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CATASTROPHIC RISKS AND FIRST-PARTY INSURANCE

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ABSTRACT

Although the insurance industry demonstrates a growing concern about the severe rise in losses from natural disasters, only about one third of all potential victims have in fact purchased first-party catastrophe insurance. Although first-party insurance has several advantages, we find that there is indeed actually no demand for and supply of first-party insurance against natural catastrophes. Therefore, the central question we examine from a behavioral law and economics perspective is why so little use is made of the possibilities of first-party insurance and why first-party insurance can constitute a viable alternative to government compensation. Further, we consider whether compulsory first-party disaster coverage may be a solution. To conclude, we consider under which circumstances the further introduction of first-party catastrophe insurance should be applauded as a means to encourage potential victims to take control over their compensatory means while also benefiting from preventative incentives.

I. INTRODUCTION

The scope and frequency of catastrophes, natural or technological, is increasing. Moreover, recent studies suggest that global warming has resulted in the intensification of floods, draughts, tropical cyclones and

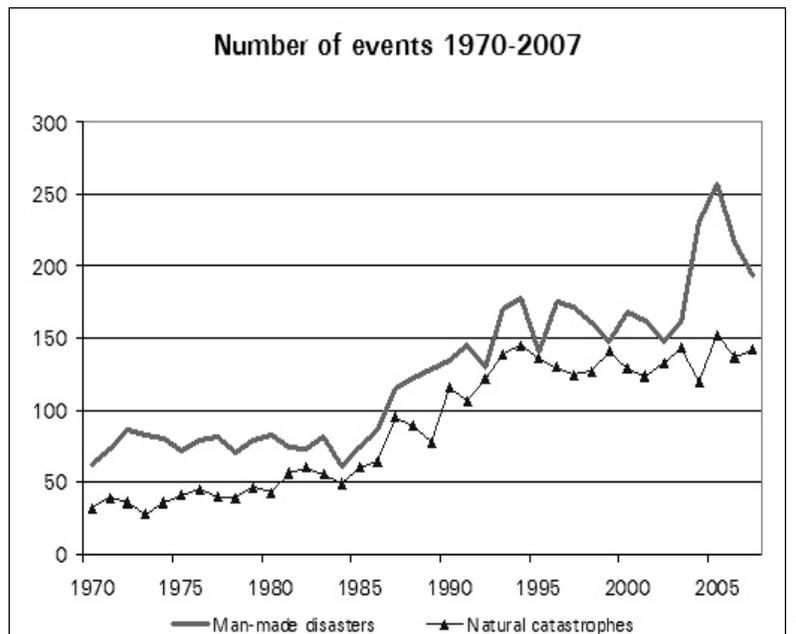
destructive hurricanes, one example being Katrina in the United States.¹ Further, earthquakes and floods are being covered more frequently in the media, which emphasizes the number of victims who lost their lives, their home and their family members, as well as the survivors remaining in the devastated areas. Apart from natural catastrophes, man-made disasters are also on the rise as the unavoidable price of technological progress and as a consequence of the so-called terrorism era. Depending upon the specific characteristics of the country, natural disasters such as earthquakes, hurricanes, volcanic eruptions, may be more common than technological disasters such as fires or explosions. Nevertheless, catastrophes threaten all countries. This is especially true for risks regarding weather conditions, like exceptional rainfall and flooding. The rise of catastrophes generates an increasing number of victims, who require assistance and compensation for their losses.

Various perspectives regarding compensation for catastrophe victims exist. Often the insurance industry is included, to some extent, as part of the proposed compensation scheme. Thus, a great deal of attention is increasingly paid to the role of insurance in providing compensation for victims of catastrophes. A key consideration in utilizing insurance as a compensatory tool turns on how catastrophe is defined in the insurance policies. Though the everyday meaning of catastrophe or disaster may seem clear, developing a formal definition can be much more difficult. In some cases, catastrophe is defined statutorily. Such statutes typically define an event as a catastrophe based upon its scale and the damage incurred both in terms of property as well as loss of life. These definitions are necessary to determine the obligations of public authorities as well as

¹ One of the expected effects of global warming is, as predicted by theory and modeling, an increase in hurricane intensity. This is not to say that there is consensus among scientists regarding the correlation between hurricane activity and climate change. See Alicia Rivera, *Katrina y Rita son hijos del azar. Entrevista con Kerry A. Emanuel, científico del MIT y experto en huracanes*, EL PAÍS, Sept. 25, 2005 (Colom.); Quirin Schiermeier, *Hurricane link to climate change is hazy*, 437 NATURE, Sept. 22, 2005 at 461 available at <http://www.nature.com/nature/journal/v437/n7058/pdf/437461a.pdf>. See generally reports from the Intergovernmental Panel on Climate Change, available at <http://www.ipcc.ch/ipccreports/assessments-reports.htm>; NICHOLAS STERN, THE ECONOMICS OF CLIMATE CHANGE: THE STERN REVIEW xvi, 3 (Cambridge University Press 2008) (2007); P.J. Webster et al., *Changes in Tropical Cyclone Number, Duration, and Intensity in a Warming Environment*, 309 SCIENCE, Sept. 16, 2005 at 1844; Johnny C.L. Chan et al., *Comment on "Changes in Tropical Cyclone Number, Duration, and Intensity in a Warming Environment"*, 311 SCIENCE, Mar. 24, 2006 at 1713b; P.J. Webster et al., *Response to Comment on "Changes in Tropical Cyclone Number, Duration, and Intensity in a Warming Environment"*, 311 SCIENCE, Mar. 24, 2006 at 1713c.

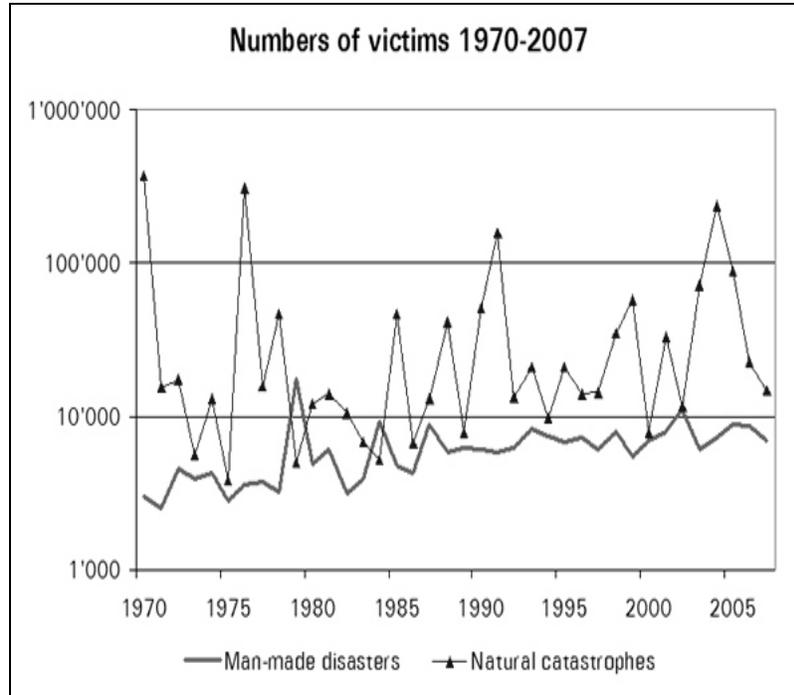
the amount of financing required. When financial loss is the focal point, the number of victims is usually the most important factor. It is this financial aspect of catastrophes that result in a large number of victims that will be the focus of this paper.²

It may be interesting to provide some more concrete facts and figures. The following charts show the increasing number of catastrophic events and of victims from 1970 until 2007.



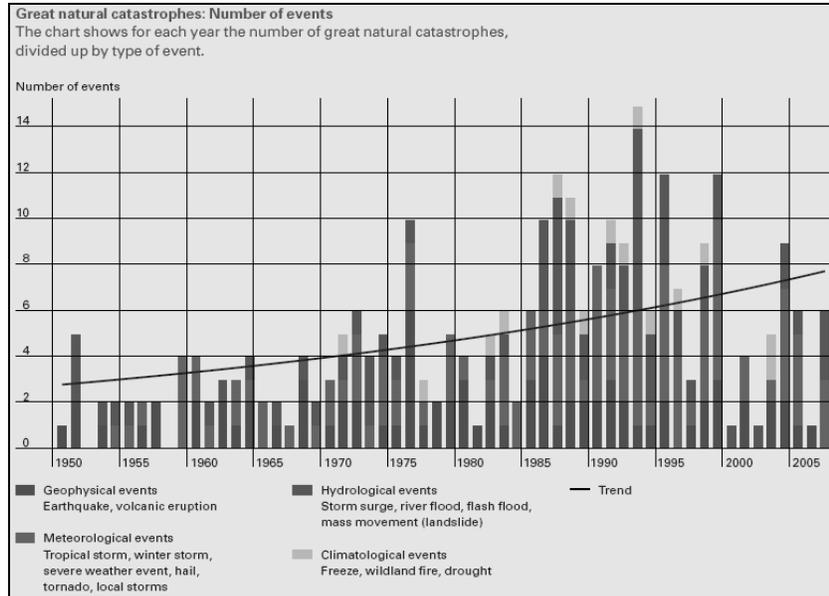
² Because of the large number of victims, the financial effect of catastrophes can be distinguished from the example of traffic accidents. The total number of victims on a yearly basis in traffic can be large as well, but that is usually not considered “catastrophic”. For a criticism, see Ulrich Magnus, *Germany*, in FINANCIAL COMPENSATION FOR VICTIMS OF CATASTROPHES: A COMPARATIVE LEGAL APPROACH, 119 (Michael Faure et al. eds., Springer-Verlag/Wien 2006) who argues that it is strange to qualify the flooding of the Elbe where only a few people died as a catastrophe, whereas all the hundreds of victims dying yearly in traffic accidents are apparently not considered “catastrophic”.

³ Swiss Re, Sigma: Natural catastrophes and man-made disasters in 2007: high losses in Europe, 5 fig.1 (2008).



Focusing only on natural catastrophes, the following figure again demonstrates a marked increase in occurrences:

⁴ *Id* at 6 fig.2.



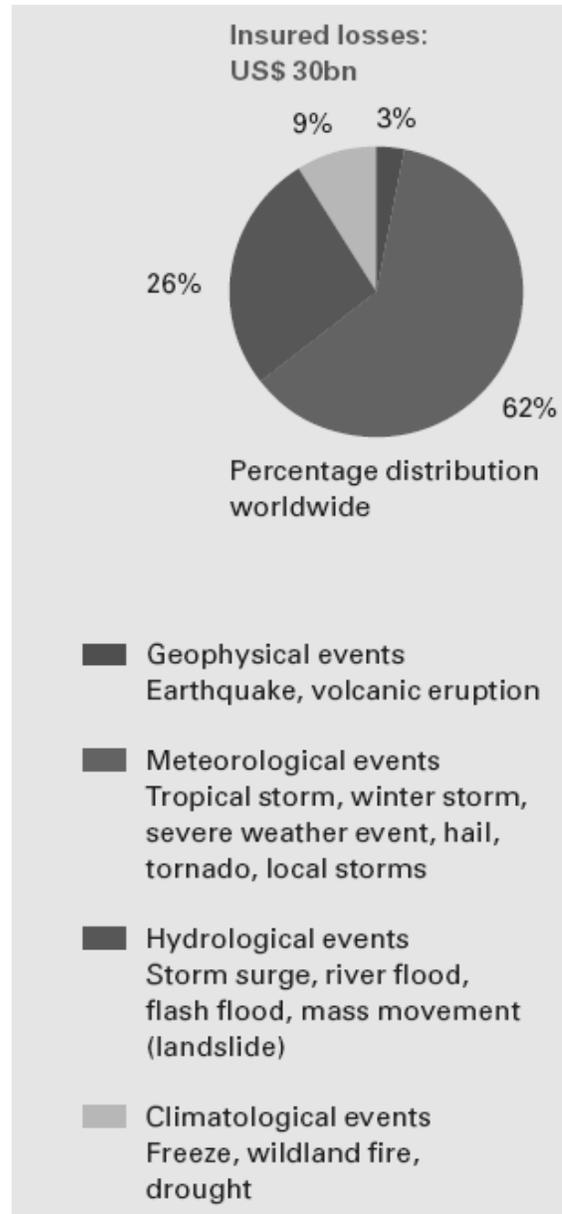
5

In 2007, more than 21,500 people lost their lives, due to approximately 335 natural catastrophes and man-made disasters. The corresponding property damage totaled more than \$ 70 billion, of which about one third, \$ 27.6 billion was covered by insurance.⁶ Of the latter amount, \$ 23.3 billion was attributable to natural catastrophes, while the remaining \$ 4.3 billion was due to major man-made disasters.⁷ This insurance coverage is represented in the following figure:

⁵ Munich Re, *Topics Geo* 2007, 45, available at http://www.munichre.com/publications/302-05699_en.pdf.

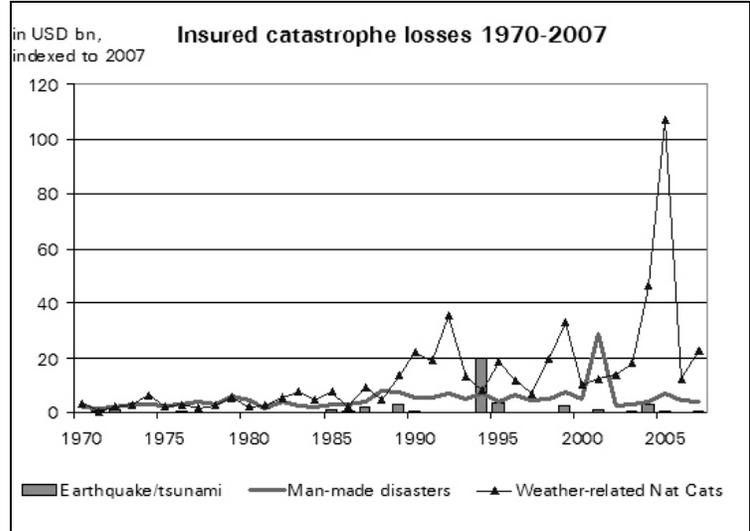
⁶ Swiss Re, Sigma: Natural catastrophes and man-made disasters in 2007: high losses in Europe, 3 (2008).

⁷ *Id.*



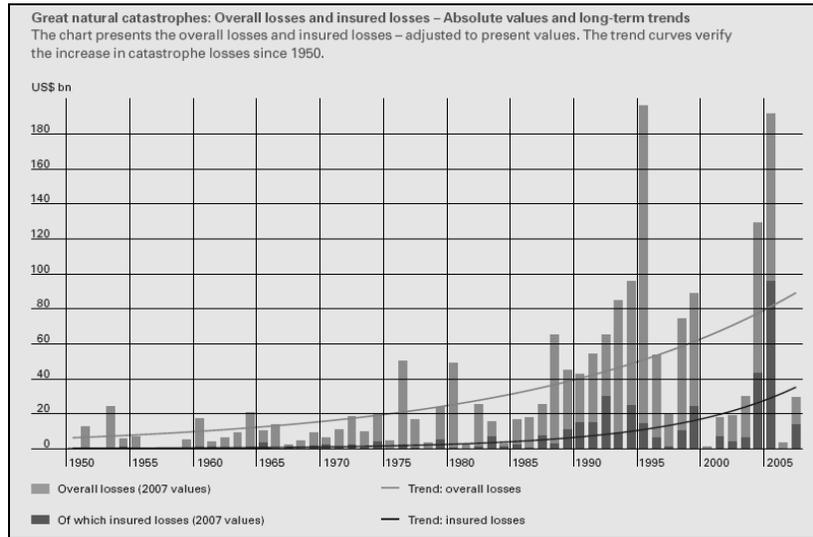
⁸ and

⁸ Munich Re, *Topics Geo* 2007, 45, available at http://www.munichre.com/publications/302-05699_en.pdf.



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Or:



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⁹ Swiss Re, Sigma: Natural catastrophes and man-made disasters in 2007: high losses in Europe, 7 fig.3 (2008).

¹⁰ Munich Re, *Topics Geo* 2007, 49 (2008) available at http://www.munichre.com/publications/302-05699_en.pdf.

These figures demonstrate surprisingly low levels of insurance coverage, most notably for geophysical, climatological and hydrological events. Accordingly, the figures raise the question of whether first-party insurance can play a greater and more influential role in the compensation of catastrophe victims. This question is particularly relevant, especially in Western society, where insurance techniques are broadly developed. Therefore, this paper only focuses on catastrophe insurance coverage for potential victims and does not address man-made or technological disasters for which a person, group, or company may be liable as tortfeasors. Consequently, third party liability insurance, which is available for possible tortfeasors, is not discussed. Moreover, most natural catastrophes do not involve a third party who can be held liable as many natural catastrophes are considered “acts of God.” The only potential liable party in case of natural catastrophes is the government (e.g. for failure to warn or to take adequate measures in case of e.g. flooding). Cases of government liability for natural catastrophes are, however, rare. Hence, the role of third party insurance plays a limited role in natural catastrophes and accordingly, this paper focuses solely on first-party insurance.

As noted this paper will address the use of first party insurance in Western societies, where insurance techniques are well developed but have not fully been utilized as a response to catastrophic losses. Instead, there seems to be a preference for either no compensatory solution or for government provided compensation. Indeed, empirical evidence, discussed below, demonstrates that even where first-party insurance is widely available, potential victims only use it to a limited extent. This of course raises the question whether catastrophic risks have specific features that make the problem difficult to treat.

Addressing the role of first-party insurance is also interesting in light of governments’ increasing attempts to provide financial solutions when the number of catastrophe victims is high.¹¹ These types of government funding are, however, heavily criticized in current law and economics

¹¹ Hirshleifer can be regarded as one of the first to address this issue. He had the insight that providing compensation after the occurrence of a disaster is so politically attractive that the government will invariably find it impossible to resist. See Jack Hirshleifer, *War Damage Insurance*, 35 THE REV. OF ECON & STAT. 144, 146-47 (1953), reprinted in 9 CONN. INS. L.J.1 (2002). See also Peter Siegelman, *A New Old Look at Terrorism Insurance: Jack Hirshleifer’s War Damage Insurance After Fifty Years*, 9 CONN. INS. L.J. 19 (2002).

literature.¹² The question therefore arises whether first-party insurance can constitute a viable alternative to government compensation.¹³ First-party insurance is indeed only one of the many approaches regarding compensation for catastrophe victims.¹⁴ It is intriguing to analyze this particular solution from an economic perspective: on the one hand we can rely on the broad law and economics literature on liability and insurance,¹⁵ and on the other hand on literature on the demand for insurance protection against catastrophes.¹⁶ This traditional law and economics literature starts from the assumption that the human race consists of all rational human beings. However, cognitive psychology research regarding patterns of human decision-making illustrates deviation from the pure rational thinking model. In other words, human behavioral patterns provide added and essential analyses that complement the traditional law and economics perspectives. Moreover, a comparative analysis will be adopted as well, by *inter alia* focusing on solutions adopted by various (Western) countries.¹⁷

Of course, this analysis is mostly applicable in societies where well-organized insurance markets exist. Thus, the question can be asked why disaster insurance, in these countries and societies, are relatively

¹² See Louis Kaplow, *Incentives and Government Relief for Risk*, 4 J. RISK & UNCERTAINTY 167 (1991); George L. Priest, *The Government, the Market, and the Problem of Catastrophic Loss*, 12 J. RISK & UNCERTAINTY 219 (1996); Richard A. Epstein, *Catastrophic Responses to Catastrophic Risks*, 12 J. RISK & UNCERTAINTY 287 (1996).

¹³ Of course, the main sources of pressure on the government concerning catastrophes are probably other than the mere claim for the loss of some definite goods. People indeed usually prefer not being flooded at all over being flooded and compensated, which is fully consistent with the common assumption that compensation, as a matter of fact, is always insufficient to put the victim back to her utility level prior to the catastrophe.

¹⁴ For other compensation mechanisms, see TRANSBOUNDARY RISK MANAGEMENT (Joanne Linnerooth-Bayer et al., eds., Earthscan Publications 2001); Organization for Economic Co-Operation and Development, CATASTROPHIC RISKS AND INSURANCE 25 (OECD Publishing 2005).

¹⁵ See, e.g., STEVEN SHAVELL, *ECONOMIC ANALYSIS OF ACCIDENT LAW* (Harvard University Press 1987).

¹⁶ Howard Kunreuther et al., *DISASTER INSURANCE PROTECTION: PUBLIC POLICY LESSONS* (John Wiley & Sons Inc. 1978); Howard Kunreuther, *Mitigating Disaster Losses through Insurance*, 12 J. RISK & UNCERTAINTY 171 (1996); Paul J.H. Schoemaker & Howard Kunreuther, *An Experimental Study of Insurance Decisions*, 46 J. RISK & INS. 603 (1979).

¹⁷ For a more general comparative approach to the financial compensation for victims of catastrophes, see MICHAEL FAURE & TON HARTLIEF, *FINANCIAL COMPENSATION FOR VICTIMS OF CATASTROPHES* (Springer 2006).

underutilized.¹⁸ First-party disaster insurance, however, is not a viable alternative in many developing countries where either insurance markets are underdeveloped or consumers lack resources to pay a premium *ex ante*.¹⁹

The remainder of this paper is structured as follows: first, we will address the potential of first-party insurance in covering catastrophic losses (Section II). Second, the question arises whether prospective victims actually seek *ex ante* protection through first-party insurance coverage (Section III). Next, after considering the demand side of the equation this paper will discuss the supply side of first-party insurance coverage (Section IV). Then the paper will critically review the phenomenon of compulsory disaster coverage as a reaction to the lack of both supply and demand (Section V). Lastly, concrete examples from France and Belgium will be used to analyze the theoretical solutions put forth (Section VI). The paper concludes with a few final remarks (Section VII).

II. FIRST-PARTY INSURANCE

First-party insurance is a system whereby insurance coverage is provided and compensation is awarded directly by the insurer to the victim. It is thus the prospective victim himself who buys this type of insurance coverage, with the eye on possible future harm and corresponding damages. The underlying principle in first-party insurance is that the insurance company – in principle – pays as soon as damage occurs, provided that it can be proven that the particular damage is an insured risk

¹⁸ As was the case in the Netherlands, for example, supply of disaster insurance was lacking due to a cartel agreement not to provide coverage.

¹⁹ The insurance market for catastrophic risk in the Caribbean Region, for example, remains a thin market characterized by high prices and low transfer of risks. Philippe Auffret, *Catastrophe Insurance Market in the Caribbean Region: Market Failures and Recommendations for Public Sector Intervention* (The World Bank, Policy Research Working Paper 2963, January 2003) offers an overview of the existing market failures, followed by recommendations for public sector interventions. *See also*, John D. Pollner, *MANAGING CATASTROPHIC DISASTER RISKS USING ALTERNATIVE RISK FINANCING AND POOLED INSURANCE STRUCTURES* (World Bank 2001). Non-life (i.e. property/casualty) insurance penetration rates were (and still are) low in those countries affected by the Asian tsunami in 2004. In Indonesia, for example, just \$8 per capita was spent on non-life insurance in 2003.

covered by the insurance policy. Contrary to third party insurance, payment by the insurance company occurs irrespective of whether there is liability.²⁰

Accordingly, insurance protection trends away from tort law and third party insurance and towards insurance schemes whereby victims *ex ante* seek coverage on a first-party basis where possible. For example, in the area of environmental insurance there is a movement toward environmental damage insurance operating as a form of first party insurance.²¹ There is a similar movement toward first-party insurance in some legal systems in medical malpractice insurance²² and when compensating traffic accident victims.²³ The benefits of various first-party insurance schemes are accordingly being used to address a range of societal issues. Indeed, Priest suggested that the shift towards first-party insurance would have been an appropriate remedy to the American insurance crisis that occurred in the eighties.²⁴ Priest reasoned that:

[I]n comparison to first-party insurance, third party tort law insurance provides coverage in excessive amounts, in a manner that substantially restricts risk segregation, and at costs that far exceed the costs of first-party insurance. For both consumer and provider risk pools, these differences will increase the correlation of risks within existing pools and, as a consequence, increase the extent of adverse selection, leading to the breakdown of the pools.²⁵

Other commentators, such as Bishop and Epstein, also favor first-party insurance.²⁶ It has particularly been argued that first-party insurance

²⁰ MICHAEL FAURE & TON HARTLIEF, *INSURANCE AND EXPANDING SYSTEMATIC RISKS* 149 (OECD 2003).

²¹ Michael Faure, *Environmental Damage Insurance in the Netherlands*, 10 ENVTL. LIAB. 31, 37 (2002).

²² See, e.g., Lotta Wendel, *Compensation in the Swedish Health Care Sector*, in NO-FAULT COMPENSATION IN THE HEALTH CARE SECTOR 367, 367 (J. Dute et al. eds., 2004) (showing Swedish system of patient insurance).

²³ Michael Faure, *Tort Liability in France: An Introductory Economic Analysis*, in 6 LAW AND ECONOMICS IN CIVIL LAW COUNTRIES 169, 177-79 (Bruno Deffains et al. eds., 2001); and A. Tunc, *The 'Loi Badinter', Ten Years of Experience*, 4 MAASTRICHT J. EUR. & COMP. L. 3 (1996).

²⁴ George L. Priest, *The Current Insurance Crisis and Modern Tort Law*, 968 YALE L.J. 1521, 1552 (1987).

²⁵ *Id.* at 1552-53.

²⁶ William Bishop, *The Contract-Tort Boundary and the Economics of Insurance*, 12 J. LEGAL STUD. 241 (1983); Richard A. Epstein, *Products Liability as an Insurance Market*, 14 J. LEGAL STUD. 645 (1985); RICHARD EPSTEIN, *SIMPLE RULES FOR A COMPLEX WORLD* 33 (Harvard University Press 1996).

schemes have the advantage of low administrative costs²⁷ as well as the ability to better adapt premiums and policy conditions to specific risks.²⁸ The latter enables first party insurance to engage in easy risk differentiation, which is advantageous for insurers. Under this arrangement it is possible for the insurer to assess *ex ante* the risk and consequently damage that a particular victim would suffer.²⁹ This *ex ante* analysis is not available with third party insurance because assessment of risk is to a third party not known at the time of contracting and potential liability that may or may not follow.³⁰ Lower administrative costs are due to the fact that under a first-party insurance policy the insurer covers the risk of damage to a particular victim or a particular site.³¹ It is therefore much easier for the insured to signal particular circumstances, which may influence the risk to the insurer.³² The reason for the trend away from third party insurance and towards first-party coverage thus becomes clear.

