2113-14.

Because employers "rarely make large payments to employee funds out of altruism," it cannot be correct that doing so does not provide any benefit to the employer.[160] While the majority points to the benefit received by an employer under the workers' compensation system as disqualification from the category of "employee benefit plans," they ignored that the same holds true for pension plans, health insurance, and life insurance; each of which is expressly included within fifth priority.[161]

Additionally, the Justices in the minority stated their opposition to what they cited as the three other bases for the majority's decision.[162] First, although the majority explained that workers' compensation plans do not fall under section 507(a)(5), because that section was intended only to include wage substitutes,[163] the dissent states that, as a matter of economic reality, workers' compensation plans are wage substitutes.[164] Recent empirical studies have confirmed that employers necessarily pass on the costs of contributions to workers' compensation insurance programs in the form of lower wages for workers.[165]

Second, the dissent departs from the majority by asserting that "the benefit [of workers' compensation] to employees is real and significant regardless of whether the government has mandated the benefit."[166] They say that while states generally "prescribe and regulate" workers' compensation and leave other benefits to private ordering, the presence of bargaining has no bearing on whether contributions should receive priority.[167] The minority questioned what would happen if states began to regulate and mandate "employee benefit plans,"[168] which are accepted under section 507(a)(5), such as health insurance and pension plans, and argued that such a development should not cause disqualification from priority bankruptcy treatment.[169] If any employee plan mandated by states

159. *See* Howard Delivery Serv., Inc. v. Zurich Am. Ins. Co., 126 S. Ct. 2105, 2119 (2006).

160. *Id.*

161. 11 U.S.C. § 507(a)(5) (2000 & Supp. 2006). *See also Howard*, 126 S. Ct. at 2119.

162. *Howard*, 126 S.Ct. at 2119.

163. *See id.* at 2110.

164. *Id.* at 2119.

165. *See* Price V. Fishback & Shawn E. Cantor, *Did Workers Pay for the Passage of Workers' Compensation Laws?*, 110 Q. J. ECON. 713 (1995).

166. Howard Delivery Serv., Inc. v. Zurich Am. Ins. Co., 126 S. Ct. 2105, 2119 (2006).

167. *Id. See also In re* Saco Local Dev. Corp., 711 F.2d 441, 448-49 (1st Cir. 1983).

168. *See* 11 U.S.C. § 507(a)(5) (2000 & Supp. 2006).

169. *Howard*, 126 S. Ct. at 2119.

is automatically disqualified from section 507(a)(5) priority, the dissent explained that, it "would amount to saying that whenever some form of protection for employees comes to be accepted as so necessary for their welfare that it is mandated as an employer responsibility it is no longer a benefit."[170]

Third, the dissent disagreed with the majority's assertion that the existence of state funds to compensate employees when their employers fail to provide workers' compensation benefits defeats priority treatment.[171] Were this the case, pension plans, which are protected in part by the Pension Benefit Guaranty Corporation,[172] would also be excluded from the priority scheme. Such a result plainly would exist in opposition with the intent of the statute.

The final main point made by the dissent is that the Court should have taken direction from the ERISA definition of "employee benefit plan" if they chose to find the term ambiguous as used in the Bankruptcy Code.[173] Under ERISA, "employee benefit plan" is defined as including an "employee welfare plan,"[174] which is further defined as "any plan, fund, or program which ... was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, ... benefits in the event of sickness, accident, disability, death, or unemployment."[175] The dissent stated that the ERISA definition is of particular relevance because the term "employee benefit plan" is used as a term of art, with a meaning that is unlikely to change based on statutory context.[176]

Since it regarded the term "employee benefit plan" to include workers' compensation coverage whether viewed as a term of art, or in accordance with its plain meaning, the dissent stated that the opinion of the majority was in error.[177]

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170. *Id.*

171. *Id.* at 2120.

172. *See* Cent. States, Se. & Sw. Areas Pension Fund v. Cent. Transp., Inc., 472 U.S. 559, 567 n.7 (1985) (citing Department of Labor Advisory Op. No. 78-28A (Dec. 5, 1978)).

173. Howard Delivery Serv., Inc. v. Zurich Am. Ins. Co., 126 S. Ct. 2105, 2120 (2006).

174. 29 U.S.C. § 1002(3) (2000).

175. 29 U.S.C. § 1002(1), 1002(3) (2000).

176. *Howard*, 126 S.Ct. at 2121.

177. *Id.* at 2121 (2006).

IV. ANALYSIS

The Court's decision in *Howard* that priority may be granted under section 507(a)(5) only to fringe benefits given in lieu of wages eliminates the possibility for any creditor other than employees of the bankrupt employer to seek fifth level priority status. The majority concluded that workers' compensation is not an "employee benefit plan," that workers' compensation does not directly benefit employees,[178] and that application of the ERISA definition to the term "employee benefit plan" is inappropriate because Congress did not specifically endorse such an interpretation.[179] In reaching these findings, the court chose to apply the most restrictive interpretation of section 507(a)(5) possible, and to reject what the dissent considered the plain meaning of its terms,[180] in order to limit the availability of fifth level priority as much as possible.[181]

Both the majority and the dissent offer what appear to be plausible rationales for their opinions. Because the question of whether workers' compensation premiums may be considered under section 507(a)(5) is such a close one, and because Congressional intent is far from clear in this matter, it appears that the motivating reasons for the court's findings were policy concerns. The majority cited in its opinion the fear that allowing workers' compensation claims to take fifth level priority would noticeably reduce the available funds for other creditors in bankruptcy proceedings.[182]

V. LIKELY IMPLICATIONS

Congress has been inconsistent in its treatment of workers' compensation claims during bankruptcy,[183] but the decision in *Howard* stands for the proposition that carriers of insurance benefits, especially those providing workers' compensation coverage, will not be allowed to occupy fifth level priority under section 507(a), and will likely be confined to general unsecured creditor status.

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178. *Id.* at 2116.

179. Howard Delivery Serv., Inc. v. Zurich Am. Ins. Co., 126 S. Ct. 2105, 2116 (2006).

180. *Id.* at 2120.

181. *See id.* at 2116.

182. *Id.*

183. Although the 1924 amendments to the Bankruptcy Code expanded claims of provable debts to include workers compensation, the Act of 1938 abolished priority status of workers' compensation claims. Specific reference to priority treatment of workers' compensation is no longer included in the statute. *See* Gille, *supra* note 55, at 501 n.129.

A. EFFECT ON EMPLOYERS

When an employer files bankruptcy under Chapter 11, the employer's business does not come to an end, but instead the business's financial obligations undergo a reorganization that restructures future obligations to allow the employer to continue operating. At that point, the employer has reduced funds with which to pay creditors, including insurers and employees. For this reason, it is likely that the funds which the insurer would ultimately collect will be diminished.

When such an employer seeks workers' compensation insurance, the potential carrier will be unable to raise rates due to the Chapter 11 plan, and will be unwilling to insure the distressed employer beyond any existing policy then in effect. When the employer seeks alternative coverage to replace the lost coverage, it will have great difficulty, and will not be in a financial position to self-insure. Such a development might make it highly difficult or impossible for a distressed employer in a Chapter 11 reorganization to continue to do business in states requiring workers' compensation coverage.

B. EFFECT ON EMPLOYEES

Although workers in most states are protected in the event of an on-the-job injury by state funds which provide an alternative remedy in the event that the employer has failed to maintain workers' compensation coverage, many of these plans require the employee to sue the already distressed employer either in tort, or under the Workmen's Compensation Act.[184] In addition to this added burden, employees of a bankrupt employer also face the possibility that the employer's operations will end more quickly than they otherwise would have, due to an inability to procure statutorily mandated workers' compensation coverage.

C. EFFECT ON INSURANCE CARRIERS

The Court in *Howard* asserted that it would be against congressional intent to allow insurers to have priority under section 507(a)(5). The Court argued that workers' compensation insurance represents a contractual agreement between an insurer and an employer, and is provided not for the

184. *See* Shores v. Charter Serv., Inc., 746 P.2d 1101 (N.M. 1987).

benefit of employees, but instead to satisfy state requirements and to protect the employer from unforeseen tort liability.[185]

In reaching its conclusion, the Court ignored the economic reality that workers' compensation coverage is actually provided at a real cost to employees in the form of lower wages.[186] This reality has been shown in empirical studies and was cited in the opinion of the dissent.[187] Because this coverage provides employees the benefit of guaranteed, speedy compensation in the event of an on-the-job injury, and comes at a cost to the employee in the form of decreased wages, it seems incongruous to exclude workers' compensation coverage from the priority scheme for "employee benefit plans" that were intended to include fringe benefits provided to employees in lieu of wages.

This choice by the Court is likely to result in earlier termination of workers' compensation coverage for employers who might otherwise be rehabilitated by insurers who now know that any claims they might bring for unpaid premiums during bankruptcy proceedings are less likely to be paid, because they cannot obtain priority as "payments to an employee benefit plan." Another possible result is the increased cost of premiums for workers' compensation coverage to all employers because their premiums must also cover those which go unpaid and uncollected due to bankruptcy.

CONCLUSION

By passing the Bankruptcy Act of 1978 and its subsequent amendments, Congress expanded the protection it provided to workers by expressly including fringe benefits that it recognized are often negotiated as a substitute for increased wages. Congress has been protecting workers caught in the uncertain circumstance of working for a bankrupt employer for more than 160 years by providing priority status for wages due.

By statutorily requiring employers to provide workers' compensation coverage for its employees, states have long recognized that such protection is crucial for both workers and employers. Because employees are guaranteed compensation in the event of a work-related injury and employers are protected from the possibility of unknown financial responsibility that the tort system would provide for injured workers,

185. *See* Howard Delivery Serv., Inc. v. Zurich Am. Ins. Co., 126 S. Ct. 2105, 2116 (2006).

186. *See id.* at 2119.

187. *Id.*

workers' compensation coverage can be seen as a type of bargained-for benefit. In contrast to this view, the U.S. Supreme Court has explained its opinion that workers' compensation is a benefit to employers, but not to employees. The Court has held that workers' compensation premiums are not contributions to an employee benefit plan because workers' compensation is not an employee benefit. As a result of this opinion, the split among Federal Circuits has been resolved and workers' compensation insurance carriers have been denied priority status.

By agreeing with those Circuits which have rejected priority status for unpaid workers' compensation premiums, the U.S. Supreme Court has decided to favor a construction of section 507(a)(5) that applies priority status to claims only when the creditors at issue are actual employees. This decision makes it less likely that any insurer or other third party creditor will be granted fifth level priority in the future.