First-party insurances can be divided into two main groups: (1) insurance, which compensates for personal injuries; and (2) insurance, which takes the form of coverage for specific property damage.³³ The schemes, which focus on personal injury compensation usually, do not vary coverage based on the source of the injury, i.e. whether the cause was a catastrophe or not.³⁴ Accordingly, it takes the form of generalized accident insurance coverage. As a result, coverage depends on the specific costs that a victim would incur as a result of an accident, such as lost income, coverage of (additional) medical expenses, and in some cases even pain and suffering.³⁵ Most European countries cover a majority of personal

²⁷ Indeed, one will not spend time nor money looking for a liable tortfeasor and bringing liability claims. RICHARD EPSTEIN, *SIMPLE RULES FOR A COMPLEX WORLD* 31 (Harvard University Press 1996).

²⁸ Ronen Perry, *Relational Economic Loss: An Integrated Economic Justification for the Exclusionary Rule*, 56 RUTGERS L. REV. 711, 771-78 (2004).

²⁹ See Bishop, *supra* note 26, at 246.

³⁰ See Richard A. Epstein, *Product Liability as an Insurance Market*, 14 J. LEGAL STUD. 645, 648-50 (1985).

³¹ See Bishop, *supra* note 26, at 249.

³² *Id.*

³³ Elizabeth Medaglia et al., *The 'Concurrent Cause' Theory: Inapplicable to Environmental Liability Coverage Disputes*, 30 TORT & INS. L.J. 823, 829 (Spring 1995).

³⁴ *Id.* at 829-30.

³⁵ This is more particularly the case in the French policy referred to as "Garantie contre les accidents de la vie". This new insurance policy provides broad (first-party) compensation against accidents and compensates as if tort law were applicable, therefore including compensation for pain and suffering. See also The French GAV® Accident

injury expenses through a social security system.³⁶ Consequently, well-informed potential victims can purchase additional or complimentary coverage according to their individual degree of risk aversion and corresponding need for insurance.³⁷

The second type of first-party insurance schemes applies (only) to property damage, for example housing insurance. In many countries, however, first-party insurance for property damage excludes damages caused by a natural disaster.³⁸ In the Netherlands, for example, property damage caused by flooding is excluded.³⁹ Therefore, this paper analyzes the demand for disaster coverage (Section III), whether competitive insurance markets are supplying such coverage (Section IV) and whether regulatory intervention is necessary to provide access to disaster insurance (Section V). Lastly, this paper will look at general legal practices surrounding the issue (Section VI).

III. DEMAND FOR FIRST-PARTY INSURANCE AGAINST NATURAL DISASTERS

A. THE DECISION TO PURCHASE FIRST-PARTY INSURANCE: EXPECTED UTILITY HYPOTHESIS

The first issue that arises is whether there is demand by the public for coverage against damage caused by catastrophes. According to the expected utility model, an individual is assumed to behave as if he engaged in a detailed analysis of the costs and benefits associated with the purchase of an insurance policy.⁴⁰ As a result, a potential victim residing in a hazard-prone area will voluntarily purchase first-party insurance if he perceives the

Compensation, SCOR Technical Newsl. (SCOR Group, Paris, France), Oct. 2003, at 2, available at http://scor.com/www/fileadmin/uploads/publics/NTNV2003_05_en_tuknv05.pdf.

³⁶ Arye Miller, *Should Social Insurance Pay Compensation for Pain and Suffering?*, 31 INT'L & COMP. L.Q. 550, 554-56 (1982).

³⁷ This assumes that competitive insurance markets offer applicable policies.

³⁸ *The Demand for Flood Insurance: Statement before the Comm. On Banking, Housing, and Urban Affairs 2* (Oct. 18, 2005) (Statement of Mark Browne, Gerard D. Stephens CPCU Chair in Risk Management and Insurance).

³⁹ *Id.*

⁴⁰ This utilitarian approach on insurance has, among others, been described by Nobel Prize winner Kenneth J. Arrow. See generally, Kenneth Arrow, *Uncertainty and the Welfare Economics of Medical Care: Reply (The Implications of Transaction Costs and Adjustment Lags)*, 55 AM. ECON. REV. 154 (1963); Kenneth Arrow, *The Economics of Moral Hazard: Further Comment*, 58 AM. ECON. REV. 537 (1968).

premium to be sufficiently low in comparison to the risks (and if he is convinced that *ex post* governmental disaster relief will not be forthcoming).⁴¹

Doherty and others, however argue that financial considerations are only one of the reasons why homeowners would purchase first-party insurance.⁴² Decisions regarding the purchase of insurance coverage may also be driven by emotion-related goals (either worry or regret), the need to satisfy legal or other official requirements, the need to satisfy social and/or cognitive norms, and the need to maintain a relationship with a trusted agent/advisor.⁴³ Indeed, regarding the emotion-related goals, there is a growing literature on how emotional goals impact individuals' decision making regarding risk.⁴⁴ Three main emotional goals pertaining to catastrophe coverage are: (1) reduction of anxiety (i.e. peace of mind); (2) avoidance of anticipated regret⁴⁵; and (3) disappointment.⁴⁶ Thus, reasons for purchasing insurance are complicated and take into account an individual's need to feel justified and avoid anxiety. Sunstein also indicated that people focus on the unpleasantness of the outcome rather than on its probability when they have strong sentimental attachment to the catastrophe.⁴⁷ Moreover, Hsee and Kunreuther found that individuals are willing to pay higher premiums for the same amount of coverage for objects they love than for ordinary non-sentimental property.⁴⁸ Further, regarding the need to satisfy social and/or cognitive norms, there is

⁴¹ Kunreuther and Pauly adhere to the expected utility theory to explain the failure of individuals to purchase insurance against low-probability large-loss events, but agree that implicit or explicit costs discovering the true probability of these events may inhibit insurance purchase. See Howard Kunreuther & Mark Pauly, *Neglecting Disaster: Why Don't People Insure Against Large Losses?*, 28 J. RISK & UNCERTAINTY 5 (2004).

⁴² NEIL A. DOHERTY ET AL., *MANAGING LARGE-SCALE RISKS IN A NEW ERA OF CATASTROPHES* 137 (Wharton Risk Management and Decision Processes Center in conjunction with the Georgia State University and the Insurance Information Institute March 2008).

⁴³ *Id.* at 137-38.

⁴⁴ George F. Loewenstein et al., *Risk as Feelings*, 127 PSYCHOL. BULL. 267 (2001).

⁴⁵ See, e.g., Michael Braun & Alexander Muermann, *The Impact of Regret on the Demand for Insurance*, 71 J. RISK & INS. 737 (2004); David E. Bell, *Regret in Decision Making Under Uncertainty*, 30 OPERATIONS RES. 961 (1982).

⁴⁶ See David E. Bell, *Disappointment in Decision Making Under Uncertainty*, 33 OPERATIONS RES. 1 (1985).

⁴⁷ Cass R. Sunstein, *Terrorism and Probability Neglect*, 26 J. RISK & UNCERTAINTY 121, 122 (2003).

⁴⁸ Christopher K. Hsee & Howard Kunreuther, *The Affection Effect in Insurance Decisions*, 20 J. RISK & UNCERTAINTY 141 (2000).

empirical evidence that the purchase of insurance is based on knowledge of what friends and neighbors have done.⁴⁹ Additionally, the decision to purchase insurance can be influenced by the pursuit of happiness. One can argue that an *ex post* injury will make victims seek *ex ante* protection. Human and economic decisions thus reflect and contribute to human happiness.⁵⁰

Whether potential victims need insurance for losses resulting from a particular catastrophe will to a large extent depend on whether they can rely on other sources, such as government, to provide compensation or not. For example, in Europe most potential victims will not have a large incentive to purchase insurance against the risks of personal injury.⁵¹ This is because coverage is mainly provided by a social security system.⁵² If, however, there is not an alternative source of compensation, it is logical that there would be an increased demand for coverage against personal and property loss generally and specifically that caused by catastrophe.

B. EXAMPLES

Contrary to our expectations, empirical evidence, reported *inter alia* by both Kunreuther⁵³ and Zeckhauser,⁵⁴ amongst others, suggests that there is generally no adequate interest in and thus no demand for voluntary insurance protecting against natural catastrophes. Consequently, this evidence suggests that most homeowners do not buy adequate levels of insurance coverage.

One example concerns the financial compensation system for natural catastrophes utilized in Germany generally, and specifically existing

⁴⁹ For more on the importance of friends and neighbors in providing information, see Mark A. Satterthwaite, *Consumer Information, Equilibrium Industry Price, and the Number of Sellers*, 10 BELL J. ECON. 483 (1979).

⁵⁰ For a study on the importance of happiness in economic analysis, see BRUNO S. FREY & ALOIS W. STRUZER, *HAPPINESS & ECONOMICS* (Princeton University Press 2002); Bruno S. Frey & Alois W. Stutzer, *Happiness Research: State and Prospects*, 62 REV. SOC. ECON. 207 (2005); Matthew D. Adler & Eric A. Posner, *Happiness Research and Cost-Benefit Analysis* (UNIV. PA. INST. LAW & ECONOMICS Research Paper No. 07-15), available at <http://ssrn.com/abstract=999928>.

⁵¹ Comité Européen des Assurances, *Reducing the Social and Economic Impact of Climate Change and Natural Catastrophes* 27-28 (2007).

⁵² *Id.*

⁵³ Howard Kunreuther, *Mitigating Disaster*, *supra* note 16, at 174.

⁵⁴ Richard Zeckhauser, *The Economics of Catastrophes*, 12 J. RISK & UNCERTAINTY 113, 115 (1996).

insurance arrangements. As a general rule, most first-party insurance policies exclude catastrophic risks which result from natural disasters such as floods and earthquakes.⁵⁵ Coverage therefore depends on the specific terms of the respective insurance policy. In practice, only a small percentage of German citizens have catastrophe insurance coverage: only about 50% of those households hit by the 2002 Elbe flooding were insured against the risk of property damage caused by natural resources. Endres, Ohl & Rundshagen have recently held that this lack of adequate insurance coverage may be the result of a lacking demand because of a lack of risk aversion.⁵⁶ Although this last topic should be subject of further empirical research, they already stress that it is too easily accepted (at the policy level) that there is risk aversion, whereby this may not always be the case. Especially since the lack in demand could just as easily be explained by the lack of flood insurances on the German market.

There are examples of this in the American market as well. Indeed, although the United States has several (government supported) initiatives to stimulate natural hazard insurance, relatively little progress has been made. The standard U.S. homeowners' insurance policy offered by private insurance carriers is an "all risk" policy and therefore covers damage to a home by fire, windstorms, hail, riots and explosions. Flood and earthquake damage receive, however, different treatment. Coverage for flood damage due to rising water is explicitly excluded in homeowners' insurance policies, but coverage for these losses is voluntarily available through the federal government's National Flood Insurance Program (NFIP).⁵⁷ Earthquake coverage on the other hand can be a separate policy or an endorsement to the homeowners or renters policy and is voluntarily available from most insurance companies. In California, it is also available through the California Earthquake Authority.⁵⁸ Although U.S. citizens are

⁵⁵ Magnus, *supra* note 2, at 129.

⁵⁶ Alfred Endres, Cornelia Oh & Bianca Rundshagen, 'Land unter!' *Ein institutionenökonomische Zwischenruf*, 29 LIST FORUM FÜR WIRTSCHAFTS- UND FINANZPOLITIK 284 (2003).

⁵⁷ For more on the NFIP, see D.R. Anderson, D. R. *The National Flood Insurance Program – Problems and Potential*, 41 J. RISK & INS. 579 (1974); H.S. Cohn and T.M. Rowe, *Overwhelmed: The Federal Flood Insurance Act of 1956*, 13 CONN INS. L.J. 329 (2006-2007); Quynh T. Pham, *The Future of the National Flood Insurance Program in the Aftermath of Hurricane Katrina*, 12 CONN. INS. L.J. 629 (2005-06); Raymond J. Burby, *Flood Insurance and Floodplain Management: The US Experience*, 3 ENVTL. HAZARDS 111 (2001).

⁵⁸ See generally Dwight M. Jaffee & Thomas Russell, Behavioral Models of Insurance: The Case of the California Earthquake Authority 1-2 (Feb. 19, 2000) (

not obliged to purchase homeowners insurance by law, the process of obtaining a mortgage often requires it. In addition, the Flood disaster Protection Act of 1973 and the National Flood Insurance Reform Act of 1994 mandate the purchase of flood insurance as a condition for federal or federally-related financial mortgages for acquisition and or construction of buildings in Special Flood Hazard Areas.⁵⁹ In general, there is however substantial evidence that most individuals in flood-prone areas do not voluntarily purchase insurance despite highly subsidized rates.⁶⁰ For example, less than 3,000 out of 21,000 flood-prone communities entered the NFIP during its first four years of operation (since 1968) and less than 275,000 homeowners voluntarily bought an insurance policy.⁶¹ Only through excessive publicity and information campaigns has knowledge of flood risks among the population increased. By 1992, a conservative estimate of coverage suggests that less than 20 percent of the homes located in the floodplain were covered by flood insurance.⁶² The Federal Insurance Administration estimates that as of 1997 about 27 percent of households living in high-risk flood areas had insurance.⁶³ This is consistent with the findings of a study where FEMA examined 1549 disaster relief applications from victims of the 1998 flood in Northern Vermont. There, almost 84 percent of Northern Vermonters residing in the Special Flood Hazard Areas did not have flood insurance coverage at the time; 45 percent of whom were required to purchase it.⁶⁴

The famous example of hurricane Katrina also deserves our attention as well. The victims of Katrina complained, rather vociferously, that the received compensation was substantially less than the actual costs of repairing or rebuilding their destroyed houses.⁶⁵ Even those covered who suffered large losses from rising water were only able to recover a portion of their losses because the maximum coverage limit on residential

unpublished manuscript prepared for the National Bureau of Economic Research Insurance Conference, Feb. 2000), available at: <http://faculty.haas.berkeley.edu/jaffee/papers/nber00.pdf>.

⁵⁹ See Pham, *supra* note 57, at 632-33, 641-43.

⁶⁰ See *id.* at 641-42.

⁶¹ Risa Palm, *Demand for Disaster Insurance: Residential Coverage*, in *PAYING THE PRICE. THE STATUS AND ROLE OF INSURANCE AGAINST NATURAL DISASTERS IN THE UNITED STATES* 51, 55 (Howard Kunreuther & Richard J. Roth, Sr. eds., Joseph Henry Press 1998).

⁶² *Id.*

⁶³ *Id.*

⁶⁴ Howard Kunreuther, *Has the Time Come for Comprehensive Natural Disaster Insurance?*, in *ON RISK AND DISASTER: LESSONS FROM HURRICANE KATRINA* 175, 179 (Ronald J. Daniels et al. ed., Univ. of Pa. Press 2005).

⁶⁵ *Id.* at 175.

buildings (not including contents) under NFIP was \$250,000 and these homeowners did not purchase excess flood coverage from private carriers.⁶⁶ However, this is not to suggest that the coverage itself was inadequate rather as we have seen repeatedly people were not purchasing necessary coverage. In the Louisiana parishes affected by Katrina the percentage of homeowners with flood insurance ranged from 57.7 percent in St. Bernard's parish to 7.3 percent in Tangipahoa parish.⁶⁷ Only 40 percent of the residents in New Orleans had flood insurance, although they were eligible to purchase such a policy through the NFIP.⁶⁸ *The Economist* reported similar numbers: in Mississippi's coastal areas, less than one in five households had flood insurance and in New Orleans it was less than fifty percent.⁶⁹

Even in less recent history, very few people had acquired coverage prior to flooding caused by tropical storm Agnes. Agnes wreaked havoc on many areas in the Northeastern United States in June 1972.⁷⁰ Again, a number of the communities in the affected regions qualified for the federal government's subsidized National Flood Insurance Program but had not taken advantage of it.⁷¹ In fact, only 1,580 claims – totaling \$5 million – were paid under this Program. Consequently Congress responded to the plight of the (uninsured) victims with liberal relief through its Small Business Administration Disaster loan program.⁷²

Another example is the Northridge Earthquake in California in 1994 which caused more than \$ 19.6 billion (in 2007 dollars) in insured losses.⁷³ Immediately after this catastrophic event, a high number of citizens decided to buy first-party disaster insurance, as a reaction to the suffered damages. Soon, however, this reactionary behavior dissipated and Californians began

⁶⁶ *Id.* at 186.

⁶⁷ *Id.* at 175 ; *See* Pham, *supra* note 57, at 640.

⁶⁸ *See* Kunreuther, *Mitigating Disaster*, *supra* note 16, at 175.

⁶⁹ United States: Now the Rebuilding Begins; Hurricane Katrina, *ECONOMIST*, Sept. 17, 2005, at 51.

⁷⁰ Howard Kunreuther, *The Changing Societal Consequences of Risks from Natural Hazards*, 443 *ANNALS AM. ACAD. POL. & SOC. SCI.* 104, 105 (1979).

⁷¹ *Id.*

⁷² *Id.*

⁷³ Robert L. Rabin & Suzanne A. Bratis, *United States*, in *FINANCIAL COMPENSATION FOR VICTIMS OF CATASTROPHES: A COMPARATIVE LEGAL APPROACH* 303 (Michael Faure & Ton Hartlief eds., Springer-Wien New York 2006).

to let those policies lapse or cancelled them.⁷⁴ Indeed, eight years after the creation of the California Earthquake Authority, the acquisition rate of coverage has decreased from thirty to seventeen percent.⁷⁵

The empirical evidence, however, does not clearly support a pure lack of demand for the lack or inadequacies of catastrophe insurance. A recent study by the Wharton Risk Management and Decision Processes Center⁷⁶ reports that after Florida went through several flooding episodes in 2004, people effectively purchased more flood insurance. They found that in 2000 there were 973,444 flood insurance policies in place versus 1,143,844 in 2005 (which represents a 17% increase, while the costs of flood insurance remained virtually the same between 2000 and 2005).⁷⁷ The authors indicate several explanations for these changes. First, regret: people living in devastated areas, who had coverage, wished they had purchased the better and larger policies that would have provided more adequate coverage. Second, flood insurance began to look like a sound financial investment. Third, the floods were a vivid experience not only for those affected but also for their neighbors and family members who were not directly affected by property loss.⁷⁸ As loss due to flooding became a reality in these people's lives purchasing flood insurance seemed more appealing and more purposeful.

Therefore, even though there is some evidence of serious under demand for catastrophe insurance, there are also cases (like in the Florida example) where (at least in the short term) the insurance purchase has increased. It is unclear whether these policies purchased in Florida in 2005 (after the 2004 flooding) will be maintained after a few flood-free years. The example of the California earthquake indeed illustrates that once the memory of the disaster is forgotten, a large quantity of the new insurance coverages were cancelled.

⁷⁴ *Id.*; Paul Slovic, Howard Kunreuther & Gilbert White, *Decision Processes, Rationality and Adjustment to Natural Hazards*, in NATURAL HAZARDS: LOCAL, NATIONAL, GLOBAL 14 (Gilbert White ed., Oxford University Press 1974).

⁷⁵ RISK MGMT SOLUTIONS, RISK ASSESSMENT MODELS, THE NORTHRIDGE, CALIFORNIA EARTHQUAKE: RMS 10-YEAR RETROSPECTIVE 11 (2004), available at http://www.rms.com/publications/northridgeeq_retro.pdf.

⁷⁶ See DOHERTY ET. AL., *supra* note 42, at 109.

⁷⁷ *Id.*

⁷⁸ *Id.*

C. BEHAVIORAL LAW AND ECONOMICS AND THE DEMAND FOR
FIRST-PARTY INSURANCE AGAINST NATURAL CATASTROPHES

Economics and behavioral law provide insight into several phenomena which may explain this lack of catastrophe insurance demand. A low demand may be caused by problems on the supply side as well, more particularly if premiums would be inefficiently high either as a result of distorted estimations of probabilities by insurers or as a result of high loading. These problems on the supply side will be discussed separately in the next section. For now, focus will be on the reasons why, even if catastrophe coverage is offered at actuarially fair premiums in competitive markets,⁷⁹ demand for coverage remains low.

First, it seems that those with a higher perceived vulnerability to future catastrophic losses are more likely to acquire first-party insurance than those who believe that a catastrophe is unlikely to affect their home or their community. Slovic concluded that a perceived probability of loss was a critical factor in triggering the purchase of catastrophe insurance.⁸⁰ Potential victims who do not purchase coverage do not deem the risk of loss to be sufficient to require such protection. They tend to take an “it will not happen to me” attitude.

Perceived vulnerability, however, constitutes a problem in the case of low-probability high-consequence events like natural disasters. Overwhelming evidence from psychologists and behavioral law and economics indicates that those events are systematically misjudged. Experiments showed that the “affect heuristic” is a large factor in this misconception. As a consequence, the characteristic most correlative to perceived risk was fear, i.e. the degree to which a hazard evoked feelings of dread.⁸¹ Risk perception is thus highly dependent upon intuitive and

⁷⁹ The price of homeowners insurance is, of course, a primary area of interest in order to purchase insurance coverage. Indeed, in the aftermath of the 2005 hurricane season in the United States, a number of insurers implemented significant rate increases to reflect the higher degree of risk and increased cost of reinsurance. The average premium in the state of Florida increased from \$ 723 at the start of 2002 to \$ 1,465 in the first quarter of 2007. *Id.* at 77-78 We can evidently assume that demand for first-party insurance is influenced by the rating of the insurance coverage against natural catastrophes.

⁸⁰ PAUL SLOVIC, *THE PERCEPTION OF RISK* xxix (Ragnar E. Löfstedt ed., Earthscan Publ'n 2000).

⁸¹ Baruch Fischhoff et. al., *How Safe is Safe Enough? A Psychometric Study of Attitudes Towards Technological Risks and Benefits*, 9 POL'Y SCI. 127 (1978). The authors also found that perceived risk declines as perceived benefit increases. Both conclusions were later confirmed by many other authors. *See, e.g.*, Ali S. Alhakami & Paul Slovic, *A*

experimental thinking, guided by emotional and affective processes.⁸² The affect heuristic further suggests that, if a general affective view guides perceptions of risk and benefit, providing information about benefit should change the perception of risk.⁸³ These ‘heuristics and biases’ thus may explain why only those who are directly affected by the risk demand insurance, whereas others who are exposed to the risk as well may wrongly estimate their exposure. This analysis fits into classic information deficiencies which lead to an under demand for catastrophe insurance. Apart from the mentioned affect heuristic, other behavioral attitudes may also explain the misjudgment of exposure and consequently need. Experimental studies have observed behavior contrary to the expected utility theory.⁸⁴ Consequently, Kahneman and Tversky proposed an alternative theory, called “prospect theory.”⁸⁵ Under prospect theory, an insurance policy that covers fire but not flood can be presented either as full protection against the specific risk of fire or as a reduction in the overall probability of property loss.⁸⁶ Prospect theory predicts that the policy will appear more attractive in the former perspective, in which it offers unconditional protection against a restricted set of problems.⁸⁷ The two authors further found empirically that low probability events generally are overweighted and high ones generally underweighted in policies.⁸⁸ Risk-averse people hence will, both under utility theory as under prospect theory, prefer insurance against low-probability high-loss events rather than against high-probability low-loss events.⁸⁹ This seems, at first, contrary to the above analysis. By taking into account, however, the “probability threshold,” which says that potential victims ignore those events for which the probability of a loss is too low to constitute a threat, the theory in fact

Psychological Study of the Inverse Relationship Between Perceived Risk and Perceived Benefit, 14 RISK ANALYSIS 1085 (2004/1994).

⁸² See Paul Slovic et al., *Risk as Analysis and Risk as Feelings: Some Thoughts about Affect, Reason, Risk and Rationality*, 24 RISK ANALYSIS 311 (2004).

⁸³ *Id.* at 315.

⁸⁴ Paul J.H. Schoemaker & Howard Kunreuther, *An Experimental Study of Insurance Decisions*, 46 J. RISK & INS. 603 (1979); Paul Slovic et al., *Preference for Insuring Against Probable Small Losses: Insurance Implications*, 44 J. RISK & INS. 237 (1977); Colin F. Camerer & Howard Kunreuther, *Decision Processes for Low Probability Events: Policy Implications*, 8 J. POL’Y ANALYSIS & MGMT. 565 (1989).

⁸⁵ Daniel Kahneman & Amos Tversky, *Prospect Theory: An Analysis of Decision Under Risk*, 47 ECONOMETRICA 263, 274 (1979).

⁸⁶ See generally *id.*

⁸⁷ See *id.* at 287.

⁸⁸ *Id.* at 281-83.

⁸⁹ See *id.* at 287; Kunreuther, *supra* note 70, at 112.

supports the lack of demand we have seen.⁹⁰ This suggests that if the chances of an event are sufficiently low, people do not even reflect on its consequences. Potential victims thus have a tendency to insure only if they feel the probability of a disaster is high enough that they will suffer damage and accordingly receive a return on their investment in the policy. More research, however, is needed to establish a solid theory regarding the perceived risks of natural hazards.

Another alternative to utility theory, “bounded rationality,” was introduced by Simon.⁹¹ This concept asserts that the cognitive limitations of the potential victim, the decision-maker, force him to construct a simplified model of the world.⁹² A person thus does not strive for maximization of his utility but for some satisfactory level of achievement.⁹³ Potential victims consequently are too limited in their cognitive capacity to adjust to natural hazards via insurance. Therefore, an individual will neglect to purchase insurance because his knowledge of the subject is limited – not because he has studied the matter carefully and concluded that the cost-benefit ratio is unattractive. Potential victims must consequently be made graphically aware of the potential losses from the disaster before considering the purchase of insurance coverage.⁹⁴

Finally, other theories emphasizing people’s limited capabilities of judging the probabilities of natural hazards include, *inter alia*, “the gambler’s fallacy” (or “negative recency effect”), which means that people have a very poor conception of randomness and thus e.g. expect that a flood which occurred in year x will not occur again in year $x+1$,⁹⁵ and the “availability heuristic,” as proposed by Kahneman and Tversky,⁹⁶ according to which the frequency of some event is estimated by judging

⁹⁰ See Kahneman and Tversky, *supra* note 86, at 282-8355.

⁹¹ Kunreuther, *supra* note 70, at 109.

⁹² *Id.*

⁹³ Paul Slovic et al., *Decision Processes, Rationality and Adjustment to Natural Hazards* in NATURAL HAZARDS: LOCAL, NATIONAL AND GLOBAL 187, 189 (Gilbert White ed., Oxford University Press 1974).

⁹⁴ See Kunreuther, *supra* note 70, at 109.

⁹⁵ See ROBERT W. KATES, HAZARD AND CHOICE PERCEPTION IN FLOOD PLAIN MANAGEMENT (University of Chicago 1962). For an experimental study on the effect of experience, see Slovic et al., *Risk as Analysis and Risk as Feelings*, *supra* note 84.

⁹⁶ Amos Tversky & Daniel Kahneman & Amos Tversky, *Judgment Under Uncertainty: Heuristics and Biases* in JUDGMENT UNDER UNCERTAINTY: HEURISTICS AND BIASES 3, 11 (Daniel Kahneman, Paul Slovic & Amos Tversky eds., Cambridge University Press 1982).

how easy it is to recall other instances of this type.⁹⁷ The availability heuristic implies that past experience may be necessary to raise an individual's awareness of the risks and prompt the purchase of insurance. So, while the financial losses could be significant should an event within the range of 1-in-50 to 1-in-500⁹⁸ occur, the great majority of people will not purchase insurance because they have never been exposed to the consequences of such an event.⁹⁹ Evidence in these low probability cases suggests that many individuals do not use an expected utility model such as the one characterized above to determine how much insurance coverage to purchase.¹⁰⁰

A second argument explaining the limited interest in voluntary first-party insurance is the knowledge of potential victims that the state or the government will provide them with *ex post* disaster assistance irrespective of insurance coverage.¹⁰¹ The intuitive appeal of this argument is clear: if victims could count on state- provided *ex post* compensation after disasters, then their incentives to purchase first-party insurance coverage may be diminished. It refers to the argument made by Hirshleifer that in the absence of insurance, the government may find it difficult to resist the political pressure to provide compensation.¹⁰² This is the so-called "Samaritan's dilemma."¹⁰³ Why pay for this coverage via insurance premiums if the government would provide compensation regardless?¹⁰⁴ The empirical evidence concerning this argument, however, provides little clarity. Kunreuther found that "there does not appear to be any evidence suggesting that individuals refuse to purchase property insurance because they feel that they will be bailed out by the government should they suffer

⁹⁷ However, availability is also affected by recent events, emotional saliency and other subtle factors, which may be unrelated to actual frequency. *Id.* at 11-12. Gambler's fallacy and the availability heuristic are therefore not necessarily contradictory.

⁹⁸ 1-in-50 to 1-in-500 refers to the annual probability of a disaster damaging a housing structure in a hazard-prone area. Howard Kunreuther & Mark Pauly, *Rules Rather than Discretion: Lessons from Hurricane Katrina*, 33 J. RISK & UNCERTAINTY 101, 105 (2006).

⁹⁹ *Id.*

¹⁰⁰ *Id.* at 105.

¹⁰¹ See Richard A. Epstein, *Catastrophic Responses to Catastrophic Risks*, 12 J. RISK & UNCERTAINTY 287, 293-94 (1996); Scott E. Harrington, *Rethinking Disaster Policy*, 23 REGULATION 40, 43-44 (2000).

¹⁰² See Hirshleifer *supra* note 11, at 146; Siegelman, *supra* note 11, at 21.

¹⁰³ James M. Buchanan, *The Samaritan's Dilemma*, in ALTRUISM, MORALITY AND ECONOMIC THEORY 71, 71-72 (Edmund S. Phelps ed., 1975).

¹⁰⁴ Kaplow, *supra* note 12, at 172-73.

damage.”¹⁰⁵ Nevertheless, a recent comparative overview of compensation systems in a variety of European countries showed that in countries where state compensation was generously (and almost automatically) provided after a disaster (such as Germany or Italy), the degree of insurance coverage was low, whereas in countries where the state takes a principal attitude of not providing any compensation after a disaster (like in the United Kingdom), the degree of insurance coverage was substantially higher.¹⁰⁶ This anecdotal evidence indicates that there is some relationship, tenuous or not, between government provided compensation and the willingness of potential victims to obtain insurance coverage.

Third, psychological experiments show that people may *ex ante* prefer uncertain losses rather than the certain loss of paying the premium.¹⁰⁷ Kunreuther discussed this concept concerning decisions to purchase insurance against the risk of flooding.¹⁰⁸ Insurance is an investment.¹⁰⁹ People prefer to insure against high-probability, low-damage events since a monetary return is more likely.¹¹⁰ The problem, according to this literature, is that with *ex ante*, the potential victim (like a house owner) is confronted with the certain loss of a premium, whereby the expected damage in the case of flooding can only be estimated and therefore constitutes an uncertain loss. There is, in other words a low expectation of a return on the “investment” during a lifetime and hence a low demand with catastrophe insurance. Consequently, potential victims who did buy first-party insurance against the risk of catastrophic losses and did not experience losses that allowed them to make claims will, within a few years, cancel their insurance coverage or allow it to lapse.¹¹¹ This reasoning can be correlated to the emotional goals mentioned earlier of peace of mind and anxiety avoidance. A similar line of reasoning applies to those who are underinsured. If one is underinsured at the time of a catastrophe, the losses are not, generally, large enough to provide incentives to buy an insurance

¹⁰⁵ Howard Kunreuther, *Mitigating Disaster Losses through Insurance*, 12 J. RISK & UNCERTAINTY 171, 177 (1996); Howard Kunreuther, *Disaster Mitigation and Insurance: Learning from Katrina*, 604 ANNALS AM. ACAD. POL. & SOC. SCI. 208, 214-15 (2006).

¹⁰⁶ Michael Faure, *Comparative and Policy Conclusions*, in FINANCIAL COMPENSATION FOR VICTIMS OF CATASTROPHES: A COMPARATIVE LEGAL APPROACH 390 (Michael Faure & Ton Hartlief eds., 2006).

¹⁰⁷ Kahneman & Tversky, *supra* note 85, at 268-69.

¹⁰⁸ Schoemaker & Kunreuther, *supra* note 16, at 610.

¹⁰⁹ *Id.*

¹¹⁰ SLOVIC, THE PERCEPTION OF RISK, *supra* note 80, at 62-71.

¹¹¹ Howard Kunreuther et al., *A Behavioral Model of the Adoption of Protective Activities*, 6 J. ECON. BEHAV. & ORG. 1,4 (1985).

policy. This is because once a catastrophe has happened, people consider it unlikely that a similar disaster will affect them in the future.¹¹²

Fourth, the lack of demand is attributed to ineffective information filtering, particularly with probabilistic information regarding catastrophes. Slovic and Monahan demonstrated that risk assessments in terms of relative frequency (“of every 100 neighbors similar to you, 10 are estimated to suffer catastrophic damages”) created more frightening images of catastrophic events than statistically represented frequencies (“neighbors similar to you are estimated to have a 10% chance of suffering catastrophic damages”).¹¹³ Moreover, according to Dake, people have “worldviews,” which influence individual judgments and actions.¹¹⁴ Consequently, the available information has little effect on individuals’ attitudes towards ‘normal’ hazards, as they are part of who we are and of how we see the world.¹¹⁵

Fifth, some families also face budget constraints which limit their interest and/or ability to voluntarily purchase adequate insurance coverage in case of a major loss. Such behavior is likely in areas where property values have increased rapidly. An increase in premium will typically then cause people to buy less insurance due to budgetary constraints. In contrast to the expected utility model where the demand for insurance depends on the premium relative to the expected loss,¹¹⁶ demand under this scenario depends only on the premium for a given amount of coverage.

Therefore, numerous reasons explain the failure of potential victims to purchase first-party insurance coverage and correspondingly necessary protection against catastrophic losses. One final remark should still be made: low demand for insurance coverage is often confused with adverse selection.¹¹⁷ For example, suppose that the only parties who wish to buy flood insurance are those with material exposure to damage. Low-risk parties thus may rationally decide not to insure. Regardless of this being

¹¹² Slovic et al., *Preference for Insuring Against Probable Small Losses*, *supra* note 84, at 252.

¹¹³ Paul Slovic et al., *Violence Risk Assessment and Risk Communication: The Effects of Using Actual Cases, Providing Instructions, and Employing Probability vs. Frequency Formats*, 24 *LAW. & HUM. BEHAV.* 271, 272, 291 (2000).

¹¹⁴ Karl Dake, *Orienting Dispositions in the Perception of Risk: an Analysis of Contemporary Worldviews and Cultural Biases*, 22 *J. CROSS-CULTURAL PSYCHOL.* 61, 62 (1991).

¹¹⁵ SLOVIC, *THE PERCEPTION OF RISK*, *supra* note 80, at xxxiv.

¹¹⁶ Christian Gollier, *Some Aspects Of The Economics Of Catastrophe Risk Insurance*, in *CATASTROPHIC RISKS AND INSURANCE* 13, 15-17 (2005).

¹¹⁷ Harrington, *supra* note 101, at 41.

true, it would not imply adverse selection. Adverse selection after all requires asymmetric information: insurers must be unable to identify high-risk buyers.¹¹⁸ Generally, it is hard to see how insured could have an informational advantage over insurers in predicting catastrophes.¹¹⁹ The reverse is more likely to be true.¹²⁰ Insured might, however, know their own potential loss better than insurers do,¹²¹ but that could be solved through inspection measures imposed by the insurer. The fact that adverse selection is not a serious problem is also confirmed in recent studies concerning hurricane insurance.¹²² Indeed, there is no evidence that those at risk have an informational advantage over the insurer. In fact, the opposite might be true: if insurance companies spend a lot of resources estimating the risk (which they do today) they might gain an informational advantage over their policyholders who cannot afford or do not want to do such research.¹²³ In recent years, there has been growing literature on the impact of insurers' knowledge advantage regarding risks. Research in this field reveals that insurers might want to exploit this *reverse information asymmetry*, which results in low risk agents being optimally covered, while high risks are not.¹²⁴ Low insurance demand even for high-risk parties can then simply stem from the high cost of coverage, the availability of alternative compensation mechanisms or from any of the other above mentioned reasons.

IV. SUPPLY OF FIRST-PARTY DISASTER INSURANCE

A. CORRELATION, UNCERTAINTY AND LIMITED CAPACITY

Even though it is – as just indicated – questionable whether there is a high demand for catastrophe insurance, there are definitely problems on the supply side. A number of insurers exclude coverage for property damage

¹¹⁸ Dominique Henriët & Erwann Michel-Kerjan, *Looking at Optimal Risk-Sharing in a Kaleidoscope: The (Market Power, Information) Rotational Symmetry* 3-4 (Risk Management and Decision Processes Center, The Wharton School, University of Pennsylvania, Working Paper No. 2008-01-21, 2008) available at [http://opim.wharton.upenn.edu/risk/library/WP2008-01-](http://opim.wharton.upenn.edu/risk/library/WP2008-01-21_DH,EMK_OptimalRiskSharing.pdf)

21_DH,EMK_OptimalRiskSharing.pdf; See DOHERTY, *supra* note 42, at 148.

¹¹⁹ DOHERTY, *supra* note 42, at 148.

¹²⁰ *Id.*

¹²¹ See Henriët, *supra* note 118, at 5-6.

¹²² See DOHERTY, *supra* note 42, at 148.

¹²³ See Henriët, *supra* note 118, at 6.

¹²⁴ *Id.* at 6, 8.

caused by (natural) catastrophes and argue that those losses are uninsurable. The three principal reasons for this attitude are the fear of catastrophic losses, the uncertainty of the risk, and the lack of insurance capacity.¹²⁵

First, natural hazards normally occur within one specified area and are highly correlative. Past disasters indicate that a significant number of (especially non-geographically diverse) insurance companies became insolvent as a result of such catastrophic losses. Consequently, property insurance became increasingly difficult to obtain in hazard-prone areas.

Second, the absence of historical data and the present imperfect scientific knowledge contributes to the supply deficiencies of first party catastrophe coverage.¹²⁶ However, this point needs to be put into perspective due to the new insights into catastrophe modeling.¹²⁷ The lack of predictability regarding both the probability of an extreme event occurring and of the outcomes of such an event results in ambiguity. This ambiguity may lead to uninsurability of a specific catastrophic event or in a specific hazard-prone area.¹²⁸ Insurers can, however, take account of this uncertainty regarding the probability of catastrophic damage by charging a so-called risk premium.¹²⁹ Nevertheless, two problems still exist: (1) a higher insurance premium can in turn decrease demand for insurance against catastrophic risks; and (2) insurance regulation might limit insurers' ability to apply high premiums to catastrophic risks.¹³⁰ Regulated rates are in fact a major problem in some countries and may be, in certain high-risk areas, the main obstacle to an effective voluntary insurance market for

¹²⁵ See Kunreuther, *Mitigating Disaster Losses Through Insurance*, *supra* note 16, at 178-79; See Gollier, *supra* note 116, at 28.

¹²⁶ See MICHAEL FAURE & TON HARTLIEF, *INSURANCE AND EXPANDING SYSTEMATIC RISKS* 84-85 (OECD 2003).

¹²⁷ See *generally*, TONY HARTINGTON ET AL., *CATASTROPHE MODELING* (1997). (Discussing scientific issues associated with catastrophes).

¹²⁸ See Howard Kunreuther, Robin Hogarth & Jacqueline Meszaros, *Insurer Ambiguity and Market Failure*, 7 J. RISK & UNCERTAINTY 71,83 (1993); Louis Kaplow & Steven Shavell, *Fairness versus Welfare*, 114 HARV. L. REV. 961 (2002).

¹²⁹ Howard Kunreuther et al., *Ambiguity and Underwriter Decision Processes*, 26 J. ECON. BEHAV. & ORG. 337, 338 (1995). Doherty et al. recently found that, under a 1-year contract, mean annual premiums are 25 percent higher when the probability of the event is ambiguous than when it is given precisely. Under the 20-year contract, aversion to ambiguity is even stronger. See *supra*, note 42, at 147. The source of the uncertainty does not affect the insurers, contrary to Cabantous' beliefs. Laure Cabantous, *Ambiguity Aversion in the Field of Insurance: Insurers' Attitude to Imprecise and Conflicting Probability Estimates*, 62 THEORY & DECISION 219, 220, 235 (2007).

¹³⁰ See FAURE & HARTLIEF, *supra* note 89, at 83, 86 (2003).

catastrophic risks. Therefore, these additional risk premiums are rarely charged in practice. Gollier adds that an insurability problem may occur only if insurers are systematically more ambiguity-averse than consumers.¹³¹

Third, insurance companies need sufficient financial reserves to cover the particular catastrophic risk.¹³² In many cases, however, and especially with catastrophic events, the expected loss may exceed the capacity of the individual insurer. The insurer can use various traditional insurance techniques to cope with this capacity problem, such as co-insurance, reinsurance, pooling of capacity by insurers, and alternative risk transfer (ART) mechanisms.¹³³ As a consequence, the supply of insurance is largely conditioned by the price and availability of reinsurance and other alternative risk transfer mechanisms. For the most part, investors who supply capital for the insurance companies control this price since they want to realize a profitable rate of return. Even these solutions, however, have their limits.

B. LIMITS OF REINSURANCE AND ART

Reinsurance helps insurance companies underwrite large risks, limits liability on specific risks, increases capacity, and shares liability when claims overwhelm the primary insurer's resources.¹³⁴ In reinsurance transactions, one or more insurers (the reinsurers) agree, for a premium, to indemnify a primary insurer against all or part of the loss that that primary insurer may sustain under its policies.¹³⁵ The contractual and business relationships between insurers and reinsurers facilitate relatively low transaction costs. However, in the case of extremely large or multiple catastrophic events, insurers might not have purchased sufficient reinsurance, or reinsurance providers might not have sufficient capital to

¹³¹ See Gollier, *supra* note 116, at 24.

¹³² Doherty accurately draws the attention upon the fact that the importance of capital as a requisite to secure an adequate rate of return is often not fully understood. After all, the capital needed by the insurance firm to be able to cope with catastrophic losses must be high enough to cover 1) the expected claims costs and other expenses, and 2) the costs of allocating risk capital to underwrite this risk. See DOHERTY, *supra* note 42, at 149.

¹³³ See FAURE & HARTLIEF, *supra* note 126, at 88-97.

¹³⁴ Matthew Rodermund, *Four Points of Confusion about Reinsurance: Comment*, 32 J. RISK & INS. 133, 134 (1965).

¹³⁵ Reinsurance is thus generally indemnity-based, since the insurer is compensated for part or all of his losses from insured claims. *Id.* at 133-34.

meet their existing obligations.¹³⁶ In any event, after a catastrophic loss, reinsurance capacity may be diminished and reinsurers might limit availability of future catastrophic reinsurance coverage. In contrast, after a catastrophic event, the demand of potential victims only increases. This simultaneous occurrence of shrinking supply and rising demand naturally leads to a sharp increase in reinsurance pricing. High reinsurance prices induce investment in the reinsurance business (e.g. new reinsurance companies may be formed, investors may be willing to purchase new tranches of equity issued by existing reinsurers). This, in turn, increases the supply of catastrophe coverage and causes prices to stabilize again. Additionally, if no major catastrophe occurs in a close time frame to another, reinsurers offer premiums at prices below expected loss and costs, while primary insurers have excess supply of capital and are therefore capable of supporting new risk exposures. In order to win or retain market share, reinsurers lower their underwriting criteria and may accept marginal risks or liberalize policy conditions. This ushers in a period of low premium rates. Reinsurance is thus clearly influenced by price cycles, which are particularly pronounced in catastrophe insurance.¹³⁷ Given the cyclic nature of the reinsurance market, investors have incentives to look for alternative capital sources to add financial capacity. After all, these instruments have the ability to absorb the effects of a hard market and to manage complex or difficult risk exposures, which are often hard to insure in the traditional insurance market. The emergence of catastrophe bonds, catastrophe derivatives, sidecars, and industry loss warranties, already complement the catastrophe reinsurance market. Therefore, many more alternative capital sources are being developed.¹³⁸ Nevertheless, capital market instruments should be characterized as a supplement, rather than an

¹³⁶ See, e.g., Anne Gron, *Insurer Demand for Catastrophe Reinsurance*, in THE FINANCING OF CATASTROPHE RISK 23 (Kenneth A. Froot ed., 1999).

¹³⁷ Reinsurance markets experience regular cycles driven by supply of, and demand for, insurance protection. These cycles are heavily related to both insurance loss experience and general investment market experience. Reinsurance then will be in a 'hard market' or in a 'soft market'. A hard market occurs when supply of risk capacity declines. A soft market occurs when the supply of risk capacity expands. See ERIK BANKS, CATASTROPHIC RISK: ANALYSIS AND MANAGEMENT 98-101 (2005); see also PETER ZIMMERLI, SWISS RE, NATURAL CATASTROPHES AND REINSURANCE 44 (2003), available at http://www.ct.gov/cid/lib/cid/app4_natcaten2006.pdf (last visited November 4, 2008).

¹³⁸ Recent reports by brokers and companies have described developing alternative capital sources. See, e.g., Guy Carpenter, <http://www.guycarp.com> (last visited October 22, 2008); Benfield Group, <http://www.benfieldgroup.com> (last visited October 22, 2008). See generally DOHERTY, *supra* note 42.

alternative, to catastrophe (re)insurance, especially since most of these tools are still in their infancy.¹³⁹

C. LIMITS OF POOLING

There are also negatives regarding the pooling capacity of insurers. One risk is that pooling may lead to welfare losses as a result of cartel agreements. For example, in the Netherlands during the 1950s, the Dutch Insurers' Association issued a so-called "binding decision" on all of its members, prohibiting them from insuring flood and earthquake risks (the latter being a relatively small risk in the Netherlands with the exception of the area around Southern Limburg). Their argument was that these risks were technically not insurable since the flooding and earthquake risks were uncertain in their nature and hence, difficult to calculate. Moreover, these types of insurance would only be attractive to high-risk individuals (e.g. those living in flood prone areas) and this would result in incurable adverse selection. As a consequence, it was determined that the members of the Dutch Insurers' Association should all refrain from covering these risks.

The arguments concerning the uninsurability seemed highly doubtful, but the Association's binding decisions also clearly violated competition law. At the time European Commission Regulation 3932/92 of December 21, 1992¹⁴⁰ exempted many cartel agreements in the insurance world from the prohibition under the old article 85(3) of the EC Treaty.¹⁴¹ The Regulation provided that certain strict conditions were met. Law and economics scholars, who argued that competition policy should be fully applied to insurance markets, heavily criticized this exemption.¹⁴² The

¹³⁹ Isabel M. Torre-Enciso & John E. Laye, *Financing Catastrophe Risk in the Capital Markets*, 1 INT'L REV. SOC. SCI J. EMERGENCY MGMT. 61 (2001).

¹⁴⁰ 1992 O.J. (L 398) 7-14, available at http://eur-lex.europa.eu/RECH_celex.do (enter Cylex number 31992R3932) (last visited October 22, 2008).

¹⁴¹ Pursuant to old Article 85 (3) of the EC Treaty, agreements, decisions by associations of undertakings and concerted practices in the insurance sector which seek cooperation with respect to: (a) the establishment of common risk-premium tariffs based on collectively ascertained statistics or on the number of claims; (b) the establishment of standard policy conditions; (c) the common coverage of certain types of risks; or (d) the establishment of common rules on the testing and acceptance of security devices, shall not be prohibited as incompatible with the common market. EC Treaty art. 85 (as in effect 1985) (now article 81), available at http://ec.europa.eu/comm/competition/legislation/treaties/ec/art81_en.html (last visited October 22, 2008).

¹⁴² Michael Faure & Roger Van den Bergh, *Restrictions of Competition on Insurance Markets and the Applicability of EC Antitrust Law*, 48 KYKLOS 65 (1995).

binding decisions not to insure flood and earthquake risks not only clearly limited supply (it effectively excludes it as a result of a cartel agreement), but it also violated the conditions of Regulation 3932/92. Consideration 8,¹⁴³ preceding the Regulation, states that standard policy conditions may not contain any systematic exclusion of specific types of risk without providing for the express possibility of including that coverage by agreement. This is repeated in article 7(1)(a) of the exemption. The European Commission also issued a report to the European Parliament and to the Council on May 12, 1999 concerning the functioning of the exemption in Regulation No. 3932/92.¹⁴⁴ In this report, the Commission explicitly discusses these binding decisions. The report states that as a result of the questions asked by the Commission, the Dutch Association of Insurers decided to bring its binding decision in line with Article 7.1, Subsection a, by simply converting it into a non-binding recommendation, which left each insurer free to extend coverage to flood risks. This example demonstrates that a minimal supply of insurance coverage may well be the result of anti-competitive behavior by insurers, who mutually agree not to cover particular catastrophic risks.

At a policy level, this demonstrates that a necessary condition of insuring catastrophic risks is a competitive insurance market that offers a wide variety of differentiated insurance policies and responds to the demand of the market. Instead of direct government intervention, government should guarantee an adequate competition policy with respect

¹⁴³ Consideration 8:

Standard policy conditions may in particular not contain any systematic exclusion of specific types of risk without providing for the express possibility of including that cover by agreement and may not provide for the contractual relationship with the policyholder to be maintained for an excessive period or go beyond the initial object to the policy. This is without prejudice to obligations arising from Community or national law.

1992 O.J. (L 398) 7-14, *available at* http://eur-lex.europa.eu/RECH_celex.do (enter Cylex number 31992R3932) (last visited October 22, 2008).

¹⁴⁴ Report from the Commission to the Council and the European Parliament on the operation of Commission Regulation No 3932/92 concerning the application of Article 81 (ex-Article 85), paragraph 3, of the Treaty to certain categories of agreements, decisions and concerted practices in the field of insurance, COM 1999, 192 final.

to insurance markets. Otherwise uninsurability may, as the Dutch example shows, simply be the result of a cartel agreement.¹⁴⁵

Therefore, as long as insurers are able to estimate the frequency and magnitude of potential catastrophic losses, catastrophic first-party insurance is and should be available. Due to problems of ambiguity, adverse selection, moral hazard, and highly correlated losses, insurance companies will want to charge a risk premium that considerably exceeds the expected loss. This premium can, however, be so high that there would be very little demand for coverage at that rate. In such cases, the insurer will not want to invest the time and money necessary to develop the product. If the insurer is convinced that there is sufficient demand, he will try to raise sufficient capacity to survive possible catastrophic losses.

V. COMPULSORY DISASTER COVERAGE?

A. CORRECTING MARKET FAILURE?

The question of whether compulsory first-party disaster coverage could solve the above mentioned problems regarding the lack of demand and/or supply at the insurance market has often been addressed. With compulsory first-party insurance, we refer to both first-party insurances against natural disasters that potential victims have to take in all countries where these are available on the insurance market, and to regulatory interventions, as a result of which voluntary coverage is mandatorily extended to include natural disasters. The latter refers more specifically to a duty on persons who voluntarily subscribed a property insurance policy to purchase a catastrophe extension. A distinction between both types of compulsory first-party insurance will only be made where necessary.

The classic economic rationale behind compulsory liability insurance is the externality argument: in the absence of adequate insurance, injurers could, through their insolvency, externalize risk. That indeed may be an argument in favor of compulsory liability insurance, but it is not very

¹⁴⁵ We do not argue, however, that competition necessarily provides better results than (state) monopolies. See Winand Emons, *Imperfect Tests and Natural Insurance Monopolies*, 49 J. INDUSTRIAL ECON. 247, 247-48 (2001) (empirical research showed that under specific circumstances, particularly when insurers are unable to differentiate risks adequately, a natural monopoly with one (state) insurer may provide better results than a competitive environment); see also Thomas Von Ungern-Sternberg, *The Limits of Competition: Housing Insurance in Switzerland*, 40 EUROPEAN EUR. ECON. REV. 1111 (1996).

convincing in the case of first-party insurance. An argument could still be made that the victims who would not be adequately insured for personal injury would then extensively call upon the healthcare system and thus “externalize” that risk. However, given the fact that most European legal systems provide, through social security, wide coverage for healthcare (precisely through mandatory healthcare insurances), one cannot see why that should be supplemented with an additional compulsory accident insurance. The same is true for the property damage that victims may suffer as a result of a natural disaster. Of course, the absence of insurance may lead those victims to make additional calls for government relief (and as a result to political pressure caused through the large number involved), but there is as such no direct issue of externalization of their harm. Of course, an argument in favor of compulsory insurance could be made if the disaster were to occur in a country (e.g. a developing country) where no social security system existed and the disaster did not merely cause property damage, but also personal injury. This increase in personal injury would then lead to an increasing call on state provided health care services. However, this would instead be an argument in favor of a compulsory social security system rather than for a mandatory insurance system merely focused on damage caused by disasters. However, an argument could be made that the availability of mandatory disaster insurance would reduce the pressure to provide government bailouts. This again is based on Hirshleifer’s argument that, in the absence of insurance, governments may not be able to resist the political pressure to compensate.¹⁴⁶ Compulsory insurance could thus be seen as a way of reducing pressure on the government.

The second traditional economic argument in favor of compulsory insurance would be the presence of information problems. Indeed, compulsory insurance may improve all agents’ welfare due to the problem of asymmetric information.¹⁴⁷ Information problems might arise in cases where the potential victim cannot accurately assess the catastrophic risk he is exposed to or the benefits of the purchase of first-party insurance. An

¹⁴⁶ See generally Hirshleifer, *supra* note 11, at 146. See also Siegelman, *supra* note 11.

¹⁴⁷ Alvaro Sandroni & Francesco Squintani, *Overconfidence, Insurance, and Paternalism*, 97 AM. ECON. REV. 1994 (2007). This argument has been demonstrated by Charles A. Wilson, *A Model of Insurance Markets with Incomplete Information*, 16 J. ECON. THEORY 167 (1977) and Bev G. Dahlby, *Adverse Selection and Pareto Improvements through Compulsory Insurance*, 37 PUB. CHOICE 547, 547 (1981).

underestimation of the risk would, in that case, lead to the wrongful decision of the potential victim not to buy first-party insurance.

In other words, this would assume that citizens are averse against the risk of large damage as a consequence of catastrophes and would be willing to pay a premium to have that risk removed from them, but simply do not purchase insurance because they lack information e.g. on the probability and magnitude of the risk and/or on the availability of insurance. Also, given the result of psychological experiments it could easily be argued that, because of imperfect information, individuals are not fully informed about their own preferences.¹⁴⁸ Regulation would then be the classic remedy to cure an information deficiency: the legislator could remedy the information problem by introducing a general duty to insure.¹⁴⁹ Information problems thus could constitute an argument in favor of compulsory first-party insurance. An example of this would be for property damage caused as a result of natural disasters if empirical evidence showed that victims would greatly underestimate these risks and would, being well informed, definitely have a demand for insurance.

Alternatively, one could again take into account the results of happiness research and argue that people might experience a higher life satisfaction or subjective well-being if *ex ante* arrangements could be made guaranteeing financial compensation after disasters. Whether that is the case is of course an empirical question. A weakness is that, as we showed above, behavioral research seems to indicate that it is not poor information that causes the low demand, but rather a lack of willingness to insure against probability events. Moreover, if there were really poor information, the remedy could consist of a mandatory disclosure of information to the public rather than in making insurance compulsory.

A third rationale for compulsory insurance is behavioral. Individuals may, as was shown above, underinsure because they are overconfident.¹⁵⁰ In that situation, compulsory insurance does not harm unbiased agents because they want to be insured, and should be imposed on overconfident individuals for their own benefit. However, Sandroni and Squintani found that the asymmetric-information rationale and the behavioral rationale for compulsory insurance do not reinforce each other. After all, compulsory insurance ceases to improve all agents' welfare when there is a significant

¹⁴⁸ See Kaplow and Shavell, *supra* note 128, at 1332-33.

¹⁴⁹ See generally Alan Schwartz & Louis L. Wilde, *Intervening in Markets on the Basis of Imperfect Information: A Legal and Economic Analysis*, 127 U. PA. L. REV. 630, 633-34 (1979).

¹⁵⁰ See Sandroni, *supra* note 147, at 1994.

fraction of overconfident agents because it makes low-risk agents worse off. As a result, behavioral biases may weaken asymmetric-information rationales for government intervention in the insurance sector because they may turn policies beneficial to all insured into wealth transfers between the insured. High-risk citizens benefit from compulsory insurance because they obtain insurance coverage at lower prices. Compulsory insurance also benefits low-risk citizens because it relaxes the incentive compatibility constraint. However, when the economy has a significant fraction of overconfident agents, the incentive compatibility constraint no longer binds. Compulsory insurance then becomes a transfer of wealth from low-risk to high-risk agents. The previously-referenced study by Sandroni and Squintani hence shows that one has to be very careful with introducing mandatory insurance to off-set information deficiencies resulting from behavioral shortcomings. Sandroni and Squintani show that in particular circumstances (in the presence of overconfident consumers) such a regulatory mechanism may lead to a decrease in social welfare.

B. MANDATORY ADDITIONAL COVERAGE?

Slovic, Fischhoff, and others, wondered if, as people prefer to insure against high-probability low-loss events, they would also insure against unlikely disasters if such insurance were sold at a reasonable extra cost along with insurance against likely losses.¹⁵¹ Their behavioral experiments showed that adding protection against a small but likely loss might help accomplish the purpose of also being insured against low-probability losses. A compound insurance will thus lead to more people being insured against catastrophic losses.

At the side of the insurers, such a comprehensive insurance policy also has several advantages. After all, it is likely that the chances that an insurer will become insolvent are reduced due to a larger premium base and the diversification of risks across a wider area.¹⁵² Moreover, if the extra premium to be paid for the mandatory additional coverage would be based on risk, then the policyholder would be charged only for the hazard that he faces. One would need to highlight this idea of all-hazards coverage to the general public, who may otherwise feel that they are paying for risks that

¹⁵¹ See Paul Slovic et al., *supra* note 84, 246.

¹⁵² An all-hazards insurance policy moreover avoids discussions between the insurer and the insured. For example, a serious amount of disputes arises after a hurricane, namely whether the losses were caused by water or by wind.

they do not face. To conclude, support for a regulatory duty to insure against disasters, in addition to voluntary housing insurances (like this is the case in France) can be received from behavioral experiments.

However, here we should recall that recent studies showed that one has to be very careful with regulatory interventions (like mandatory insurance) to cure behavioral shortcomings since, in particular market situations (more particularly in the presence of overconfident consumers), this may lead to a reduction in welfare.¹⁵³ Thus, whether such a compound insurance will have beneficial effects may well depend upon the particular market and is largely an empirical matter.

C. DRAWBACKS

However, there are various drawbacks to a duty to purchase first-party insurance against (natural) catastrophes.

First, let's turn back to the basic principles of insurance as developed by the expected utility theory on insurance. One of the most important benefits of insurance is that it removes the risk from risk-averse persons and thus increases their utility. Are those benefits now large enough to warrant the introduction of compulsory insurance?¹⁵⁴ A problem with this argument is that the degree of risk aversion varies. The introduction of a generalized duty to insure might be inefficient in as far as it forces some people that would normally not have a demand for insurance to purchase insurance. Insurance does not increase these people's expected utility. A generalized duty to insure might therefore create a social loss. This means that the simple fact that insurance increases utility can as such not justify the introduction of a duty to insure, as long as it is assumed that all individuals are informed about the risk to which they are exposed and the availability of insurance.

This argument also rather paternalistically assumes that insurance is under all circumstances beneficial to potential victims. The argument neglects the fact that the insured has to pay a price to have the risk removed from him. This price will unavoidably be a lot higher than the actuarially fair premium, as insurer's ambiguity increases the price with a risk

¹⁵³ See Sandroni and Squintani, *supra* note 14, at 1999-2000.

¹⁵⁴ Michael Faure & David Grimeaud, *Financial Assurance Issues of Environmental Liability*, in *TORT AND INSURANCE LAW* 5, 180 (European Centre for Tort and Insurance Law ed., 2003).

premium. For some potential victims this premium will still be attractive, but for others it may not.

Compulsory insurance generally neglects the fact that the demand for insurance may vary according to the individual risk situation (and financial possibility) of every possible victim. Of course one could rebut that, as shown above individuals often do not buy insurance for reasons that are not consistent with standard economic theory.¹⁵⁵ There are indeed behavioral shortcomings that are a main argument advanced in favor of comprehensive disaster insurance. Still, the danger exists that behavioral shortcomings are then used as an argument for a regulatory intervention, the effects of which on social welfare are not always clear.

A second drawback is not related to the insights of the utilitarian approach. This drawback relates to the fact that it is not only the lack of information on the risk that causes the low demand for insurance, but a bounded rationality linked to the idea that “it will not happen to me,” combined with the unwillingness to pay the premium for a highly unlikely hazard. The question thus arises whether forcing people to take out disaster coverage should not be considered as a paternalistic intervention which would have unclear effects on social welfare.

Third, if, to the contrary, one would assume that potential victims are poorly informed on their potential exposure to disasters and on the benefits of first-party insurance, then a regulatory intervention should aim at a mandatory disclosure of such information to potential victims rather than at a mandatory coverage. Again, this is supported by behavioral experiments which show that graphic presentations may – to some extent – increase the perceived risk of that hazard.¹⁵⁶

A fourth disadvantage relates to cross-subsidization. A general duty to purchase disaster coverage may be disadvantageous for those victims who do not run any risk. Take the example of flood insurance: one can imagine that a person living in a house close to a river might have a demand for flood insurance, but the same is probably not true for someone living in an apartment in a city on the 20th floor. A generalized duty to purchase insurance coverage would therefore force all individuals to take insurance coverage, even those that run no risk at all and therefore have no demand for insurance. This could thus create inefficiencies and lead to cross-subsidization or negative redistribution whereby those who run no risk

¹⁵⁵ See *supra* section III.

¹⁵⁶ As already discussed above. See Slovic et al., *supra* note 84.

would have to contribute to the premium of those who may actually benefit from the insurance coverage.¹⁵⁷

A more efficient (and fairer) solution may therefore be the one whereby the compulsory coverage (e.g. for flood risks) is limited to those individuals who actually are exposed to the particular risk. This result can of course be reached when risk-based premiums are used. The extra risk premium can in other words vary according to the individual risk situation of each insured. Moreover, if the premiums were based on risk, then insurance would provide information on ways that individuals could protect themselves against a disaster.¹⁵⁸ However, it could be very costly to develop premiums, which would differentiate between types of structures and location. Additionally, the complexity of the rate schedule would be very confusing to the homeowner. There is also no easy way to make sure that the homeowner has met the standards upon which his premium is based. Thus, there would have to be a cost of checking reflected in the rate structure. If this cost were incorporated into the rates, then the premium might be considerably higher than the actuarial figure. It might then unnecessarily discourage some individuals and businesses from locating in a particular area where it might have been profitable for them to do so. Moreover, the question arises whether lower income residents would be able to pay these risk-based premiums and hence whether politicians would allow insurers to relate premiums to risk.¹⁵⁹

Fifth, compulsory insurance against disasters may be necessary to avoid the risk of adverse selection, wherein only bad risks purchase coverage. Thus, some argue that, in order to make the risk insurable, good risks should also be covered and disaster insurance (for instance, flooding insurance) made compulsory. As we have argued above, this argument is a bit odd given that the adverse selection problem is unlikely in the of disaster insurance context. If the insured knew his potential loss exposures better than insurers, the insurer could easily impose inspection measures.¹⁶⁰ But, the adverse selection argument is in fact wrongly presented by some

¹⁵⁷ See Harrington, *supra* note 101, at 41.

¹⁵⁸ Howard Kunreuther, *Disaster Insurance: A Tool for Hazard Mitigation*, 41 J. RISK & INS. 287, 299 (1974).

¹⁵⁹ See DOHERTY, *supra* note 42, at 137-38 (discussing other disadvantages of a risk-based premium in an all-hazards policy).

¹⁶⁰ See *supra* Part III.

(e.g. Dutch) insurers,¹⁶¹ who suggest that disaster risk would only be insurable if everyone, even those who run no risk at all, were forced to purchase insurance coverage.¹⁶² Adverse selection can also be avoided if only those who are exposed to the risk are forced to take the mandatory coverage. Otherwise, people would be forced to pay for insurance that they do not need.¹⁶³ Fortunately, within risk-prone groups, insurers can adequately differentiate risks and premiums, as a remedy to adverse selection.¹⁶⁴ This is again an argument in favor of risk-based premiums.

Further, the second type of compulsory disaster insurance schemes involves a tie-in agreement, whereby a potential buyer of property insurance is forced to purchase insurance against catastrophic loss. Tie-in agreements limit competition because consumers cannot opt to include catastrophe insurance and because separate markets for both types of insurance cannot develop. Consequently, a compulsory catastrophe extension of first-party property insurance potentially generates effects that competition law tries to avoid. Introducing a duty to insure may only be efficient if sufficient competition on the particular insurance market exists. Obviously, in a monopolistic market compulsory insurance will create inefficiencies. Hence, the additional premium for the disaster coverage should not be fixed by law but should be the result of competition between insurers.¹⁶⁵

Of course, the concern about tying disaster coverage to ordinary insurance limiting competition assumes the development and existence of a full-blown disaster insurance market. This paper began by noting that people do not widely purchase first-party disaster insurance. Therefore, a large degree of competition is unlikely in current insurance markets offering disaster coverage. In that respect the tie-in argument may not be very strong in the early development of a market for disaster coverage.

¹⁶¹ Reimund Schwarze & Gert G. Wagner, *In the Aftermath of Dresden: New Directions in German Flood Insurance*, 29 GENEVA PAPERS ON RISK AND INS. 154, 162 (2004).

¹⁶² Priest, *supra* note 12, at 225-26.

¹⁶³ One can of course understand why some insurers advance this argument in policy discussions with the government. With mandatory insurance coverage for everyone (including those who incur no risk) insurers will have more insured individuals paying premiums, thereby increasing their income and reducing their overall risk exposure.

¹⁶⁴ This argument confuses a lack supply with adverse selection.

¹⁶⁵ See Roger Van den Bergh & Michael Faure, *Compulsory Insurance of Loss to Property Caused by Natural Disasters: Competition or Solidarity?* 29 WORLD COMPETITION: LAW & ECON. REV. 25, 33-35 (2006) (describing the effects of additional premiums for disaster coverage on competition law).

Finally, some particular catastrophic risks may be so “new” that insurance markets may not yet have developed. One could question whether it makes sense to introduce mandatory insurance if coverage is limited (or not subject to sufficient competition) on private insurance markets.

D. COMPREHENSIVE INSURANCE OR THE PUBLIC PURSE?

Notwithstanding these objections, there is an important advantage to mandatory disaster insurance: if a comprehensive first-party insurance system exists, it will remove pressure on governments to provide disaster relief. Though politicians may always have the tendency to provide compensation when a large number of victims are affected by a disaster,¹⁶⁶ randomly using public means to compensate disaster victims has been highly criticized.¹⁶⁷ First-party insurance at least guarantees that victims pay themselves for the compensation they will afterwards obtain. And, with adequate risk differentiation, first-party insurance can have preventive effects which are usually absent in government relief programs.¹⁶⁸ Indeed, insurance can encourage risk mitigation prior to a disaster through premium reductions and/or lower deductibles while providing financial assistance after a disaster through claim payments.¹⁶⁹ If insurance is to play a central role in a hazard management program, then rates need to be based on risk so that those in disaster-prone areas are responsible for the losses after a disaster occurs.

A limitation of any government insurance program is that premiums are not likely to be risk-based because of political pressure to make coverage affordable to those residing in high-hazard areas. One way to encourage adoption of cost-effective mitigation measures is to have banks provide long-term mitigation loans that could be tied to the property. The bank holding the mortgage on the property could offer a home improvement loan with a payback period identical to the life of the mortgage.¹⁷⁰

¹⁶⁶ See Hirshleifer, *supra* note 11, at 145.

¹⁶⁷ See Priest, *supra* note 12, at 221, 228; see also Kaplow, *supra* note 12, at 168.

¹⁶⁸ See Epstein, *supra* note 12, at 296-97.

¹⁶⁹ Kunreuther, *supra* note 64. See also Pierre Picard, *Natural Disaster Insurance and the Equity – Efficiency Trade-Off*, 75 J. RISK & INS. 17, 18 (2008).

¹⁷⁰ See Kunreuther et al., *Disaster Mitigation and Insurance: Learning from Katrina*, *supra* note 105, at 221.

Nevertheless, government assistance in protection against natural disasters may not be optimal *ex ante*, but it may be optimal *ex post*. Suppose that an uninhabited area is likely to be affected by tropical storms, and that this risk is so high that it is not socially desirable from an *ex ante* perspective for the population to settle there. The necessary protective assistance, which only the government can undertake, is too costly. The question then is what action the government would undertake if the area is in fact settled: either it assists settlers in constructing protective devices to limit losses in the event of a storm, or it refrains. When it is socially desirable to provide protection *ex post*, there is a time consistency problem.¹⁷¹ If the government can commit to not providing such assistance in the event the area is settled, the citizens will simply not settle there and the socially desirable outcome is attained. If, on the other hand, the government cannot commit, there will be settlement, since the citizens then know that they will receive assistance and protection, and a socially less desirable outcome is obtained.

In sum, from an *ex ante* perspective, there are strong arguments in favor of a comprehensive disaster insurance program where disaster coverage is made mandatory in addition to insurance for more likely events, provided that premiums can sufficiently reflect risks.¹⁷² Such an insurance program can avoid the negative redistribution resulting from government intervention, while still providing incentives for risk

¹⁷¹ Finn E. Kydland & Edward C. Prescott, *Rules Rather than Discretion: The Inconsistency of Optimal Plans*, 85 J. POL. ECON. 473, 473-74 (1977). The essence of the time consistency problem is as follows: a policy which economic policymakers regard as the best option in advance, when it can influence households' and firms' expectations about policy, will often not be implemented later on, when these expectations have already been formed and shaped private behavior. Economic policymakers will therefore revise their decision, so that the policy they ultimately conduct will be worse than if they had had less discretion in policy choice. This result does not hinge on policymakers being guided by objectives different than those of citizens at large; rather, the difference appears in the constraints on the economic policy problem at different points in time. (http://nobelprize.org/nobel_prizes/economics/laureates/2004/public.html) Indeed, a time consistency problem can arise the moment the government has discretionary powers to pursue a policy. A credibility problem is threatening to exist when citizens realize that the government can make *ex post* a new consideration that can turn out differently than announced *ex ante*.

¹⁷² There is an optimal trade-off to be respected since a too detailed differentiation of risks can be extremely costly. See FAURE, *supra* note 154, at 127.

mitigation. This conclusion is supported by law, economic scholarship, and most particularly in the many Kunreuther publications.¹⁷³

VI. EXAMPLES

One can now notice a European-wide tendency towards an increasing use of partially mandatory catastrophe insurance. This tendency can partly be explained by the fact that government-provided compensation is, because of increasing pressure on public budgets, losing popularity.¹⁷⁴ Mandatory insurance is thus seen as a way to avoid “catastrophic responses to catastrophic risks” referring to the negative incentives for prevention and the development of insurance markets resulting from government-provided compensation.¹⁷⁵ We will summarize the compulsory insurance programs in France and Belgium, which raise a set of points that suggest why such coverage may be a good idea and why it may not.¹⁷⁶

A. FRANCE

France is probably the most well known example of a country, which for many years has had compulsory first-party insurance against catastrophes.¹⁷⁷ The French model indeed introduced mandatory first-party insurance, where all individuals whom have taken out first-party property damage insurance policies have to pay a supplementary premium for a mandatory coverage for natural disasters. Hence, France does not have a generalized duty to insure, but a compulsory complementary coverage on voluntary property damage contracts. However, those property damage

¹⁷³ Since 1968 Kunreuther argued for mandatory comprehensive disaster insurance. Howard Kunreuther, *The Case for Comprehensive Disaster Insurance*, 11 J. LAW & ECON. 133, 150 (1968). Kunreuther later repeated his argument with added theoretical and empirical data. Kunreuther, *supra* note 16, at 182-83.

¹⁷⁴ For a comparison of government provided compensation and insurance: see Michael Faure, *Financial Compensation for Victims of Catastrophes: A Law and Economics Perspective*, 29 LAW & POL'Y 339, 356 (2007).

¹⁷⁵ See Epstein, *supra* note 12, at 296. For further examples see FAURE & HARTLIEF, *supra* note 17, at 406-15.

¹⁷⁶ But further examples could be provided as well. See FAURE & HARTLIEF *supra* note 17.

¹⁷⁷ Michel Cannarsa, Fabien Lafay & Olivier Moréteau, *France*, in FINANCIAL COMPENSATION FOR VICTIMS OF CATASTROPHES: A COMPARATIVE LEGAL APPROACH 81, 85-90 (Michael Faure & Ton Hartlied eds., Springer 2006).

policies are widespread and all individuals who purchase such a policy have to pay for the additional coverage for natural disasters.

This system is apparently accepted in France because the risk of cross subsidization may be small: France seems to be confronted with many types of natural disasters. This means that if one is presumably (as e.g. inhabitant of an apartment on the 12th floor) not exposed to the risk of flooding, one may be exposed to other natural disasters, such as earthquakes or heavy storms.

The system is financed with a fixed premium on property insurance contracts. The initial rate was 5.5% when the system started in 1982; it was raised to 9% the following year and to 12% in 2000. The insurer compensates, within three months as from the date of the submission of the estimate of damaged property or losses sustained, on the basis of the scheme when an event is declared a “natural catastrophe” through an administrative decision. The insured must bear a share of the loss (a so-called deductible or franchise), which is higher in municipalities that have not adopted a “prevention of risk plan.” This should provide incentives for the municipality and for the local population to adopt such a prevention plan or to move to safer places.¹⁷⁸ Economic loss is not compensated in case of a natural catastrophe except where expressly provided for in the insurance policy.

Note, moreover, that in France, as a result of the explosion in Toulouse on 21 September 2001, a legislative change was effectuated in July 2003. As a result of this change, victims now also have additional compulsory coverage for damage caused by technological risks (such as the explosion in Toulouse). This system is financed by an additional premium of € 5 per year and per contract. On the basis of the € 50 million contracts existing in 2005, this means there is € 250 million in anticipation of the coverage of this risk.

That latter solution is, however, debated (also in France). It is not so clear why in this case of technological disasters, where a liable wrongdoer can be identified, a mandatory coverage for victims was introduced rather than examining the introduction of solvency guarantees on the side of the wrongdoer, such as compulsory liability insurance. Insurance coverage will be excluded in special areas recognized in a “prevention plan of

¹⁷⁸ Olivier Moréteau, *Policing the Compensation of Victims of Catastrophes: Combining Solidarity and Self-Responsibility*, in *SHIFTS IN COMPENSATION BETWEEN PRIVATE AND PUBLIC SYSTEMS* 199, 217 (Willem H. Van Boom & Michael Faure eds., 2007).

technological risks” as causing a serious risk to human life, for all buildings erected in this area after the plan has been published, and where a building is erected in violation of administrative rules.

Reinsurance is provided through the “Caisse Centrale de Réassurance,” (CCR) which is state-controlled. Half the premiums levied to cover the consequences of catastrophes go to the CCR, which will always cover half the damage insured. This way, the CCR is acting as a mutual fund, which balances the risk of catastrophes among all insurance companies. The CCR is itself covered by the State, which provides an unlimited guarantee.

Further, the French initiative in the field of reinsurance against risks of terrorism should be mentioned. In 2002, the French insurance companies and the companies authorized to carry on direct insurance business on French territory created a pool called GAREAT (“Gestion de l’assurance et de la réassurance des risques attentats et actes de terrorisme”). This pool was originally created for one year, but it was renewed in 2003 and it is still in force today. GAREAT reinsures damage to the property of enterprises, local authorities and large buildings caused by terrorist attacks where the insured capital exceeds € 6 million. Reinsurance is also provided by CCR, with unlimited State cover. The premium ceded to the pool is determined in relation to the premium currently charged for the natural catastrophe cover. Meanwhile, France accepted a new Terrorism Act in 2007. Prior to the new Terrorism Act, all property contracts were to include terrorism cover. Following the introduction of the new Act, only contracts with a fire guarantee must cover terrorism. Therefore, GAREAT will no longer accept risks where there is no fire guarantee.

B. BELGIUM

Belgium had a compensatory Disaster Fund since 1976. As a result of a legislative change in May 2003 compulsory flood coverage, in addition to the voluntary fire insurance contract, was introduced. It looks like the French system, but the major difference is that this mandatory supplementary coverage would only apply for specific flood-prone areas. This would hence avoid a negative redistribution because those who are not exposed to the risk are not forced to take out the coverage. Due to disagreement, however, regarding the demarcation of those risk areas, the act could not enter into force. Thus recently, the system has been changed again: since September 2005, the compulsory first-party coverage includes

not only flooding but natural catastrophes in general, regardless of whether the catastrophe happened in a risk area.¹⁷⁹

The Belgian legislature thus created the 17 September 2005 Act establishing a general solidarity between all citizens who have fire insurance coverage for the so-called simple risks – comprising 90 to 95% of the Belgian population – by introducing a mandatory extension to natural disaster coverage. The natural catastrophe insurance coverage comprises four perils: flooding, earthquake, the flowing over or the impoundment of public sewers, and landslide or subsidence. The insurer can investigate the natural hazard risk for every individual case and will adjust the extra premium accordingly. As a result, an inhabitant of the 10th floor of an apartment building in the centre of the city will normally pay a lower extra premium than the average premium increase, which is expected to be € 3 to 4 per € 25.000 insured. The final premium will hence differ in function of the real risk.

However, Colle found that insurers operate with two different systems: half of the insurance companies charge the same extra premium for all its insured, namely between € 2,60 and € 3,76 per € 25.000 insured good (plus a tax of 15,75%), while the other insurance companies vary their premiums according to the location of the ground, past damage, and deductibles.¹⁸⁰ The maximum indexed deductible for the disaster coverage amounts to € 610 per claim. Further, every individual insurer has been given some limits regarding the monetary burden he can carry, since the disaster coverage concerns catastrophic risks, which can take extraordinary proportions. The *ratio legis* is to avoid the financial downfall of the insurance companies. The law sets up an intervention limit on the basis of a formula by event and by individual insurer according to his premium income for the coverage for fire as concerns the simple risks: € 8 million for earthquakes, decreased to € 3 million for other natural catastrophes. When this limit is attained, the Disaster Fund makes up the amount with a general upper limit of € 280 million (€ 700 million for earthquakes). In case these amounts would not be sufficient to compensate the victims, then the intervention of the Disaster Fund will be reduced in proportion.

Thus, to conclude, a public-private partnership has now been created in the Act of 17 September 2005: the government created the conditions under

¹⁷⁹ For this recent legislative change: see Philippe Colle, *De wet van 17 september 2005 betreffende de verzekering van natuurrampen*, 23 RECHTSKUNDIG WEEKBLAD, Feb. 4, 2006, at 881-885.

¹⁸⁰ Colle as interviewed by Verhaeghe in DE STANDAARD (October 18, 2006).

which the natural catastrophe risk became insurable thanks to the solidarity between all the holders of a fire insurance agreement for simple risks, and the insurers will fully play their social role. Every family can insure itself against the direct damages to their goods which are a consequence of a natural catastrophe for a reasonable price and will receive full compensation, apart from the freely stipulated, but maximum franchise of € 610.

Further, the Belgian State created very recently a system of mandatory insurance against damage caused by terrorist attacks. The Act of 1 April 2007 extends the life insurance policy, hospitalization insurance policy, accident insurance policy and health insurance policy to mandatorily include terrorism cover – apart from the already existing compulsory coverage in the workers' compensation insurance policy, the motor liability insurance policy and in the fire insurance policy for simple risks. Moreover a Committee has been set up to judge whether concrete events can be considered to be terrorist actions and to decide on the amounts of compensation. The total compensated amount will be set for the first time after six months and a revision of this amount is possible every six months. The final decision with respect to this amount will be set after three years. The Act of 1 April 2007 guarantees the cover of terrorism claims during a calendar year up to a global annual limit of € 1 billion. Hereto, a solidarity-based pooling arrangement has been established, which is financed by the Belgian State, the insurers and reinsurers, and other legal persons who are active in the performance of duties. Participation at the Fund is not compulsory, but the liability of the participants is capped at € 1 billion, which will not be the case for possible non-participants. If no other agreement has been made between the Belgian State and the participants to the Fund or by the King, then the Fund will pay the first € 700 million to the victims of terrorism,¹⁸¹ while the Belgian government will pay a maximum of € 300 million. The part payable by the State should be considered as a reinsurance against which the government receives a reimbursement.

¹⁸¹ Of this € 700 million, the intention is for the insurers to keep the first € 300 million (this amount is not yet fixed – amounts from € 280 million up to € 350 million are mentioned) in retention and distribute this according to market share. The next € 400 million or so will be reinsured. See the thesis of Evy Nolman, entitled “Terrorisme: nieuwe uitdagingen voor de verzekeringswereld en de overheid” (2007) at the Economics Faculty of the Catholic University of Leuven, 30.

C. COMPARATIVE AND POLICY CONCLUSIONS ON FRANCE AND BELGIUM

The French system undoubtedly has the advantage that it provides comprehensive disaster insurance for a large part of the population, all of those who already have voluntarily purchased first-party property damage insurance. The problematic aspect is that all insured have to take the disaster coverage mandatorily. Theoretically, those who are never exposed to the risk of natural disasters may thus be forced to purchase coverage even though they have no demand. The seriousness of this danger of cross-subsidization depends on the extent to which some are forced into the system even though they have no risk at all. Belgium originally had a new Act adopted in 2003, which provided that the mandatory supplementary coverage would only apply for specific flood-prone areas. Hence, this would completely avoid any negative risk distribution since only those exposed to the risk would be forced to purchase the coverage. However, the political costs to identify those areas seemed so large that it was impossible to identify those risk zones as a result of which the Act remained a dead letter. The new 2005 Act has enlarged the coverage to include (in addition to flooding) also other risks, such as earthquake, damage due to flowing-over of public sewers and landslide. This enlargement may, like in the case of France, reduce the danger of cross-subsidization: even if an insured is not exposed to the risk of flooding he may be exposed to another covered natural disaster risk, such as e.g. earthquake.

However, a major difference between the French and the Belgian system is that premiums in France are fixed by the regulator, whereas in Belgium insurers fix the premiums on a risk-based basis. In France, premiums are not at all related to the risk and moreover, the regulatory intervention may limit competition. Competition is still possible as far as the basis, for example, housing insurance, is concerned.¹⁸² The Belgian system seems preferable to the extent that it incorporates risk-related premiums. However, the French system has also incorporated some incentives for prevention by providing that compensation will be lower if a community has adopted a “prevention of risk plan”. This should provide incentives to voters to demand the adoption of such a plan within their community.

¹⁸² See Van den Bergh & Faure, *supra* note 165, at 26-36.

In addition, in both countries, the governments largely intervene by providing reinsurance (in the case of France) and by intervening above certain limits (in the case of Belgium). Insurers don't have to pay any contribution for this state intervention; as a result of this, it effectively constitutes a subsidy.¹⁸³ This idea of states being able to intervene in providing intervention without market distortive effects certainly deserves more attention.

VII. SUMMARY AND CONCLUSIONS

In this paper, we merely dealt with one aspect of the compensation for victims of catastrophes. We more specifically addressed the question whether potential victims can and do purchase first-party insurance to obtain *ex ante* protection against the damage they could be exposed to as a result of natural catastrophes. Of course, many other questions also related to catastrophe insurance could be tackled.¹⁸⁴ Moreover, although our paper specifically focused on natural catastrophes, the results may have consequences for man-made disasters (like terrorism) as well, even though more difficulties might arise in that respect with the insurability of the terrorism risk. We therefore focused on the question of why, in the case of natural catastrophes (where often coverage is available on commercial insurance markets), victims often do not use the existing possibilities.

Indeed, a general finding as far as the use of first-party insurance by potential victims of catastrophes is concerned was that there is a remarkably low degree of coverage. This could be supported by examples from a flooding in Germany, but also by reference to the number of available first-party insurances. After earthquakes in California, and recently after Hurricane Katrina, it was again established that the number of insured victims was relatively low.

The question why victims seek so little *ex ante* protection through first-party insurance has been addressed in the literature from various angles. The traditional neo-classic answer would be that victims apparently lack information on the catastrophe risk and that the lacking demand for catastrophe coverage is thus a classic example of market failure. However,

¹⁸³ At least as concerns the natural catastrophes; a reinsurance premium should indeed be paid in Belgium for state intervention in the terrorism risk.

¹⁸⁴ For instance, the scope of liability insurance on the side of liable operators might be addressed as well. However, since our focus was on natural catastrophes we assumed that liability insurance will mostly not play a role, except in the rather exceptional cases that public authorities can be held liable for failure to prevent natural catastrophes.

more recent literature resulting from psychological experiments in the field of behavioral law and economics showed that even in cases where victims were well informed, they did not seek coverage or only to a limited extent. The explanation by behavioral law and economics is that victims apparently have no demand for insurance against low-probability high-damage events. To some extent, it has to do with the well known “heuristics and biases” that decision-making concerning the purchase of insurance is subjected to. The most important problem in that respect is apparently the fact that many consider insurance as a type of investment and hence expect some return over a lifetime. With low-probability events, there is a large likelihood of merely paying a premium and never receiving any return.

A more difficult question is, however, whether these heuristics and biases are an argument at the policy level to introduce mandatory cover for catastrophic risks. The classic counterargument would be that such a paternalistic duty might be inefficient since people may be forced to purchase insurance coverage even if it does not match with their preferences. However, an alternative model (instead of outright mandatory cover for catastrophes), which is increasingly popular in many countries, is the introduction of a mandatory cover for natural catastrophes in addition to voluntarily purchased insurances, like e.g. a home insurance. This model, which has worked in France for a long time and which has been recently introduced in Belgium, seems to have various attractions.¹⁸⁵ It offers victims at least some guarantee that *ex post* compensation will be available. This construction can moreover decrease the pressure for government relief. Law and economics scholars have often criticized government-provided compensation after catastrophes since it does not provide any incentives to those exposed to catastrophic risks to make efficient preventive efforts. Insurance is traditionally much better able to cope with this moral hazard problem.

Moreover, since potential victims pay *ex ante* for the protection they will receive, this model also has benefits compared to government relief in the sense that a negative redistribution from the general taxpayer towards particular victims exposed to catastrophic risks is avoided. The mandatory catastrophe cover in addition to voluntary insurances against more likely losses also received support from behavioral law and economics. The traditional disadvantage also with this construction is still that insurance

¹⁸⁵ The model of comprehensive natural disaster insurance was also proposed by Kunreuther after Hurricane Katrina. See Kunreuther, *supra* note 64, at 176.

cover is forced upon some individuals who would perhaps have no demand for coverage. This problem can to some extent be limited if at least the additional duty to obtain catastrophe coverage is limited to those individuals who are actually exposed to the specific risk (e.g. those living in flood-prone areas). Thus, the cross subsidization inherent in a generalized duty could be avoided. However, the administrative costs of a differentiation between individuals exposed to natural catastrophes and those who are not may be high, taking also into account the fact that there may be considerable political costs involved with such a differentiation. The Belgian example showed that the political costs to introduce such a differentiated comprehensive insurance (limited to specific risk areas) were apparently too high.

This particular model of additional mandatory catastrophe coverage, supplementing voluntary housing insurances was first introduced in France, but seems to become increasingly popular in many other European countries as well. It was recently introduced in Belgium, is the subject of a bill in Italy and has been proposed in the literature in Germany as well. The most important motivation for these institutional arrangements is that this structural solution can take away some of the pressure on governments to provide *ex post* relief to victims of catastrophes, the latter often being arbitrary and of course leading to cross-subsidization.¹⁸⁶ However, we do not claim here that the Belgian or French solutions are necessarily the most efficient ones. One could also envisage other solutions whereby a combination of limited government funding and insurance would be introduced. It is beyond the scope of this paper to examine all of these alternative arrangements. Moreover, it should be repeated that the insurance solution of course is only possible within the institutional context of a country where a well functioning insurance market is available and where potential consumers have sufficient financial capacity to buy the insurance products that have been developed. In many developing countries, these conditions will often not be fulfilled and in those situations disaster insurance can of course not be the panacea for victims of catastrophes. Other mechanisms, like *ex post* government compensation, will then still be necessary.

¹⁸⁶ We do not argue here that (mandatory) first-party insurance is generally more effective in providing compensation than government provided compensation since this was not the focus of this paper. However, generally law and economics scholars are very critical of government provided compensation. See, e.g., Kaplow, *supra* note 12; Priest, *supra* note 12; Epstein, *supra* note 12.

In addition, there are many other problems related to the insurance against damage caused by catastrophes than merely the problems with demand discussed in this paper. As we briefly indicated, there may be serious problems on the supply side as well. Also in that respect, one can notice a variety of regulatory solutions whereby governments intervene to facilitate the functioning of insurance markets.¹⁸⁷

Finally we would like to make a few recommendations as to what next steps can be taken to deal with the problem here discussed. First of all, natural catastrophe insurance, and especially flood and earthquake insurance, should be made more attractive by presenting information on the probability of a disaster on a different time interval than the traditional one-year period through normal channels to increase the concern of potential victims. Homeowners should moreover be better educated in order to see insurance as an investment with a big return. Homeowners insurance could further be expanded with flood and earthquake coverage so that this forms a package, with the extra premiums on the compulsory coverage reflecting the hazard risk of each individual. Second, the example of flooding insurance in the Netherlands¹⁸⁸ shows that government policy should also be addressed to stimulate insurers to provide attractive products for disaster coverage at actuarially fair prices. If insurers would collectively decide (like it was the case in the Netherlands) not to cover e.g. flooding and earthquake risks a *de facto* uninsurability is of course reached. Finally, it should be examined whether in case where problems on the supply side exist, government support can be provided (eventually at a temporary basis) to stimulate the development of efficient insurance markets. This type of government intervention, stimulating market solutions, may be preferred to the traditional *ex post* government relief which *de facto* only inhibits the development of market solutions to the compensation for victims of catastrophes.

¹⁸⁷ These facilitative strategies have especially been developed in the United States, e.g. as far as earthquake and hurricane insurance is concerned. An interesting example is also provided by the California earthquake authority. For a detailed description of these models: see Rabin & Bratis, *supra* note 73, at 327-30.

¹⁸⁸ See discussion *supra* section IV.

INFLUENCES OF ORGANIZATIONAL FORM ON MEDICAL MALPRACTICE INSURER OPERATIONS

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ABSTRACT

Medical malpractice insurance is a highly specialized and risky business. Over the past three decades, the market has experienced three dramatic periods of rising prices and shrinking supply. For medical care providers subject to such market volatility, a response has been the development of physician-owned and physician-run entities as their insurance providers. Yet regulators and rating agencies demonstrate concern over geographic and business risk concentration of these entities, encouraging them to diversify across state lines as well as across lines of business. We hypothesize that physician-directed insurers are inherently more conservative and better informed than non-physician directed insurers, calling into question the value of such diversification, which we believe reduces their informational advantage. We test this hypothesis through analysis of insurer loss reserving practices and find that physician-directed insurers are more likely to over reserve and less likely to under reserve than are non-physician-directed insurers. We also find that physician-directed insurers that do under-reserve have smaller relative errors than their non-physician-directed counterparts. Importantly, we also observe that rapidly growing insurers have demonstrated risky reserving practices. We consider these results as relevant to regulators and rating agencies in assessing medical malpractice insurer riskiness.

* We thank participants at the 2008 Searle Symposium as well as the 2006 American Risk and Insurance Association Annual Meeting (Washington, DC) for their comments. We give special thanks to J. Tyler Leverty for his comments as discussant on the paper. Carrie Hirst assisted with editing this paper. Yu Lei gratefully acknowledges the financial support of the Barney School of Business at the University of Hartford.

INTRODUCTION

Medical Malpractice insurance is a highly volatile product in terms of price and supply. It also provides coverage against liabilities that are often specific to location and medical specialty. A natural outgrowth of these underlying conditions is that the majority of premiums written in medical malpractice are earned by insurers that focus on this particular line of coverage, that operate in only one or a few states, and that are owned by health care providers themselves. Yet from a risk standpoint, such specialization should lead to increased volatility because of lack of diversification. Indeed, we have observed that regulators and rating agencies encourage such insurers to expand their geographic market as well as the lines of coverage offered.¹ We believe that such encouragement may be counter-productive; we test our belief in the research reported here. Our purpose is to analyze differences in reserving practices between medical malpractice insurers defined as physician-directed versus those that are not. Since reserving practices provide an indication of an insurer's stability and strength, we hypothesize that specialized physician-directed insurers will be more conservative in their liability estimates than will less specialized widely-owned insurers.

Many readers will think of "bed-pan mutuals" in our discussion of physician-directed insurers. These readers are correct in their thinking, yet the list of physician-directed insurers extends beyond bed-pan mutuals. Bed-pan mutuals began in the 1970s in response to the initial "crisis" in medical malpractice insurance. They are small mutual insurers owned by health care providers to offer medical malpractice insurance to their members. These insurers will be included in our group of physician directed insurers. In addition to the bed-pan mutuals, risk retention groups, which became possible in the 1980s following the passage of the Federal Liability Risk Retention Act of 1986,² also will be considered "physician-directed insurers" in our analysis if they focus on medical malpractice insurance and are owned by health care providers. Importantly, some stock insurers also fit within our definition of "physician directed." These are insurers formed by medical societies or others for the purpose of offering their members and owners medical malpractice coverage. They differ from mutuals, however, in that they are organized as corporations with ownership distributed through corporate stock. Importantly, not all mutual

¹ A review of Best's Insurance Reports demonstrates this practice.

² Federal Liability Risk Retention Act, 15 U.S.C. §§ 3901-3906 (2000).

insurers selling medical malpractice insurance are considered “physician directed.” Large, diversified entities, such as Liberty Mutual, which participate in the medical malpractice market but which are not managed by nor focused on health care providers will not be considered physician directed. Because of their special characteristics, physician-directed insurers have formed their own industry trade group, the Physician Insurers Association of America (PIAA).³ The PIAA has created a listing of physician-directed versus non-physician directed insurers. We use this listing as generously provided by Patricia Danzon, Andrew Epstein and Scott Johnson. We supplement this listing with information from the Risk Retention Reporter.

Our underlying premise is that physician-directed insurers provide a significant service to the market, one not typically observed in mutual insurers, which usually provide coverage on less-complex risks. We anticipate that physician-directed insurers will operate differently from non-physician directed insurers for two reasons: they have differing organizational goals; and they have differing informational opportunities. While non-physician-directed insurers can be expected to set their primary organizational goal as maximization of the firm’s value or profit, physician directed insurers are generally formed with the purpose of offering a stable insurance environment and even to try to alter the underlying tort system. A personal review of numerous physician-directed insurer Web pages indicates that their mission statements generally focus on supporting the health care community through legal advocacy, strong loss-control support, and other mechanisms designed to alter the underlying loss conditions rather than simply to finance those losses.⁴ As stated above, physician-directed insurers are often owned by or at least initiated by state medical societies. Their objective tends not to be profit maximization. Moreover, in many instances, these two types of insurers are subject to different levels of

³ See generally Patricia Danzon, Andrew J. Epstein, & Scott J. Johnson, *The Crisis in Medical Malpractice Insurance*, BROOKINGS-WHARTON PAPERS ON FIN. SERVICES, 2004, at 56, 68. See also Medical Liability Insurers—U.S., <http://www.piaa.us/directory/public/results.asp?st=member&mt=primary&loc=usa> (last visited Nov. 9, 2008); Directory of RRGs and PGs, <http://www.rrr.com/trgspgs/advancedSearchResults.cfm> (last visited Nov. 9, 2008).

⁴ A review of numerous physician-directed insurer websites reveals these priorities. See, e.g., The Applied Medico-Legal Risk Retention Group *available at*, <http://www.amsrrg.com/> (last visited Nov. 9, 2008); Centurion Medical Liability Protective http://www.cmlpins.com/over_history.html (last visited Nov. 9, 2008); The Emergency Physicians Insurance Company, <http://www.epicrrg.com/index.asp> (last visited Nov. 9, 2008); Novus Insurance Company Risk Retention Group, <http://www.novusrrg.com/> (last visited Nov. 9, 2008); Premier Physicians Insurance Company, http://www.ppicdocs.com/about_history.html (last visited Nov. 9, 2008).

regulation. For instance, medical malpractice risk retention groups, which usually are physician-directed, are established under the Federal Liability Risk Retention Act of 1986, which preempts certain aspects of state laws regulating the activities of risk retention groups.⁵ As a result, operating practices are likely to differ between the two types of organizations.

One possible variation comes in the area of loss reserve practice. Prior research has hypothesized that insurers may manage loss reserve estimates to achieve organizational goals, including reducing taxes, enhancing apparent financial strength to avoid regulatory actions, and smoothing income for the benefit of investor preferences.⁶ Managers of physician-directed insurers, however, generally do not face the same pressure to maximize profits because they do not have to answer to investors preoccupied with maximizing profits. Additionally, these insurers tend to be subject to less stringent regulation than are most non-physician-directed insurers. We anticipate, therefore, that physician-directed insurers will approach operational decisions such as loss reserving practices differently from non-physician-directed insurers.

Moreover, physician-directed insurers may have informational or risk-sharing advantages over other insurers in writing medical malpractice insurance, which makes it more plausible that physician-directed insurers differ from non-physician-directed insurers in loss reserving accuracy.⁷ This informational advantage is generated from the insurer's strong connection to the medical community, and by its focus on the medical malpractice line of business. While some physician-directed insurers offer general liability coverage to their participating insureds, it is rare for those insurers to sell property coverage or other major lines of liability insurance, unlike many non-physician directed medical malpractice carriers, whether stock or mutual. Certainly non-physician-directed insurers can hire health care providers to close some of this informational gap, but we contend that physician-directed insurers possess such informational advantage throughout the entity because of their focus on affecting the underlying

⁵ 15 U.S.C. § 3603 (2000).

⁶ See, e.g., Kathy R. Petroni, Stephen G. Ryan & James M. Wahlen, *Discretionary and Non-discretionary Revisions of Loss Reserves by Property-Casualty Insurers: Differential Implications for Future Profitability, Risk and Market Value*, 5 REV. OF ACCT. STUD. 95, 96 (2000).

⁷ See Danzon Rule 15 *supra* note 3, at 56; Neil A. Doherty & Georges Dionne, *Insurance with Undiversifiable Risk: Contract Structure and Organizational Form of Insurance Firms*, 6 J. OF RISK AND UNCERTAINTY 187, 197 (1993).

exposure itself. In short, physician-directed insurers have a different underlying purpose.

To test our hypothesis that physician-directed insurers are more conservative in their business practices, and therefore more financially secure, than non-physician-directed insurers, we test for differences in loss reserving across physician-directed and non-physician directed insurers. We also consider the influence of geographic and business specialization. In the following section of the paper, we review the literature on loss reserve development, and follow with a discussion of organizational form. With this background as a foundation, we present our data and methodology, leading to results. The last section concludes the paper with a summary of our findings and suggestions for future research.

LITERATURE ON LOSS RESERVE DEVELOPMENT

Insurance companies are required to hold loss reserves to account for all unpaid losses and loss adjustment expenses. These reserves are first established in the year of coverage and then updated with new information as time passes. Because many years may pass between an initial malpractice event or claim and ultimate payment for the underlying injury, and because not all events are known when they occur, insurers must estimate their future liabilities with quite a bit of uncertainty. This requirement leads to inevitable errors along the way. The difference between the initially reported *estimate* of ultimate loss payments (the “loss reserve”) for any given coverage year and the ultimate *realized* paid losses for that coverage year is known as the loss reserve error (or loss reserve development), which reflects the estimation error in the originally reported reserve. This amount can be positive or negative. Loss reserves are important representations of insurance company financial performance, directly affecting current profits. How they are estimated, therefore, creates significant implications for insurers.

Two major theories have been proposed in the rich literature regarding the underlying influences on the size and direction of reserve errors. The first theory is that reserve errors simply represent mistakes in original loss estimates due to uncertainty regarding future claims.⁸ As new information about claims becomes available, loss reserves are frequently revised until all claims are settled. Differences between the original estimates and

⁸ Mary Weiss, *A Multivariate Analysis of Loss Reserving Estimates in Property-Liability Insurance Companies*, 52 J. OF RISK & INS. 199, 204 (1985).

ultimate payments represent the reserve error. Grace and Leverty conclude that mis-estimation is the dominant cause of reserve errors in the long run.⁹ The second major theory regarding causes of reserve errors is that management consciously manipulates them to manage earnings.

Three sub-categories of theories or propositions have been developed to explain the practice of earnings management using reserve errors. The first proposition is the income-smoothing theory. According to the income-smoothing theory, management may be encouraged to set reserves in a way that minimizes earnings variability from period to period. Prior research indicates that indeed reserve errors are not random and tend to stabilize underwriting income,¹⁰ including evidence that the firms in the left tail of the earnings distribution understate reserve errors while those in the right tail overstate reserve errors.¹¹

The second proposition associated with reserve management is the tax-reducing theory. As noted above, early efforts to understand reserving practices focused on income smoothing. Such focus was due in part to regulatory concern with transparency and the concern that manipulating an insurer's financial status could harm shareholders and consumers alike. A full understanding of reserve management, however, required development of an overall theory about insurer reserving practices. An early approach to a full-picture analysis of reserve management assumes insurers follow a cash flow maximization objective, with income smoothing constraints. In such a model, tax deferral can become significant.¹² Empirical examination of property-liability insurers is supportive, finding that the examined insurers' reserving practices aided in reduction of tax liabilities.¹³

The third proposition associated with reserve management is the regulatory constraint theory which holds that insurers may revise loss

⁹ Martin Grace & J. Tyler Leverty, *Property-Liability Insurer Reserve Errors-Motive, Manipulation, or Mistake*, SOC. SCI. RES. NETWORK, May 31, 2007, at 25-26, available at <http://ssrn.com/abstract=964635> (The authors also test rate regulation incentives, but given that we are considering a single line of insurance, this issue is not relevant in the current study).

¹⁰ See Barry D. Smith, *An Analysis of Auto Liability Loss Reserves and Underwriting Results*, 47 J. OF RISK & INS. 305, 317 (1980); Weiss, *supra* note 8, at 203.

¹¹ William H. Beaver, Maureen F. McNichols & Karen K. Nelson, *Management of the Loss Reserve Accrual and the Distribution of Earnings in the Property-Casualty Insurance Industry*, SOC. SCI. RES. NETWORK, October 2000, available at <http://ssrn.com/abstract=247702> or DOI: 10.2139/ssrn.247702.

¹² Elizabeth Grace, *Property-Liability Insurer Reserve Errors: A Theoretical and Empirical Analysis*, 57 J. OF RISK & INS. 28, 33 (1990).

¹³ Grace, *supra* note 12, at 42.

reserves to enhance financial strength to avoid regulatory actions. According to the theory, financially weak insurers may tend to understate their reserves more than other insurers. Empirical study supports the theory with findings that insurers “close to” receiving regulatory review do underestimate their reserves considerably.¹⁴ Furthermore, Beaver, McNichols, and Nelson show that both financially healthy and distressed firms manage earnings to avoid financial losses, and that both types of firms contribute to an overall appearance of income smoothing and opportunistic regulatory reporting.¹⁵

INFLUENCE OF PHYSICIAN-DIRECTED INSURERS

Insurance industry organizational form has been the subject of numerous studies, likely spurred by the strong presence of both mutual and stock insurers.¹⁶ Most of the literature to date has focused on conditions appropriate for each form to dominate the market. The majority of these studies conclude that the mutual form tends to dominate insurance lines that require limited managerial control, given the absence of shareholder pressure on performance. Mutuals, therefore, are expected to be more common in the standardized personal insurance products such as homeowners, while commercial liability lines are considered better suited to the stock insurance form. Generally these expectations are met in the market.

The medical malpractice insurance industry, however, presents an anomaly to the underlying theory, with mutual and mutual-like physician-directed insurers representing a large portion of the premium volume. We are interested in understanding this situation better. Our expectation is that the owners of physician-directed medical malpractice insurers differ from policyholder owners of the traditional mutual insurers in other lines because as physicians themselves they are in a better position to understand the potential for loss, to underwrite business and adjust claims, and

¹⁴ See Kathy R. Petroni, *Optimistic Reporting in the Property-Casualty Insurance Industry*, 15 J. ACCT. & ECON. 485, 486 (1992).

¹⁵ Beaver et al., *supra* note 11 at 1, 2, 4, 21-22.

¹⁶ Paul Joskow, *Cartels, Competition and Regulation in the Property-Liability Insurance Industry*, 4 BELL J. OF ECON. & MGMT. SCI. 375, 377-79, 391 (1973). Joskow offers an early discussion of organizational form, with Mayers and Smith providing the impetus for much of the research that followed. See also David Mayers & Clifford W. Smith, Jr., *Contractual Provisions, Organizational Structure, and Conflict Control in Insurance Markets*, 54 J. OF BUS 407, 412 (1981).

generally to manage the coverage. Whether or not this position is true is quite important for regulatory and rating agency review. Regulators and rating agencies tend to recommend that small physician-directed insurers expand their book of business for diversification purposes. If we find, however, that physician-directed, specialized, and geographically concentrated medical malpractice insurers tend to show greater levels of conservatism (i.e., more likely to over reserve) with their reserving practices, as we hypothesize, such encouragement may be counter to its purpose.

Recent work by Harrington, Danzon, and Epstein¹⁷ highlights the importance of our research. They consider whether or not under-reserving in medical malpractice markets during the 1990s led to under-pricing, which in turn led to a market “crisis.” Their intent is to discern the effects of under-pricing versus actual increases in underlying losses on later periods of rapidly rising prices (i.e., “crises” periods). They discover that insurers who specialize in medical malpractice insurance grew less rapidly in soft markets than did non-specialists. They also observe that specialists tended to experience better loss development than did the non-specialists. Consistent with these results, Danzon, Epstein, and Johnson find that physician-directed firms tend to be less likely to exit the market than are non-physician directed firms, particularly in comparing small insurers. They conclude that the physician-directed insurers appear to help stabilize the medical malpractice market.¹⁸ These empirical investigations are consistent with Baker’s explanation for the underwriting cycle in medical malpractice.¹⁹ Baker outlines the importance of uncertainty due to the long tail quality of medical malpractice claims, as well as behavioral elements of decision makers within this market.

As stated *supra*, therefore, the loss reserving practices of physician-directed insurers are likely to be different from those of non-physician directed insurers. The informational or risk-sharing advantages of physician-directed insurers along with organizational objectives associated with market stability may lead them to report more accurate loss reserve than non-physician-directed insurers. Therefore, we hypothesize that physician-directed insurers are more likely to over-reserve and less likely

¹⁷ Scott Harrington, Patricia M. Danzon, & Andrew J. Epstein, ‘Crises’ in Medical Malpractice Insurance: Evidence of Excessive Price-Cutting in the Preceding Soft Market, 32 J. BANKING & FIN. 157, 168-169 (2008).

¹⁸ See Danzon et al., *supra* note 3, at 87.

¹⁹ Tom Baker, *Medical Malpractice and the Insurance Underwriting Cycle*, 54 DEPAUL LAW REV. 393, 436 (2005).

to under-reserve than non-physician-directed insurers. We further hypothesize that physician-directed insurers are more likely to have smaller absolute reserve errors than are non-physician-directed insurers.

DATA AND MODEL

From the above, we anticipate that medical malpractice insurer reserves will be affected by: organizational form, geographic and business specialization, incentives to smooth income, opportunities to minimize tax liabilities, and a desire to limit regulatory intervention. To test our hypotheses, we rely primarily on the National Association of Insurance Commissioners (NAIC) database which contains information reported on insurers' annual statements. As discussed in the prior literature, a limitation of the NAIC database is that it does not include all medical malpractice insurers. Despite these limitations, the NAIC database remains the single best source of insurer financial information available. We use data from 1994 to 2006.

DEFINITION OF MEDICAL MALPRACTICE INSURERS

Our focus in this study is on the medical malpractice insurance market, primarily on organizational form of insurers in that market. To conduct our analyses, we first need to define a "medical malpractice insurer." One possible definition of a medical malpractice insurer for inclusion in our study is any insurer with positive direct premiums written (DPW) in the medical malpractice line. Using this definition would yield 491 insurers for our sample period; however, as pointed out by Nordman, Cermak and McDaniel,²⁰ this sample selection criterion may pose difficulty. Specifically, the NAIC database does not distinguish between active and inactive insurers, resulting in unrepresentative observations from very small insurers that may not be seeking new business.

To address this problem, we follow Danzon, Epstein and Johnson²¹ by defining a medical malpractice insurer as one with at least \$100,000 in direct premiums written in medical malpractice (in 2001 dollars) in at least one state. This definition gives us data from 324 insurers over the sample

²⁰ ERIC NORDMAN, DAVIN CERMAK, AND KENNETH MCDANIEL, MEDICAL MALPRACTICE INSURANCE REPORT: A STUDY OF MARKET CONDITIONS AND POTENTIAL SOLUTIONS TO THE RECENT CRISIS 17 (2004).

²¹ See Danzon et al., *supra* note 3, at 60.

period, although not all insurers have observations from each year. When missing data are considered, the sample involves 230 insurers, 59 of which are physician-directed.

RESERVE ERROR

In order to examine differences in loss reserving practices between physician-directed and non-physician directed insurers, we conduct our analysis at the firm-year level. We follow the literature by measuring reserve error as the difference between the total incurred losses as estimated in the year of coverage and the total incurred losses as estimated in some future period $t+j$.²²

$$Error_{i,t} = \text{Incurred Losses}_{i,t} - \text{Incurred Losses}_{i,t+j}$$

where

$Error_{i,t}$ = insurer i 's medical malpractice loss reserve error for losses incurred in year t ;

$\text{Incurred Loss}_{i,t}$ = insurer i 's medical malpractice reserve for losses incurred in year t and reported in year t ; that is, insurer i 's incurred losses as estimated in the year associated with coverage for those losses;

$\text{Incurred Losses}_{i,t+j}$ = insurer i 's revised estimate of the year t medical malpractice loss reserve as reported in year $t+j$; that is, the updated value of losses covered by policies in year t but updated in year $t+j$ as additional information is available, including most of the claims being closed by the time of our ultimate evaluation.

In the above equation, estimated incurred losses are obtained from Part 2F of Schedule P of insurers' financial statements. A positive (negative) $Error$ indicates that the originally reported loss reserve was overstated (understated).

In order to calculate loss reserve errors, we need to specify the development period j . In this study, we use a five-year development period ($j=5$) which we apply to all the sample years. Due to data availability issues, some researchers have used shorter time periods; the shorter development period, however leaves the value less certain. Therefore, we employ the longer five year development period, which others argue is a

²² In Grace and Leverty, *supra* note 9, this measure is referred to as the "P" estimate for Petroni. Petroni proposed this measure in Petroni, *supra* note 14. An alternative is to compare the original estimate with cumulative developed losses paid at some future date, known as the Weiss, or "W," error for Mary Weiss. See Weiss, *supra* note 8. Both measures have benefits and detriments. We found similar results for both P and W errors and report only the P error analyses.

sufficient development period for analyses such as ours.²³ The most recent NAIC data currently available is for year 2006; hence, the initial observation period examined in our study is 1994 through 2001.

Based on the variable *Error*, we construct four dependent variables for four distinct analyses. The first is an indicator variable *Over*, which takes the value of 1 if *Error* is positive and 0 otherwise. The second dependent variable is an indicator *Under*, which takes the value of 1 if *Error* is negative and 0 otherwise. We conduct these two tests to observe whether physician-directed insurers are more or less likely than non-physician-directed insurers to err in the positive or negative direction.

Yet, this kind of analysis is incomplete because it does not account for the size of error; therefore, we conduct two additional tests with the dependent variable $\log(Abserror/Assets)$, which is the logarithm of the absolute value of the error variable divided by net admitted assets.²⁴ We create two tests with this dependent variable in order to separate positive errors from negative errors. Other literature on reserve error has suggested that behavior may differ for positive and negative errors, leading us to conduct two distinct tests, one for positive errors, and the second for negative errors.²⁵ Our results support the suggestion that positive and negative errors are influenced by differing factors.

We now have four equations to test. For each, the dependent variable is assumed to be a function of two sets of independent variables. The first set of independent variables reflects the difference between physician-directed

²³ See Smith, *supra* note 6, at 308; and Paul M. Kazenski, William R. Feldhaus and Howard C. Schneider, *Empirical Evidence for Alternative Loss Development Horizons and the Measurement of Reserve Error*, 59 J. OF RISK & AND INS. 668-69, 675 (1992). While final claim value is not yet known after 5 years, evidence presented in these papers indicates that reserve error has developed sufficiently to be able to test the sorts of theories considered in here. We know of no prior study that uses a longer development period to study reserve error.

²⁴ Other scaling measures associated with revenue volume such as net premium written (NPW) or direct premium written (DPW) were also employed. Differences were not significant. We scale the value of the error because it is relevant only in relation to the overall size of the insurer.

²⁵ We would have liked to be able to run a fixed effects and/or random effects model, but were unable to estimate the coefficient of *Physician Direct*. The reason is that firm-specific intercepts have absorbed the effect of *Physician Direct (PD)*, which is also firm-specific and does not vary with time. The model takes the form: $\text{Log}(Abserror/assets) = a_i + b(PD_i) + cX_{i,t}$, where a_i are the firm-specific intercepts. Since our PD variable is also firm-specific and does not change with time (t), when we run regression, a_i and PD will be combined, producing just one set of coefficients. There is no value for b generated from regressions.

and non-physician-directed malpractice insurers in terms of organizational form, geographic focus, medical malpractice concentration and riskiness. The second set of independent variables represents factors that are linked to other theories about reserve errors in the literature: income-smoothing theory, tax-reducing theory, and regulatory constraint theory. Table 1 lists all the dependent and independent variables used in the study, along with a detailed description of each variable and its expected relationship with the dependent variable. Our discussion below indicates that some of the variables appear relevant in one or two of the models but not all four. We report the results with the selected control variables within the manuscript. In the Appendix, we also show results with the full model for each analysis. The reader will note that results are substantially the same.

Table 1: Variable Definitions and Anticipated Sign					
Variables	Description	Expected Sign			
		Over	Under	log(Abserror/Assets)	
				Positive ^a	Negative ^b
LOG(ABSERROR/ASSETS) _{i,t}	Logarithm of the absolute value of firm i's medical malpractice loss reserve error assessed as of year t+j for the reserve reported in year t, divided by its net admitted assets in year t	N/A			
OVER _{i,t}	Dummy variable equals 1 if ERROR>0; 0 otherwise	N/A			
UNDER _{i,t}	Dummy variable equals 1 if ERROR<0; 0 otherwise	N/A			
PHYSICIAN DIRECT _i	Dummy variable equals 1 if firm i is physician-directed; 0 otherwise	+	-	-	-
GeographicConcentration _{i,t}	Firm-level Herfindahl-Hirschman Index for firm i in year t	+	-	-	-

SPECIALIZATION _{i,t}	Firm i's premiums written in medical malpractice divided by total premiums written	+	-	-	-
REINS _{i,t}	reinsurance ceded in medical malpractice/(direct business written in medical malpractice + reinsurance assumed in medical malpractice) for insurer i in year t.	-	*	*	*
GROWTH _{i,t}	[DPW in med mal at (t) – DPW in med mal at (t-1)]/ DPW in med mal at (t-1)	-	+	*	+
GROUP _i	Dummy variable equals 1 if firm i belongs to a group; 0 otherwise	-	+	-	+
TAX _{i,t}	(net income + prior year's loss reserve)/assets	+	-	+	*
SMOOTH _{i,t}	Pre-managed earnings – target earnings	+	-	+	-
RBCLow _{i,t}	Dummy variable equals 1 if firm i's risk-based capital ratio in year t is less than 2.	*	+	*	+
RBCClose _{i,t}	Dummy variable equals 1 if firm i's risk-based capital ratio in year t is within [2, 2.5]	-	+	*	*
NPW _{i,t}	Firm i's net premiums written in year t	-	+	-	+
Y _i (i=1995,...,2001)	Year dummy if year=i	+/-			
a: for firms that have positive reserve errors; b: for firms that have negative reserve errors *Not included in given equation					

FACTORS AFFECTING THE SIZE AND DIRECTION OF RESERVE ERRORS

The variable of primary interest to our study is organizational form. We differentiate between medical malpractice insurers considered *Physician directed* or not, using a dummy variable equal to 1 if considered physician directed. While the NAIC database classifies insurers as stock, reciprocal, mutual, risk retention group, or “other,” we consider this categorization insufficient. For example, a number of physician-directed medical malpractice insurers are stock companies, with the stock held by the state Medical Society and/or health care providers. Alternatively, some mutual insurers clearly are not physician directed, such as Boston-based, multi-line insurer, Liberty Mutual. We take the conservative approach of designating as physician directed only those insurers identified as physician directed by the Physician Insurers Association of America (PIAA),²⁶ or for which we have other clear evidence of such status (for example, a review of Best’s Reports or firm web page). The resulting sample includes 59 insurers designated as *Physician directed*. We anticipate that physician-directed insurers will be more likely to over-reserve, less likely to under-reserve, and to have smaller absolute value of reserves either positive or negative.

MARKET SPECIALIZATION

Our hypotheses regarding physician-directed insurers rest on the notion that these insurers have differing organizational objectives. They also may possess better information than their counter-parts, a possibility we account for with several variables. Superior information may generate from market specialization, both in terms of knowledge of the specific legal context for their exposure and in terms of the medical malpractice line of insurance itself. To capture these factors, we include measures of geographic concentration and business focus. The majority of physician-directed insurers focuses on medical malpractice insurance rather than sell a full range of coverage. Additionally, these insurers tend to focus their business in one or a few states. We incorporate measures of these qualities in order to separate the effect of specialization from the effect of organizational ownership. Without including these variables, we might see an effect of

²⁶ We thank Patricia Danzon, Andrew Epstein and Scott Johnson for generously sharing this PIAA list.

physician-directed insurers, when the real effect is due to market specialization.

Given the state basis of medical malpractice law, both in terms of the legal doctrines as well as medical practices, we use geographic concentration as one measure of superior knowledge. Specifically, we use the firm-level geographic Herfindahl-Hirschman Index, defined as the sum of the squares of the percentage direct premiums written (DPW) market share in each state by each firm, to measure *GeographicConcentration*. A higher value of *GeographicConcentration* implies more concentration; that is, the firm operates in fewer states. More geographically concentrated insurers could be riskier because they are exposed to the systematic risk of all of their exposures affected simultaneously to expansions of liability, such as when a new precedent is set through plaintiff success with a novel legal theory. Rating agencies comment on their concern over such risk in their company discussions, and often recommend expansion to additional states.²⁷ We anticipate, however, that such insurers will compensate for such potential riskiness by over-reserving more often and under-reserving less often. We also anticipate that the superior knowledge we hypothesize these insurers possess will lead to more accurate reserves in absolute value of their error. Hence, they will have smaller relative over- and under-reserve errors.

We also measure an insurer's superior knowledge by the extent to which an insurer focuses on medical malpractice or offers a wide range of coverage. Specifically, *Specialization* equals the dollar value of an insurer's premiums written in medical malpractice divided by total premiums written. The higher the value, the larger the percent of business devoted to medical malpractice insurance. We anticipate a very similar effect and for the same reasons as for geographic concentration. That is, we anticipate that *Specialization* will be positively associated with over-reserving and negatively associated with under-reserving and the size of their reserve errors.

RISK PROFILE

Reserving practices in effect represent part of an insurer's risk management. Higher reserves generally yield lower risk, all else equal. Another important aspect of insurer risk management is its use of

²⁷ See, e.g., the discussion of any single-state medical malpractice insurer in the A.M. Best's Ratings Reports.

reinsurance. We incorporate a *Reinsurance* variable equal to reinsurance DPW ceded in medical malpractice divided by the sum of all direct premiums written (DPW) in medical malpractice plus reinsurance DPW assumed in medical malpractice. We anticipate that use of reinsurance will mitigate the need to be conservative with reserving practices; hence, the greater the relative level of *Reinsurance*, the less likely is an insurer to over-reserve. We do not anticipate an effect either on under- or over-reserving in absolute relative value.

Harrington, Danzon and Epstein observe that rapidly growing medical malpractice insurers likely do so at the expense of taking greater risk in their underwriting decisions.²⁸ We therefore include a *Growth* variable to account for this condition. We define *Growth* as the relative change in medical malpractice direct premiums written (DPW) from year t-1 to t.²⁹ Our expectation is that firms with rapid growth will be more likely to under- and less likely to over-reserve. We further expect higher levels of under-reserving with greater growth but no necessary effect on over-reserving.

Two additional variables associated with firm risk are included: size and whether or not the insurer is a member of a group of companies. We consider reserving practice a form of risk management. Over (under) reserving is a method to reduce (increase) risks, and would be included within an insurer's overall risk strategy. Large firms and those affiliated with a group generally have a variety of risk management techniques available to them; hence, we would anticipate that they could take more risk in their reserving practices. For both, therefore, we would anticipate greater (lesser) frequency of under (over) reserving, and larger (smaller) under (over) reserves when they do occur. Our size variable is net premiums written (*NPW*)³⁰ and we designate *Group* for those firms with group affiliation.

TAX, SMOOTHING, REGULATORY THEORIES

In addition to these measures of anticipated superior knowledge (organizational form, geographic concentration, and business

²⁸ See Harrington et al., *supra* note 17, at 167.

²⁹ We also conducted the analysis standardizing for overall market growth. Results are substantially the same in either analysis. We thank an anonymous reviewer for suggesting this addition.

³⁰ Conducting the analysis with total assets as our size variable instead does not alter the basic results.

specialization) and risk (reinsurance purchases, growth, size, and group affiliation), we anticipate a variety of other factors may affect reserve errors. These factors relate to the loss reserving theories discussed above. Tax issues, income smoothing, and regulatory concerns represent the bulk of the literature on hypothesized opportunities for managerial discretion to influence loss reserving practices. We do not anticipate that these incentives will differ between physician-directed insurers and non-physician-directed insurers, and include control variables in order to try to highlight the effect of ownership form on differences in reserve estimation practices.

Regarding taxes, we expect to observe over-reserving more often among firms with large tax liabilities, which can be deferred through current reserves. We further anticipate a positive relationship between *Tax* and the size of over-reserving, given that the larger the tax benefit, the larger would be the likely reserve. We anticipate no relationship between taxes and the size of under reserving. The tax variable is defined as³¹:

$$Tax = (\text{net income} + \text{prior year's loss reserve})/\text{assets}$$

In addition to tax benefits, reserving management may be desirable in order to smooth out income for the debt and equity markets. According to the smoothing hypotheses, if a firm's current year's earnings are unexpectedly higher (lower) than target earnings, then it tends to over (under) reserve. Following Baker, Collins and Reigenga,³² we define the smoothing variable as:

$$Smooth = \text{pre-managed earnings} - \text{target earnings}$$

Where pre-managed earnings are the earnings purged of estimated reserves.

$$= (\text{net income} + \text{loss reserve})/\text{assets};$$

Target earning uses a historical growth model to estimate next period's earnings:

$$= \begin{cases} [\text{Net income}_{t-1} + (\text{Net income}_{t-1} - \text{Net income}_{t-4})/4]/\text{assets} & \text{if Net income}_{t-1} > \text{Net income}_{t-4} \\ \text{otherwise Net income}_{t-1}/\text{assets} \end{cases}$$

³¹ We use the prior year's loss reserve because of possible endogeneity issues; however, we conducted the analysis using the current year's loss reserve as used by Elizabeth Grace. Grace, *supra* note 12, at 37. We found no major differences in regression results.

³² Terry Baker, Denton Collins, & Austin Reitenga, *Stock Option Compensation and Earnings Management Incentives*, 18 J. OF ACCT. AUDITING & FIN. 557, 580 (2003). We also conducted the analysis with two alternative smoothing variables previously used in the literature, ROA (return on assets) as employed by Petroni, et al., *supra* note 6, and the average value of net income adjusted by assets as used by Grace and Leverty, *supra* note 9. Our results are substantially the same with each of these measures.

Our expectation is that *Smooth* will be positively (negatively) related to the likelihood of over- (under-) reserving. We also anticipate that the larger (smaller) the value of *Smooth*, the greater will be the value of over- (under-) reserving errors.

In addition to preferences for smooth earnings and lower (or deferred) taxes, managers are also believed to prefer less regulatory oversight and therefore may be encouraged to pursue a particular loss reserving strategy consistent with minimizing regulatory attention. To capture this incentive, we use a dummy variable derived from the NAIC risk-based capital (*RBC*) ratio, which is total adjusted capital divided by authorized control level risk-based capital. Our variable, *RBCClose*, takes the value of 1 if the risk-based capital ratio is no less than two (below which is the first level of regulatory action) and no greater than 2.5, considering this region “close to” regulatory action, indicating firms which might have incentive to find means to limit regulatory attention. The risk-based capital ratio is used by regulators to indicate whether or not a firm should be subject to a certain level of regulatory action.³³ We anticipate greater likelihood of under-reserving and less over-reserving in this region for the appearance of greater surplus. We do not anticipate a relationship with size of error.

We also anticipate that firms below 2.0 may differ from those above, perhaps signaling that the state regulator is scrutinizing their actions. We use a second dummy variable, *RBCLow* for all firms with RBC below 2 to designate these insurers, and expect it to be positively related to under-reserving. Assuming financial difficulty for these firms, we also expect larger size of under-reserving errors.

In addition to the firm-specific characteristics considered thus far, economic conditions have also been shown to affect reserve errors.³⁴ We believe that a variety of economic conditions, including inflation, the

³³ The NAIC recommends five different levels of actions against a company depending on the value of its risk-based capital ratio, as shown in the following table.

risk-based capital ratio ≥ 2	OK, no action taken
$2 >$ risk-based capital ratio ≥ 1.5	Company action level
$1.5 >$ risk-based capital ratio ≥ 1	Regulatory action level
$1 >$ risk-based capital ratio ≥ 0.7	Authorized control level
$0.7 \geq$ risk-based capital ratio	Mandatory control level

³⁴ Both Weiss, *supra* note 8, at 212, and Grace, *supra* note 12, at 42 provide empirical evidence that reserve errors are associated with unanticipated inflation.

underwriting cycle, and other factors, are likely to affect reserve errors over time; hence, we include year dummy variables for each year of analysis.

For firms to be included in our sample, they first must be identified as medical malpractice insurers according to our definition mentioned earlier. They also must have complete information to calculate all the dependent and independent variables. After applying these screens, 1142 firm-year observations remain in our final sample.

SUMMARY STATISTICS

Summary statistics for the entire sample are shown in Table 2. The entire sample is used to test whether or not physician-directed insurers are more likely to over-reserve and less likely to under-reserve. We also created two sub-samples to test the size of any error as related to insurer organizational structure. The first sub-sample consists of observations that have positive reserve errors (i.e., over-stated errors), and we call it Positive. The second sub-sample includes those that have negative reserve errors (i.e., under-stated errors), and we call it Negative. We anticipate differences between insurers that over-reserve- from those that under-reserve, which is the purpose of using the two samples. Summary statistics for the sub-samples of Positive and Negative are shown in Tables 3 and 4 respectively, and as discussed below we do observe differences between them.

As shown in Table 2, insurers in our sample are far more likely (65% to 35% approximately) to over reserve than under reserve. They also tend to be specialized in the medical malpractice line, with an average of 55.52% of total direct premiums written going toward this specific line. Our sample insurers are also geographically concentrated, with a geographic Herfindahl of almost .60. In terms of premium growth, we see notable variability among insurers, with the mean being 0.7043 and the median only at 0.0579. Most insurers seem to have a very healthy RBC ratio. Only 6.83% of the observations report RBC ratio below 2 and 5.43% of them fall within 2 and 2.5. Also we notice 66.73% of the observations belong to a group. Approximately one-third (33.19%) of the observations are from physician-directed insurers.

Table 2: Summary Statistics of Full Sample (N = 1142)					
Variables	MIN	MAX	MEAN	MEDIAN	STD
LOG(ABSERROR/ASSETS)	-12.5251	0.7243	-4.0818	-3.6760	2.2738
OVER	0	1	0.6480	1	0.4778
UNDER	0	1	0.3520	0	0.4778
PHYDIRECT	0	1	0.3319	0	0.4711
GEOGRAPHIC CONCENTRATION	0.0359	1	0.5935	0.6426	0.3693
SPECIALIZATION	0	1	0.5552	0.7782	0.4455
REINS	-178.7576	1.2001	0.2495	0.3180	5.3134
GROWTH	-106.9752	84.82778	0.7043	0.0579	6.2976
GROUP	0	1	0.6673	1	0.4714
TAX	0	7.9982	0.3101	0.2226	0.4611
SMOOTH	-147.653	123.0438	-4.0948	0.0017	16.7344
RBCLow	0	1	0.0683	0	0.2524
RBCClose	0	1	0.0543	0	0.2267
NPW (X10 ⁸)	-0.0847	55.4442	2.4756	0.3375	6.9149

As can be seen from Tables 3 and 4, sample Positive has a different profile from sample Negative. About 40% of the observations in sample Positive are associated with physician-directed insurers, whereas in sample Negative the percentage is only 20%. We also see higher average values of geographic concentration and specialization in sample Positive. It is interesting to note that on average insurers in sample Negative experienced higher premium growth and are more likely to belong to a group. They also have a larger size in terms of net premiums written.

Variables	MIN	MAX	MEAN	MEDIAN	STD
LOG(ABSERROR/ASSETS)	-12.5251	0.7243	-3.9375	-3.1419	2.3251
OVER	1	1	1	1	0
UNDER	0	0	0	0	0
PHYDIRECT	0	1	0.4014	0	0.4905
GEOGRAPHIC CONCENTRATION	0.0412	1	0.6236	0.7593	0.3747
SPECIALIZATION	0.0001	1	0.5998	0.9114	0.4418
REINS	-178.7576	1.0536	0.1344	0.2657	6.5953
GROWTH	-106.9752	56.9746	0.3696	0.0451	5.0734
GROUP	0	1	0.6270	1	0.4839
TAX	0	7.9982	0.3353	0.3168	0.4015
SMOOTH	-147.6531	123.0438	-5.3206	0.0243	19.2818
RBCLow	0	1	0.0676	0	0.2512
RBCclose	0	1	0.0432	0	0.2035
NPW (X10 ⁸)	-0.0847	52.1785	1.8627	0.3184	5.3417

Variables	MIN	MAX	MEAN	MEDIAN	STD
LOG(ABSERROR/ASSETS)	-11.8255	0.2805	-4.3474	-4.2258	2.1539
OVER	0	0	0	0	0
UNDER	1	1	1	1	0
PHYDIRECT	0	1	0.2040	0	0.4035
GEOGRAPHIC CONCENTRATION	0.0359	1	0.5381	0.5158	0.3530
SPECIALIZATION	0.0000	1	0.4732	0.4467	0.4413
REINS	-0.2429	1.2001	0.4612	0.3970	0.3127
GROWTH	-18.1491	84.8278	1.3203	0.0952	8.0515
GROUP	0	1	0.7413	1	0.4385
TAX	0	6.7555	0.2637	0.0884	0.5519
SMOOTH	-101.279	58.9131	-1.8385	-0.0363	10.1874
RBCLow	0	1	0.0697	0	0.2549
RBCclose	0	1	0.0746	0	0.2631
NPW (X10 ⁸)	-0.0023	55.4442	3.6037	0.4118	9.0278

REGRESSION ANALYSIS

We conducted four separate regression analyses. The first models the likelihood of a medical malpractice insurer to over reserve; the second models the likelihood to under reserve. For these analyses, we use logistic regression.³⁵ The third and fourth dependent variables equal the logarithm of the absolute value of loss reserve error divided by net assets, one for those instances when insurers over-reserve, and the other when they under-reserve. We use ordinary least squares (OLS) regression for this model.³⁶ As indicated in Table 1, we conducted the analyses with differing sets of independent variables; however, we also conducted the tests with all variables included. Results are substantively the same and are shown for the full set of independent variables in the Appendix. For each equation, Variance Inflation Factors are all below 2.5, eliminating concern regarding overall multi-collinearity. The likelihood ratio tests of the two Logistic regression equations reject the null hypothesis that the global regression coefficients are zero, indicating a good overall fit. The F-tests of the two OLS regression equations also imply a reasonable fit, with an adjusted R-square of 63.77% and 43.11%, respectively.

Results of the logistic regression using the dependent variable *Over* are shown in Table 5; those associated with the dependent variable *Under* are shown in Table 6. Both coefficient estimates and marginal effects are reported for the two logistic regressions.³⁷ Results of the OLS analyses

³⁵ Logistic regression is an appropriate statistical tool when the dependent variable takes on the value of zero or one, and the intention is to predict the probability of an occurrence of an event. In this case, we are interested in predicting the probability of a firm over or under reserving. Importantly, in logistic regression, no assumption that the relationship between the dependent and independent variables is linear exists.

³⁶ Ordinary Least Squares, or OLS, analysis is a statistical technique often used when the dependent variable is continuous, as is true for our analyses of the size of positive and negative errors. The technique finds the curve which matches the relationship between the dependent variable and the group of independent variables with the smallest amount of squared error (or “residual,” which is the difference between predicted and observed values).

³⁷ Logistic regression takes the form of $\log[p/(1-p)] = b'X$ where p is the probability of an event (in our case it's either over reserving or under reserving), and b is the coefficient matrix. The estimated value of b is the coefficient estimate. Because the equation is of the logistic form, however, the coefficient estimate does not indicate the size of effect for each variable; therefore, we also report marginal effects. Marginal effects represent the change in p when the independent variable increases by one unit. For instance, in Table 5, the marginal effect for geographic concentration is 0.0969, which means a one unit increase in “geographic concentration” increases the probability of over reserving by 0.0969.

using the relative absolute error as the dependent variable are shown in Tables 7 and 8 for those instances of over- and under-reserving respectively.

Table 5: Logistic Regression of OVER (N = 1142)			
Variable	Estimate	Marginal Effects	Standard Error
Intercept	1.0219		0.3134
PHYSICIAN DIRECT	1.1682	0.2544	0.1931 ***
GEOGRAPHIC CONCENTRATION	0.4450	0.0969	0.1966 **
SPECIALIZATION	-0.2916	-0.0635	0.2266
REINS	-0.1780	-0.0388	0.2239
GROWTH	-0.0320	-0.0070	0.0134 **
GROUP	-0.0661	-0.0144	0.1751
TAX	0.0629	0.0137	0.1641
SMOOTH	-0.0120	-0.0026	0.0056 **
RBCClose	-0.7963	-0.1734	0.2963 ***
NPW (X10 ⁸)	-0.0212	-0.0046	0.0103 **
Y95	0.5049	0.1100	0.2989 *
Y96	-0.4130	-0.0899	0.3169
Y97	-0.5259	-0.1145	0.2736 *
Y98	-0.9451	-0.2058	0.2703 ***
Y99	-0.9109	-0.1984	0.2714 ***
Y00	-1.3513	-0.2943	0.2729 ***
Y01	-1.6043	-0.3494	0.2761 ***
Likelihood Ratio Test			
Chi-Square		182.1639	
Pr > ChiSq		<.0001	
***, **, * indicate statistical significance at the 1%, 5% and 10% levels, respectively.			

LOGISTIC REGRESSION OF OVER

As discussed above, we hypothesize that physician-directed medical malpractice insurers are more likely to over-reserve than are non-physician-directed insurers. Therefore, our primary variable of interest is *Physician Direct*, and results are consistent with our hypothesis that these insurers tend to be more conservative than others. As can be seen from the table, the marginal effect for *Physician Direct* is 0.2544, which suggests that a firm that is physician directed is 25.44% more likely to over reserve than a firm that is non-physician-directed. We had anticipated that more geographically

concentrated and specialized insurers also would tend to over-reserve to account for the greater risk associated with such lack of diversification, but only geographic concentration appears statistically significant.

As anticipated, fast-growing insurers are less likely to over-reserve than are their counterparts. We consider the results on growth to offer regulators and rating agencies additional reason to pay close attention when medical malpractice insurers show rapid growth.³⁸

According to income-smoothing theory, if a firm's current year's earnings are higher than target earnings, it tends to over reserve. The negative coefficient on *Smooth* suggests the other way around. In other words, our results do not support the income-smoothing theory.

We further observe that insurers with RBC ratios close to the benchmark for regulatory attention are less likely to over reserve. This result is consistent with the literature on reserve management for limiting regulatory scrutiny. We also find that size, as measured by net premiums written (NPW) is statistically significant in the direction anticipating, allowing insurers to take on more risk as the firm grows in size.

³⁸ These results support those of Harrington, et al., *supra* note 17, at 169.

Table 6: Logistic Regression of UNDER (N = 1142)			
Variable	Estimate	Marginal Effects	Standard Error
Intercept	-0.9800		0.2940
PHYSICIAN DIRECT	-1.1643	-0.2556	0.1907***
GEOGRAPHIC CONCENTRATION	-0.5097	-0.1119	0.1988**
SPECIALIZATION	0.2573	0.0565	0.2248
GROWTH	0.0322	0.0071	0.0133**
GROUP	0.1530	0.0336	0.1800
TAX	-0.1090	-0.0239	0.1659
SMOOTH	0.0123	0.0027	0.0056**
RBCLow	0.4694	0.1031	0.2841
RBCClose	0.8606	0.1889	0.2997***
NPW (X10 ⁸)	0.0198	0.0043	0.0102*
Y95	-0.5020	-0.1102	0.2994*
Y96	0.4310	0.0946	0.3162
Y97	0.5405	0.1187	0.2738**
Y98	0.9563	0.2100	0.2706***
Y99	0.9000	0.1976	0.2708***
Y00	1.3561	0.2977	0.2730***
Y01	1.6190	0.3554	0.2765***
Likelihood Ratio Test			
Chi-Square	182.8377		
Pr > ChiSq	<.0001		
***, **, * indicate statistical significance at the 1%, 5% and 10% levels, respectively.			

LOGISTIC REGRESSION OF UNDER

As already noted, we hypothesize that physician-directed insurers are more conservative than are non-physician directed insurers and therefore will be less likely to under-reserve. Our variable of interest, therefore, remains *Physician Direct* and here too we see a statistically significant relationship between ownership form and reserving practices. In this case, there is a negative relationship, consistent with our hypothesis of conservative behavior on the part of physician-directed insurers. Geographic concentration and business line specialization again are included in the analysis to measure superior knowledge of the underlying risk, which we anticipate will be negatively related to under-reserving practices. As with over-reserving, geographic concentration supports our

hypothesis. Specialized insurers, however, show no difference to more diverse insurers.

Consistent with expectations, rapidly growing insurers are more likely to under-reserve than are others. As above, this result offers reason for regulators and rating agencies to give special scrutiny to high-growth insurers. Firms with RBC ratios “close to” regulatory attention also are more likely to under-reserve, as we had anticipated. They might be attempting to avoid regulatory scrutiny; or perhaps they are already in poor financial condition. Firms with low RBC ratios, however, do not show a statistically significant tendency to under-reserve more than do others. We had anticipated a stronger relationship with this factor. We could be picking up unusual results from firms in significantly poor financial position. In the analysis of the likelihood of under-reserving, we also find that smoothing again has the opposite sign from anticipated, in this case showing a positive relationship between smoothing and the likelihood of under-reserving.

OLS REGRESSION OF THE LOGARITHM OF THE ABSOLUTE
VALUE OF ERRORS/ASSETS

We hypothesize that physician-directed insurers are more conservative than others and that they have superior knowledge compared with others. While this leads to expectations of greater likelihood of over-reserving and lesser likelihood of under-reserving, we also anticipate more overall accuracy in reserving, based on superior knowledge. To test this hypothesis, we conduct OLS analyses on the logged relative size of error independently for both those firms that over reserve, and those firms that under-reserve. Results, shown in Table 7 for firms that over reserve, and in Table 8 for those that under-reserve, are consistent with our hypotheses for under-reserving, but show no statistical difference in the OLS on firms that over-reserve. Geographic concentration shows the same pattern. Both factors, therefore, can be said to be related to somewhat conservative, but mostly stable reserving practices.

Table 7: OLS Regression of LOG (ABSPERROR/ASSETS) (N = 740) – Sample Positive		
Variable	Estimate	Standard Error
Intercept	-5.4994	0.2140
PHYSICIAN DIRECT	0.1212	0.1401
GEOGRAPHIC CONCENTRATION	0.0242	0.1463
SPECIALIZATION	3.2896	0.1889***
GROUP	-0.5327	0.1273***
TAX	0.8225	0.1565***
SMOOTH	-0.0004	0.0035
NPW (X10 ⁸)	-0.0058	0.0104
Y95	-0.2019	0.1816
Y96	-0.3853	0.2238*
Y97	-0.3659	0.1957*
Y98	-0.5847	0.2053***
Y99	-0.7869	0.2058***
Y00	-0.6907	0.2204***
Y01	-0.6587	0.2306***
F-Value	93.91	
Pr>F	<.0001	
Adjusted R-square	0.6377	
***, **, * indicate statistical significance at the 1%, 5% and 10% levels, respectively.		

Specialized insurers, however, demonstrate less accuracy in their reserve errors, showing larger errors in both samples of over- and under-reserving insurers. Having already accounted for an insurer's status as physician directed or not, a specialized insurer seems to have some disadvantage. We note that specialization did not show significance in the likelihood of over- (under-) reserving.

The extent of growth appears unrelated to an insurer's accuracy regarding reserving, somewhat contrary to our expectations. Insurers with greater opportunities for tax deferral do seem to over-estimate reserves by larger amounts, consistent with our hypothesis.

We did not find the variable of *Group* to be significant in the likelihood of over (under) reserving. However, our results show that in both samples of over- and under-reserving insurers, firms that belong to a group report smaller absolute value of reserve errors, contrary to our expectation that such firms may be less accurate in their reserving practice.

For firms that under reserved, those that have RBC ratio below 2 report larger reserve errors, a result consistent with our hypothesis that firms in

financial difficulty tend to under reserve more in order to appear stronger to avoid regulatory actions. We have also found that larger size firms in terms of net premiums written are able to take more risks, as evidenced by their larger reserve errors.

Variable	Estimate	Standard Error
Intercept	-5.4448	0.3693
PHYSICIAN DIRECT	-0.6216	0.2400**
GEOGRAPHIC CONCENTRATION	-0.5180	0.2555**
SPECIALIZATION	3.0095	0.2509***
GROWTH	-0.0050	0.0103
GROUP	-0.7605	0.2247***
SMOOTH	0.0075	0.0096
RBCLow	1.0173	0.3457***
NPW (X10 ⁸)	0.0248	0.0098**
Y95	-0.0111	0.4220
Y96	-0.3110	0.4275
Y97	0.1819	0.3665
Y98	0.7176	0.3499**
Y99	1.0300	0.3507***
Y00	0.8737	0.3427**
Y01	0.6058	0.3388*
F-Value	21.26	
Pr>F	<.0001	
Adjusted R-square	0.4311	
***, **, * indicate statistical significance at the 1%, 5% and 10% levels, respectively.		

CONCLUSION

Dramatic market structure changes have occurred in the medical malpractice insurance market in response to the high cost of medical malpractice insurance and the shrinking supply of carriers. Many health care providers have formed their own companies to offer malpractice coverage. Given that physician-directed firms are likely to have different organizational goals than traditional insurers, their loss reserving practices are likely to differ as well.

We test the hypothesis that physician-directed medical malpractice insurers differ in their loss reserving practices, using the NAIC data base for the years 1994-2006. Our results show consistent differences between physician-directed and non-physician-directed medical malpractice insurers. Those which are closely aligned with physicians appear to be more conservative and more accurate in their reserving practices. We therefore encourage rating agencies and regulators to consider the positive influence of these insurers in evaluating their risk profile.

We also note the importance of rapid premium growth on reserve errors. As Harrington, Danzon and Epstein³⁹ already indicated, market problems may be due at least in part to insurers who are making poor underwriting decisions, thereby growing too rapidly and causing market dislocations. Whether these are pure mistakes or intentional decisions is not discernable from our analysis, but deserves additional investigation.

³⁹ *Id.* at 168-169

**APPENDIX: REGRESSION RESULTS USING FULL SET OF
VARIABLES IN ALL EQUATIONS**

Logistic Regression of OVER (N = 1142)			
Variable	Estimate	Marginal Effects	Standard Error
Intercept	1.0545		0.3149
PHYSICIAN DIRECT	1.1564	0.2522	0.1932***
GEOGRAPHIC CONCENTRATION	0.4953	0.1080	0.2001**
SPECIALIZATION	-0.2885	-0.0629	0.2270
REINS	-0.1317	-0.0287	0.2252
GROWTH	-0.0319	-0.0070	0.0133**
GROUP	-0.1422	-0.0310	0.1825
TAX	0.0973	0.0212	0.1679
SMOOTH	-0.0120	-0.0026	0.0056**
RBCLow	-0.4442	-0.0969	0.2867
RBCClose	-0.8541	-0.1863	0.2998***
NPW (X10 ⁸)	-0.0207	-0.0045	0.0103**
Y95	0.5045	0.1100	0.2994*
Y96	-0.4202	-0.0916	0.3168
Y97	-0.5354	-0.1168	0.2739*
Y98	-0.9537	-0.2080	0.2707***
Y99	-0.9090	-0.1983	0.2716***
Y00	-1.3491	-0.2942	0.2732***
Y01	-1.6133	-0.3519	0.2766***
Likelihood Ratio Test			
Chi-Square	184.5209		
Pr > ChiSq	<.0001		
***, **, * indicate statistical significance at the 1%, 5% and 10% levels, respectively.			

(Note: We do not show the results for UNDER because they are just the opposite of those of OVER, given that we are using the identical set of variables in these two analyses. In other words, for each variable, the absolute value of the coefficient is still the same, but the sign is just the opposite.)

OLS Regression of LOG (ABSPERROR/ASSETS) (N = 740) – Sample Positive		
Variable	Estimate	Standard Error
Intercept	-5.4430	0.2172
PHYSICIAN DIRECT	0.1041	0.1409
GEOGRAPHIC CONCENTRATION	0.0513	0.1478
SPECIALIZATION	3.2762	0.1903***
REINS	0.0000	0.0079
GROWTH	-0.0052	0.0102
GROUP	-0.5883	0.1317***
TAX	0.8612	0.1583***
SMOOTH	-0.0003	0.0035
RBCLow	-0.3588	0.2202
RBCClose	-0.1833	0.2557
NPW (X10 ⁸)	-0.0057	0.0104
Y95	-0.2012	0.1819
Y96	-0.3911	0.2240*
Y97	-0.3718	0.1958*
Y98	-0.5965	0.2056***
Y99	-0.7842	0.2073
Y00	-0.6872	0.2205***
Y01	-0.6578	0.2307***
F-Value	73.14	
Pr>F	<.0001	
Adjusted R-square	0.6373	
***, **, * indicate statistical significance at the 1%, 5% and 10% levels, respectively.		

OLS Regression of LOG (ABSPERROR/ASSETS) (N=402) – Sample Negative		
Variable	Estimate	Standard Error
Intercept	-5.3772	0.3850
PHYSICIAN DIRECT	-0.6245	0.2427**
GEOGRAPHIC CONCENTRATION	-0.5540	0.2558**
SPECIALIZATION	2.8556	0.2625***
REINS	-0.1105	0.2860
GROWTH	-0.0042	0.0103
GROUP	-0.7647	0.2276***
TAX	0.2896	0.1732
SMOOTH	0.0080	0.0096
RBCLow	1.0039	0.3536***
RBCClose	0.1080	0.3341
NPW (X10 ⁸)	0.0241	0.0099**
Y95	-0.0051	0.4219
Y96	-0.2780	0.4280
Y97	0.1867	0.3678
Y98	0.7024	0.3518**
Y99	1.0000	0.3525***
Y00	0.8536	0.3428**
Y01	0.6275	0.3389*
F-Value	18.01	
Pr>F	<.0001	
Adjusted R-square	0.4330	
***, **, * indicate statistical significance at the 1%, 5% and 10% levels, respectively.		

**“SEZ WHO?”:
STATE CONSTITUTIONAL CONCERNS WITH
EXTERNAL REVIEW LAWS AND THE
RESULTING CONUNDRUM POSED BY
*RUSH PRUDENTIAL HMO V. MORAN***

*William Pitsenberger**

ABSTRACT

This article discusses state constitutional problems with the 2002 Supreme Court decision *Rush Prudential HMO v. Moran*, which gave the power to determine medical services for health organizations not preempted by ERISA to an external review entity. Procedural fairness issues abound in the procedural impacts of the decision, especially when requirements set out in state constitutions are considered. External review laws of this nature are perhaps constitutionally infirm, but judicial review and ERISA preemption may counter such negative impacts. The article extensively discusses state external reviews laws and their categorization among the larger questions of appealability and their binding nature. While many states have “open courts” provisions in their constitutions, as well as embracing a separation of powers doctrine, the decision in question still presents concerns. The recent *Hawaii Management* case seemingly adds to the confusion, since judicial review should not be allowed for the external review in order to avoid preemption, but not allowing so may violate constitutional separation of powers issues. The ultimate decision as to this clash may be to either accept the current dichotomy under *Rush* or to push for a system of mandated benefits to avoid the issue altogether.

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INTRODUCTION

In *Rush Prudential HMO v. Moran*,¹ the United States Supreme Court determined, in a five-to-four decision, that an Illinois law giving an external review entity the power to determine the medical necessity of services for a health maintenance organization subscriber was not preempted by the Employee Retirement Income Security Act (ERISA),² on the grounds that it did not provide an alternative remedy to those exclusive remedies set forth in ERISA. When considered in contemplation of state constitutional doctrines of separation of powers and of open access to courts, that decision gives rise to a major legal conundrum.

One scholar has identified a fundamental problem with the *Rush* result – that an external review process including rights to judicial appeal in state courts may not be preempted, but those without such rights, while not preempted, are lacking in procedural fairness - as follows:

[O]ne ironic consequence of the Court's finding that external review systems are not a form of remedy could be to insulate them from due process review. The more distant a mechanism is from the basic adjudicatory function, the less likely it will be scrutinized for procedural fairness, the very motivation for external review laws in the first place. Conversely, the presence of a more fully developed set of procedures within an external review system makes ERISA preemption more likely.

The first signal of weakness created by stronger procedural protections for patients came in *Hawaii Management Alliance Ass'n v. Insurance Commissioner*, in which the Hawaii Supreme Court held that ERISA preempted that state's external review law because it "too closely resemble[d] adjudication." In distinguishing *Moran*, the Hawaii court found it "fatal" to that state's system that it allowed judicial review of external review decisions, incorporated portions of the state's Administrative Procedure Act, established procedural requirements for hearings, and provided for review by a three-member panel. Numerous

¹ 536 U.S. 355 (2002).

² Employee Retirement Income Security Act (ERISA) of 1974, 29 U.S.C. § 1001 (2008).

other state external review schemes include at least some of these same features.³

This article focuses on how procedural fairness is guaranteed under state constitutions and identifies a conundrum: if procedural fairness, with all the necessary constitutional safeguards, is provided for in an external review law, the law is probably preempted, while if such safeguards are not in place, the law is probably unconstitutional. It explains that some external review statutes appear to be susceptible to challenge under state constitutions as a violation of state separation of powers doctrines and constitutional access to courts provisions, because they delegate judicial authority to non-judicial entities without the opportunity for subsequent court review. It further suggests that where the external review procedure is cloaked with appropriate due process (that is, where it allows for judicial review and hence does not violate those constitutional strictures), the process becomes an alternative remedy to ERISA and hence is preempted. That suggestion is given force by *Hawaii Management Alliance Association v. Insurance Commissioner*,⁴ which found that the availability of judicial review converts the external review process from a determination of medical necessity to a state-level adjudication of the appropriateness of claims processing under an ERISA plan, i.e., into the sort of alternative remedy prohibited under ERISA and the case law that has developed around it.

In Part I below, I provide a brief description of the basis for the *Rush* decision and an overview of the dilemma it poses, i.e., an external review law which is not preempted may be constitutionally infirm, and an external review law that is not constitutionally infirm may be preempted by ERISA. In Part II, I describe external review laws with a focus on the finality of the external review decision, noting five categories of such laws: (a) those that are binding on the insurer but not the insured with no right of appeal; (b) those that are binding on both the insurer and the insured with no right of appeal; (c) those that allow for judicial review but still require compliance with the decision; (d) those that provide for full judicial review before the decision is effective; and (e) those few that fit none of those categories. In Part III, I address state constitutional provisions assuring access to courts and state separation of powers doctrines, particularly with respect to

³ Nan D. Hunter, *Managed Process, Due Care: Structures of Accountability in Health Care*, 6 YALE J. HEALTH POL'Y, L. & ETHICS 93, 127-28 (2006).

⁴ See *Haw. Mgmt. Alliance Ass'n v. Ins. Comm'r*, 100 P.3d 952, 958, 965-967 (Haw. 2004), discussed *infra* at 112-118.

binding arbitration and to the few cases that have raised constitutional concerns about external review laws. I suggest that lack of judicial review is constitutionally fatal to external review laws that purport to be binding. In Part IV, I more fully describe the potential for ERISA preemption when a state external review law authorizes judicial review, discussing the post-*Rush* case from Hawaii that specifically addressed that issue. I suggest that the availability of judicial review results in preemption of external review laws. In Part V, I briefly discuss policy choices that might be adopted in the wake of this conundrum.

PART I. OVERVIEW – THE RUSH DECISION AND THE RESULTING CONUNDRUM

ERISA preempts any state law creating an alternative remedy that duplicates, supplements or supplants ERISA's exclusive remedial scheme.⁵ The concern in *Rush* was whether the Illinois law created such an alternative remedy. The Supreme Court's conclusion that it did not observed that the determination by the reviewing physician was "similar to the submission to a second physician, which many health insurers are required by law to provide before denying coverage."⁶ The Court analogized the state law to mandated benefit laws, a law simply calling for inclusion of an additional contract term.⁷ The law is well-settled that a state may require specific benefits in an insurance contract, and that such requirement will be saved from preemption under ERISA by virtue of the

⁵ *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987).

⁶ *Rush*, 536 U.S. at 383. It is worth noting that the Court wholly misconstrues the nature of the laws relating to second opinions to which it cites in its footnote to the above quotation. For example, CAL. INS. CODE § 10123.68 (West 2005) simply requires an insurer to pay for a second opinion if requested by the insured *when the insured questions the medical necessity* of a service or the plan of care, a circumstance entirely the reverse of one in which the insurer questions the medical necessity of a service; IND. CODE ANN. § 27-13-37-5 (LexisNexis 1999) calls for payment for a second opinion without elaboration; N.J. STAT. ANN. § 17B: 26-2.3 (West 2006) requires an insurer to pay for a second opinion for elective surgeries that would require an inpatient admission, as does R.I. GEN. LAWS § 27-39-2 (2002) (both of which arguably are aimed at the same consideration as the California statute). In each of these cases, it is not the proposed service that must be covered but rather the second opinion, and clearly the statutes are aimed at having an insurer pay for second opinions that might avoid the need for the service proposed, not call for coverage of the service proposed. The Oklahoma statute cited, OKLA. ADMIN. CODE § 365:10-5-4, is simply incomprehensible, authorizing exclusion of "cost containment," with a list following that includes second opinions.

⁷ *Rush*, 536 U.S. at 386.

“savings clause” which saves from preemption laws regulating insurance.⁸ Although even a law that regulates insurance and would appear on its face to be saved from preemption would still be preempted under the broader sweep of ERISA preemption of alternative remedies, the Court’s view of the Illinois law was that it provided the beneficiary nothing more than benefits for services under a health plan.⁹ That is, the Court concluded that the statute did not constitute an alternative remedial scheme to that of ERISA, providing the beneficiary no different remedial result than the beneficiary might obtain in an action for benefits brought under ERISA. A remedy of that kind, the Court seemed to suggest, was substantively different from other alternative remedial schemes it had condemned, such as claims asserting tortious breach of contract,¹⁰ wrongful discharge¹¹ and emotional distress and punitive damages.¹²

The *Rush* result is bothersome for many reasons, not the least of which is that it creates a lack of symmetry in terms of rights of the health plan (more specifically, the insurer of the health plan) and of the insured. In effect, if the independent physician determined the service was not medically necessary, the beneficiary would still have the right under ERISA to seek equitable relief in federal court,¹³ while if the independent physician determined the service was medically necessary, the HMO would have no further avenue of relief. In essence, the independent reviewer acts as a court of last resort when deciding adversely to the HMO.

The simile of the independent reviewer acting as a court is well-taken, for many of the state laws calling for external review of the medical necessity determinations of a health insurer, managed care organization, or health maintenance organization explicitly provide that the decisions of such an external reviewer are binding on the insurer, and some purport to be binding on the insurer and the insured. Although some such laws describing external review decisions as binding also appear to contemplate appeal or even separate federal (i.e., ERISA) actions, several of those laws provide that an appeal does not stay the implementation of the external

⁸ *Metro. Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 732-36 (1985).

⁹ *Id.* at 724.

¹⁰ *Pilot Life*, 481 U.S. at 54 (1987).

¹¹ *See Ingersoll-Rand v. McClendon*, 498 U.S. 133 (1990).

¹² *See Mass. Life Ins. Co. v. Russell*, 473 U.S. 134 (1985).

¹³ *See Reply Brief for the Petitioner at 6, Rush Prudential HMO v. Moran*, 536 U.S. 355 (2002) (No. 00-1021). The Petitioner argued, “[U]nder respondents’ theory, they would even be entitled to two bites of the apple: if a claim is denied by the Section 4-10 reviewer, a beneficiary could file an ERISA action seeking the same benefits.” *Id.*

review decision. The binding nature of such decisions, when made by a private entity or adopted as an order of a regulatory agency, raises state constitutional questions specifically relating to separation of powers doctrines and (at least in a majority of states) an intertwined concept, the constitutional right of access to courts.¹⁴

In addition, where separation of powers or other state constitutional concerns are not an issue – where appellate review by a court of the determination with respect to a particular service exists – a peculiar conundrum is created by the concepts in *Rush*: the very existence of constitutionally-acceptable state-level appeal mechanisms seems to make clear that such external review laws are not analogous to a second opinion, that they do something more than incorporate an additional contract term saved from preemption in insurance contracts. Rather, they arguably create mechanisms providing for judicial relief at a state level that duplicates, supplements, or supplants the exclusive remedies under ERISA. That is, if the course of appeal of an external review decision runs through state courts, it would appear to displace use of a 29 U.S.C. 1132(a) claim as the “exclusive vehicle for actions by ERISA-plan participants and beneficiaries asserting improper processing of a claim for benefits.”¹⁵

The concern, then, is that separation of powers doctrines / “open courts” concepts and the *Rush* decision create a “Catch-22”.¹⁶ Simply put,

¹⁴ It is at least arguable, as well, that such laws raise state constitutional questions about a right to trial by jury. Martin H. Redish, *Legislative Response to the Medical Malpractice Insurance Crisis: Constitutional Implications*, 55 TEX. L. REV. 759, 797 (1977) identifies that 48 states provide for a right to trial by jury. The analysis of whether a right to a jury trial exists usually begins with the question of whether such a right was cognizable with respect to a claim of the nature at issue under common law at the time the state’s constitution was adopted. *See, e.g.*, *Smith v. Printup*, 866 P.2d 985, 993 (Kan. 1993). Although actions under ERISA are characterized as equitable actions, “[C]ases involving ERISA benefits are inherently equitable in nature, and not contractual, and...no right to jury trial attaches to such claims,” from the perspective of a state-level challenge to denials of claims under an insurance contract, they more closely resemble simple contract actions for damages yielding a right to a jury trial. *Tischmann v. ITT/Sheraton Corp.*, 145 F.3d 561, 568 (2d Cir. 1998) (quoting *DeFelice v. Am. Int’l Life Assurance Co. of N.Y.*, 112 F.3d 61, 64 (2d Cir. 1997).

¹⁵ *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 52 (1987).

¹⁶ JOSEPH HELLER, *CATCH-22* (1955). The title of Joseph Heller’s novel, *Catch-22*, has become a commonplace way of describing a bifurcated choice system in which neither solution yields the result desired. In the novel, it is captured by this exchange:

There was only one catch and that was Catch-22, which specified that a concern for one’s safety in the face of dangers that were real and immediate was the process of

if the external review law is saved from preemption per *Rush*, it most likely violates the state constitution, and if it does not violate the state constitution, it most likely is not saved from preemption.

PART II. EXTERNAL REVIEW LAWS

Health insurers, including health maintenance organizations, typically include within their contracts exclusions of services that are not medically necessary or that are experimental or investigational. The obvious reason for such exclusions is to avoid paying for services that provide no medical value, or for services for which the medical value has not yet been demonstrated.¹⁷ Because someone has to determine what constitutes medical necessity, such exclusions have been a source of continuing litigation between insurers and their insureds, and challenges to those exclusions have resulted in insurers adopting increasingly complex definitions of “medical necessity,” “experimental,” and “investigational.”¹⁸

In spite of the efforts of insurers to develop ironclad ways to insulate themselves from challenges as to the criteria they use for determining medical necessity, there remains concern about the propriety of insurers reserving such judgment to themselves, even when the judgmental criteria contained within the insurance contract is elaborate. Those concerns are prompted both by recognition that by denying benefits, the insurer’s financial position is enhanced and by the sense that what services are needed should be left solely in the hands of the treating physician. The two concerns are necessarily intertwined – that financial motives are the cause of insurers looking over the doctor’s shoulder, second-guessing the

a rational mind. Orr was crazy and could be grounded. All he had to do was ask; and as soon as he did, he would no longer be crazy and would have to fly more missions. Orr would be crazy to fly more missions and sane if he didn’t, but if he was sane he had to fly them. If he flew them he was crazy and didn’t have to; but if he didn’t want to he was sane and had to. Yossarian was moved very deeply by the absolute simplicity of this clause of Catch-22 and let out a respectful whistle. ‘That’s some catch, that Catch-22,’ Yossarian observed. ‘It’s the best there is,’ Doc Daneeka agreed. *Id.* at 52.

¹⁷ See, e.g., Louis S. Reed, *Private Health Insurance in the United States: An Overview*, 28 SOC. SEC. BULL. 3, 7 (1965).

¹⁸ See Mark A. Hall & Gerard F. Anderson, *Health Insurers’ Assessment of Medical Necessity*, 140 U. PA. L. REV. 1637, 1639, 1645-1647, 1662-1666 (1991-1992).

appropriate course of treatment, and interfering with the physician's delivery of needed, and the patient's receipt of desired, medical services.

Those concerns have led many states to adopt laws requiring that when an insurer denies a claim based on lack of medical necessity or on the service being experimental or investigational, the insured has the right to external review by an independent review organization, usually specifying the composition of such an entity and requiring that reviews be conducted by qualified physicians. The counts of such laws vary – the petitioners in *Rush* assert that thirty-seven states and the District of Columbia had enacted such laws as of 2000,¹⁹ while another source asserts that forty-two states and the District of Columbia had enacted external review laws as of 2002.²⁰ Some such laws call for the independent review organization to be selected by an insurance commissioner, and others provide for qualified

¹⁹ Brief for the Petitioner at 8, *Rush Prudential HMO v. Moran*, 536 U.S. 355 (2002) (No. 00-1021).

²⁰ Lindsey G. Churchill, Comment, *Rush Prudential HMO v. Moran: Federal Intervention Looms as Supreme Court Rules That ERISA Does Not Preempt State Laws Requiring Independent Review of Medical Necessity Decisions and Lays Groundwork for Different Independent Review Provisions From All Fifty States*, 19 GA. ST. U. L. REV. 535, 536 (2002). See: ALASKA STAT. § 21.07.050 (2006), ARIZ. REV. STAT. ANN. § 20-2533 (2002), CAL. HEALTH & SAFETY CODE § 1374.30 (West 2005), CAL. INS. CODE § 10169.1 (West 2008), COLO. REV. STAT. § 10-16-113.5 (2007), CONN. GEN. STAT. § 38a226c (West 2007), 18 DEL. CODE ANN. §§ 332, 6416 (1999), D.C. CODE ANN. § 44-301.07 (LexisNexis 2006), FLA. STAT. ANN. § 641.511 (West 2005), FLA. STAT. ANN. § 408.7056 (West 2002), GA. CODE ANN. §§ 33-20A-31, 33-20A-40 (LexisNexis 2003), HAW. REV. STAT. § 432E-1 (2005), 215 ILL. COMP. STAT. § 125/4-10 (West 2000), IND. CODE ANN. §§ 27-8-29-12, 27-13-10.1-1 (LexisNexis 1999), IOWA CODE ANN. § 514J.1 (West 2007), KAN. STAT. ANN. § 40-22a13 (2000), KEN. REV. STAT. ANN. §§ 304.17A-600, 304-17A-623 (West 2006), LA. REV. STAT. ANN. §§ 22.3070, 22:3080 (2004), ME. REV. STAT. ANN. § 4301-A (2000), MD. CODE ANN. INS. § 15-10A-05 (LexisNexis 2006), MASS. GEN. LAW ANN. ch. 176O § 14 (West 1998), MICH. COMP. LAWS SERV. § 62Q.73 (LexisNexis 2001), MINN. STAT. ANN. § 550.1903 (West 2005), MO. ANN. STAT. § 376.1387 (West 2002), MONT. CODE ANN. § 33-37-201 (2008), N.H. REV. STAT. ANN. § 420-J:3 (LexisNexis 2004), N.J. STAT. § 26:2S-12 (West 2007), N.M. STAT. ANN. § 59A-57-4 (2007), N.Y. PUB. HEALTH LAW § 4910 (McKinney 2002), N. C. GEN. STAT. ANN. § 58-50-80 (2002), OHIO REV. CODE § 1751.84 (LexisNexis 2004), OKLA. STAT. TIT. 63, § 2528.6 (2004), OR. REV. STAT. § 743.859 (2007), 40 PA. STAT. § 991.2162 (West 1999), R.I. GEN. LAWS § 23-17.12-10 (2001), S.C. CODE ANN. § 38-17-1920 (2002), TENN. CODE ANN. § 56-32210 (2000), TEX. INS. CODE ANN. § 4201.401 (Vernon Supp. 2008), UTAH CODE ANN. § 31A-22-629 (2005), VT. STAT. TIT. 8, § 4089F (2001), VA. CODE ANN. § 38.2-5900 (2007), WASH. REV. CODE ANN. § 48.43.535 (West 2008), W. VA. CODE ANN. § 33-25C-3 (LexisNexis 2006), WIS. STAT. ANN. § 632.835 (West 2004).

organizations to bid for the right to perform such external reviews.²¹ In any event, the reviewing entity is almost uniformly a nongovernmental entity, although some have a regulatory official entering an order based on the review entity's conclusions.²²

The various external review laws differ in multiple ways, including at least one salient aspect: the finality of a determination by the external review organization. Some make clear that both the insurer and the insured have recourse to remedies through the courts, some purport to make the decision of the external review entity binding on both the insurer and the insured without recourse to appeal or other legal remedy, and some make the decision binding on the insurer but give the insured the right to pursue legal remedies.

To the extent that some of these statutes create binding results without the capacity to seek legal redress, they raise two interrelated state constitutional questions: whether the statutes unconstitutionally eliminate a right to access to courts for redress of grievances and whether such statutes unconstitutionally confer judicial authority on the executive branch or on private entities, i.e., whether they violate state separation of powers doctrines.

A TAXONOMY OF THE BINDING EFFECT OF EXTERNAL REVIEW LAWS

External review laws vary widely in the extent to which they purport to make the results of the independent review binding. There are essentially four main types of laws, with a few additional variations:

1. Type 1 laws²³ indicate they are binding on the insurer, but not on the insured, and provide no suggestion of potential court review following the decision of the independent review organization.
2. Type 2 laws indicate they are binding on both the insurer and the insured, and offer no indication of further court review.
3. Type 3 laws either explicitly or implicitly anticipate additional court review (generally treating the decision of the

²¹ See generally Wendy K. Mariner, *Independent External Review of Health Maintenance Organizations' Medical-Necessity Decisions*, 347 NEW. ENG. J. MED. 2178 (2002).

²² *Id.*

²³ A term used herein solely for convenience.

independent review organization as an agency decision and following the state's administrative procedures act), but provide that notwithstanding any such court review, the decision of the external reviewer must be implemented.

4. Type 4 laws expressly provide for court review.

5. There are other statutes that simply do not address the effect of external review or are otherwise unclear.

TYPE 1 LAWS

As noted above, some external review laws purport to make the decision of an external review entity binding on the insurer, but not on the insured. New Hampshire has a typical such statute, providing:

The external review decision of the independent review organization shall be binding on the health carrier and shall be enforceable by the commissioner [of insurance] pursuant to the penalty provisions of RSA 420-J:14. The external review decision of the independent review organization shall be binding on the covered person except to the extent the covered person has other remedies available under federal or state law. The external review process shall not be considered an adjudicative proceeding within the meaning of RSA 541-A [the law providing for judicial review of administrative proceedings], and the external review decision of the independent review organization shall not be subject to rehearing and appeal pursuant to RSA 541.²⁴

Apparently of similar effect, but less explicit, is the Kentucky external review statute:

(9) The decision of the independent review entity shall be binding on the insurer with respect to that covered person. Failure of the insurer to provide coverage as required by the independent review entity shall:

(a) Be a violation of the insurance code of a nature to warrant the executive director revoking or suspending the insurer's license or certificate of authority; and

(b) Constitute an unfair claims settlement practice as set forth in KRS 304.12-230.²⁵

²⁴ N.H. REV. STAT. ANN. § 420-J: 5-e (LexisNexis 2008).

²⁵ KY. REV. STAT. ANN. § 304.17A-625 (West 2006).

Iowa’s external review law is explicit about the lack of symmetry in terms of insurer and insured rights to court review:

1. The review decision by the independent review entity conducting the review is binding upon the carrier or organized delivery system. The external review process shall not be considered a contested case under chapter 17A, the Iowa administrative procedure act.

2. The enrollee or the enrollee’s treating health care provider acting on behalf of the enrollee may appeal the review decision by the independent review entity conducting the review by filing a petition for judicial court either in Polk county district court or in the district court in the county in which the enrollee resides... The petition for judicial review must be filed within fifteen business days after the issuance of the review decision. The petition shall name the enrollee or the enrollee’s treating health care provider as the petitioner. The respondent shall be the carrier or the organized delivery system. The petition shall not name the independent review entity as a party. The commissioner shall not be named as a respondent unless the petitioner alleges action or inaction by the commissioner under the standards articulated in section 17A.19, subsection 10. Allegations against the commissioner under section 17A.19, subsection 10, must be stated with particularity. The commissioner may, upon motion, intervene in the judicial review proceeding. The findings of fact by the independent review entity conducting the review are conclusive and binding on appeal.

3. The carrier or organized delivery system shall follow and comply with the review decision of the independent review entity conducting the review, or the decision of the court on appeal. The carrier or organized delivery system and the enrollee’s treating health care provider shall not be subject to any penalties, sanctions, or awards of damages for following and complying in good faith with the review decision of the independent review entity conducting the review or decision of the court on appeal.

4. The enrollee or the enrollee’s treating health care provider may bring an action in Polk county district court or in the district court in which the enrollee resides to enforce the review decision

of the independent review entity conducting the review or the decision of the court on appeal.²⁶

The Illinois law at issue in *Rush* was not typical of these external review laws, in that it does not refer to external review but rather uses in its title the phrase, adopted by the majority of the Supreme Court, “second opinion”; nonetheless, it falls into this first category:

§ 4-10. (a) Medical Necessity – Dispute Resolution – Independent Second Opinion. Each Health Maintenance Organization shall provide a mechanism for the timely review by a physician holding the same class of license as the primary care physician, who is unaffiliated with the Health Maintenance Organization, jointly selected by the patient (or the patient’s next of kin or legal representative if the patient is unable to act for himself), primary care physician and the Health Maintenance Organization in the event of a dispute between the primary care physician and the Health Maintenance Organization regarding the medical necessity of a covered service proposed by a primary care physician. In the event that the reviewing physician determines the covered service to be medically necessary, the Health Maintenance Organization shall provide the covered service. Future contractual or employment action by the Health Maintenance Organization regarding the primary care physician shall not be based solely on the physician’s participation in this procedure.²⁷

California law states, “The Commissioner shall immediately adopt the determination of the independent medical review organization, and shall promptly issue a written decision to the parties that shall be binding on the insurer.”²⁸ Likewise, the Georgia statute provides that “[a] decision of the independent review organization in favor of the eligible enrollee shall be final and binding on the managed care entity and the appropriate relief shall be provided without delay.”²⁹ That statute goes on to reflect the asymmetrical position of the parties, contemplating appeal by the insured to court of a decision in favor of the managed care entity by providing, “A

²⁶ IOWA CODE ANN. § 514J.13 (West 2007).

²⁷ 215 ILL. COMP. STAT. ANN. 125/4-10 (West 2000 & Supp. 2008).

²⁸ CAL. INS. CODE § 10169.3 (West 2005).

²⁹ GA. CODE ANN. § 33-20A-37 (West 2003).

determination by the independent review organization in favor of the managed care entity shall create a rebuttal presumption in any subsequent action that the managed care entity’s prior determination was appropriate....³⁰ Indiana provides simply, “A determination made under [...] this chapter is binding on the insurer,”³¹ and Maine, equally brief, states, “An external review decision is binding on the carrier.”³²

TYPE 2 LAWS

Some states make the results of external review binding on both the insurer and the insured without providing any mechanism for appeal. For example, Louisiana statutes provide:

B. An external review decision made pursuant to this Chapter shall be binding on the MNRO and on any health insurance issuer or health benefit plan that utilizes the MNRO for making medical necessity determinations.

C. An external review decision shall be binding on the covered person for purposes of determining coverage under a health benefit plan that requires a determination of medical necessity for a medical service to be covered.³³

³⁰ *Id.* § 33-20A-37(b); presumably the reason for making a decision in favor of the managed care entity a rebuttable presumption is to discourage appeal.

³¹ IND. CODE ANN. § 27-8-29-16 (Supp 2007) (LexisNexis).

³² ME. REV. STAT. ANN. tit. 24-A § 4312 (Supp. 2007). For other “Type 1” laws, see also N.Y. INS. LAW § 4914 (McKinney 2008) (“[The determination of the external appeal agent shall] be binding on the plan and the insured....”); N.C. GEN. STAT. § 58-50-84 (2002) (“(a) An external review decision is binding on the insurer. (b) An external review decision is binding on the covered person except to the extent the covered person has other remedies available under applicable federal or state law.”); S.C. CODE ANN. § 38-71-1990 (2002) (“(A) An external review decision is binding on the health carrier. (B) An external review decision is binding on the covered person except to the extent the covered person has other remedies available under applicable federal or state law.”); VT. STAT. ANN. tit. 8, § 4089f (Supp. 2007) (“The independent review organization shall issue to both parties a written review decision that is evidence-based. The decision shall be binding on the health benefit plan.”). *But see* Schulman v. Group Health Inc., 816 N.Y.S.2d 806, 807 (2006), (an insured may seek administrative review and judicial review of an external agent’s decision, despite a provision in the law describing the decision of an external review agent as binding on both the plan and the insured), *aff’d* 833 N.Y.S.2d 62 (2006); *Nenno v. Blue Cross and Blue Shield of Western New York*, 757 N.Y.S.2d 165, 167 (2003), *aff’d* 841 N.Y.S.2d 916 (2007); *Vellios v. IPRO*, 764 N.Y.S.2d 568, 570, *aff’d* 765 N.Y.S.2d 222, 225 (2003).

³³ LA. REV. STAT. ANN. § 22:3085 (2004).

Massachusetts states the bilateral nature of the effect of the external review decision simply: “The decision of the review panel shall be binding. The superior court shall have jurisdiction to enforce the decision of the review panel.”³⁴ Less succinct are statutes in Virginia and Washington. Virginia provides, “The Commissioner or his designee, based upon such recommendation [of the external review entity], shall issue a written ruling affirming, modifying, or reversing the final adverse decision within 10 working days after his receipt of the recommendation of the impartial review entity....”³⁵ Unlike the other statutes mentioned, rather than giving a private entity the power to issue a binding determination, this confers such power on a regulatory agency, but the statute makes clear that such a determination is not treated in the same fashion as an order from an agency appealable under the state’s statutes allowing for judicial review of administrative agency actions:

Such written ruling shall not be construed as a final finding, order or judgment of the Commission, and shall be exempt from the application of the Administrative Process Act (§ 2.2-4000 et seq.). The written ruling of the Commissioner or his designee shall affirm the recommendations of the impartial health entity unless the Commissioner or his designee finds in his ruling that the impartial health entity exceeded its authority or acted arbitrarily or capriciously. The written ruling of the Commissioner or his designee shall bind the covered person and the utilization review entity to the extent to which each would have been obligated by a judgment entered in an action at law or in equity with respect to the issues which the impartial review entity may examine when reviewing a final adverse decision under this section.³⁶

Although opaque, Washington also appears to make external review binding on both parties without providing for appeal: “Carriers must timely implement the certified independent review organization’s determination and must pay the certified independent review organization’s charges.”³⁷ North Dakota provides simply, “A determination by the independent external reviewer is binding on the parties.”³⁸

³⁴ MASS. GEN. LAWS ANN. ch. 176O § 14 (West Supp. 2008).

³⁵ VA. CODE ANN. § 38.2-5902 (2007).

³⁶ *Id.*

³⁷ WASH. REV. CODE ANN, § 48.43.535 (West 2008).

³⁸ N.D. CENT. CODE § 26.1-36-44 (2007).

TYPE 3 LAWS

Some states allow for judicial review of the decision of an independent review organization, but as a practical matter make that review moot by requiring compliance with the decision with respect to the enrollee. For example, Kansas statutes provide:

The decision of the external review organization may be reviewed directly by the district court at the request of either the insured, insurer or health insurance plan. The review by the district court shall be *de novo*. The decision of the external review organization shall not preclude the insured, insurer or health insurance plan from exercising other available remedies under state or federal law. *Seeking a review by the district court or any other available remedies exercised by the insured, insurer or health insurance plan after the decision of the external review organization will not stay the external review organization's decision as to the payment or provision of services to be rendered during the pendency of the review by the insurer or the health plan.* (emphasis added)³⁹

While Kansas law calls for adherence to the external review decision only during the pendency of an appeal, as a practical matter, if the decision called for coverage of a service, in all likelihood the service would be provided and paid for before any judicial decision could occur.

Other states that expressly address judicial review are less coy about the effect of such an appeal. For instance, Arizona law provides in pertinent part:

The decision by the independent review organization is a final administrative decision pursuant to title 41, chapter 6, article 10 and, except as provided in § 41-1092.08, subsection H, is subject to judicial review pursuant to title 12, chapter 7, article 6. *The health care insurer shall provide any service or pay any claim determined to be covered and medically necessary by the independent review organization for the case under review regardless of whether judicial review is sought.*(emphasis

³⁹ KAN. STAT. ANN. § 40-22a16 (2000).

added).⁴⁰

Delaware law is to similar effect:

If the arbitrator makes a decision in favor of the carrier, that decision shall give rise to a rebuttable presumption to that effect in any subsequent action brought by or on behalf of the covered person with respect to the decision. Should the decision favor the covered person, the carrier shall have the right to appeal the matter to the Court, in accordance with Court rules. *The outcome of that appeal, however, shall have no effect on the covered person, as to whom the decision of the arbitrator shall control.* (emphasis added).⁴¹

Likewise, Pennsylvania statutes indicate, “The managed care plan shall authorize any health care service or pay a claim determined to be medically necessary and appropriate [by an external review entity] whether or not an appeal to a court of competent jurisdiction has been filed.”⁴²

It is unclear why a health plan would appeal a decision by an independent reviewer that a service should be covered in cases such as these. Independent review organizations are clearly not courts of record; there would be no element of precedent, of *stare decisis*, in their decisions, and it would seem unlikely that adherence by a carrier to such decisions would be argued in other cases as a basis for estoppel or would form the basis for an assertion, when the carrier is resisting a similar claim in the future, of arbitrary decision-making. In addition, if the service has already been covered, the potential for a court dismissing an appeal as moot would seem to be very strong, especially given the relatively unique circumstances surrounding many cases of questionable medical necessity. The practical effect of this type of law, then, might be no different than laws described as Type 1 and 2.

TYPE 4 LAWS

Some states expressly provide for judicial review of external review decisions without giving immediate effect to the decision. Michigan

⁴⁰ ARIZ. REV. STAT. ANN. § 20-2537 (2002).

⁴¹ DEL. CODE ANN. tit. 18, § 332 (1999 & Supp. 2006).

⁴² PA. STAT. ANN. § 991.2162 (West 1999).

provides a particular example:

An external review decision and an expedited external review decision are the final administrative remedies available under this act. A person aggrieved by an external review decision or an expedited external review decision may seek judicial review no later than 60 days from the date of the decision in the circuit court for the county where the covered person resides or in the circuit court of Ingham county.⁴³

Some statutes are less explicit but of equal effect either by making the external review advisory only, allowing for alternative approaches to dispute resolution including litigation, or in providing for judicial review of external review decisions without giving effect to the decision. The District of Columbia provides, “The decision of the independent review organization shall be nonbinding on all parties and shall not affect any other legal causes of action.”⁴⁴

In several cases, the apparent capacity for judicial review or a separate contract action is only implicit. Some states provide that the external review decision forms a rebuttable presumption in any subsequent litigation, or otherwise provides for its admissibility, thereby implying the right to a judicial decision.⁴⁵ Other state laws, while indicating the results of the external review are binding on the insurer and insured, provide that external review is not the only remedy available to the parties, indicating that external review does not eliminate other remedies under state or federal law, or specifically indicating that judicial review is available.⁴⁶ Several statutes do not speak to appealability or to the binding nature of an external review decision, but provide for the decision being an order of the insurance regulatory official;⁴⁷ it seems reasonable to believe that such an

⁴³ MICH. COMP. LAWS SERV. § 550.1915 (LexisNexis Supp. 2008).

⁴⁴ D.C. CODE ANN. § 44301.07 (LexisNexis 2001 & Supp. 2006).

⁴⁵ See COLO. REV. STAT. § 10-16-113.5 (2007); R.I. GEN. LAWS § 23.17.12-10 (LexisNexis 2001 & Supp. 2007) (“The decision of the external appeal agency shall be binding; however, any person who is aggrieved by a final decision of the external appeal agency is entitled to judicial review in a court of competent jurisdiction.”).

⁴⁶ See UTAH CODE ANN. § 31A-22-629 (Supp. 2005) (“Nothing in this section may be construed as...altering the legal rights of any party to seek court or other redress in connection with: (i) an adverse decision resulting from an independent review...”).

⁴⁷ See FLA. STAT. ANN. § 408.7056 (Supp. 2007) (after issuance of the review entity’s recommendation, the regulatory agency may adopt the recommendations or findings of fact as a proposed order) HAW. REV. STAT. § 432E-6 (2005) (the commissioner shall issue

order, like other orders of an administrative agency, would be appealable under the state's laws regarding judicial review of administrative actions. New York, where the external review law states it is binding on the parties, has the most fully developed case law on the subject of appeal of external review decisions. Section 4914(b)(4)(A)(iv) of the New York Insurance Laws provides that the determination of an external appeal agent shall be "binding on the plan and the insured," but part (v) that sections provides that the external appeal agent's determination shall "be admissible in any court proceeding."⁴⁸ And, the statute introducing external review, section 4907, provides that "[t]he rights and remedies conferred in this article upon insureds and health care providers shall be cumulative and in addition to and not in lieu of any other rights or remedies available under law."⁴⁹ Based on this language, in three separate cases in which the effect of the "binding" reference was considered, New York courts have concluded the legislature intended for appellate review of external review agency's decision.⁵⁰

STATUTES OF OTHER KINDS

In addition to the laws captured by the above taxonomy, there are some statutes that are either *sui generis* or are simply unclear about the effect of an external review decision. Oregon is the primary representative of the former, allowing an insurer to choose between being bound or not by the

an order affirming, modifying or reversing the decision of the review entity within thirty days); MD. CODE ANN., INS. § 15-10A-05 (Supp. 2006) ("[T]he Commissioner may select and accept and base the final decision [of whether a health care service is medically necessary] on the professional judgment of an independent review organization or medical expert."); MO. ANN. STAT. § 376.1387 (West 2002) (the decision of an independent review organization, while binding on the enrollee and the carrier, shall be considered a final agency decision within the discretion of the director of insurance, subject to a judicial review based on the record and involving consideration of whether the action of the director is unconstitutional, unlawful, unreasonable, arbitrary, capricious or involves an abuse of discretion or is in excess of the authority of the director).

⁴⁸ N.Y. INS. LAW § 4914(b)(4)(A)(iv) to (v) (McKinney 2008).

⁴⁹ *Id.* at § 4907.

⁵⁰ *Schulman v. Group Health Inc.*, 816 N.Y.S.2d 806, 807, *aff'd* 833 N.Y.S.2d 62, 63 (2006); *Nenno v. Blue Cross and Blue Shield of Western New York*, 757 N.Y.S.2d 165, 167 (2003), *aff'd* 841 N.Y.S.2d 916 (2007); *Vellios v. IPRO*, 1 Misc.3d 487, 764 N.Y.S.2d 568, 570 (2003) (where the court concluded that an external review agent functions as an agent of the state, thus making the laws governing judicial review of administrative actions applicable), *aff'd* 765 N.Y.S.2d 222, 225 (2003).

decisions of independent review organizations.⁵¹ Oklahoma⁵² and Wisconsin⁵³ appear to be unclear about the effect of external review.

PART III. RIGHTS TO ACCESS TO COURTS AND SEPARATION OF POWERS

A. “OPEN COURTS” PROVISIONS

At least thirty-seven states have an “open courts” provision in their constitutions.⁵⁴ Such constitutional provisions typically provide that all courts shall be open and that every person shall have a remedy by due process of law for any injury done to him or his property.⁵⁵ Those constitutional provisions have figured prominently in challenges alleging that a variety of statutes limit appropriate access to courts, including caps on damages in legislation addressing medical malpractice,⁵⁶ statutes of repose in legislation dealing with medical malpractice or products liability,⁵⁷ or the opportunity for voluntary arbitration in consumer protection statutes such as “Lemon Laws”,⁵⁸ among others.

Given the analogy of the Illinois second opinion statute to arbitration offered by Justice Thomas in *Rush*,⁵⁹ specific consideration of the

⁵¹ OR. REV. STAT. § 743.859 (2007).

⁵² OKLA. STAT. tit. 63, § 2528.6 (2004).

⁵³ WIS. STAT. § 632.835 (WEST 2004).

⁵⁴ *Lankford v. Sullivan et al.*, 416 So. 2d 996, 999 (Ala. 1982).

⁵⁵ *See, e.g.*, ALA. CONST. art. I, § 13; IND. CONST. art. I, § 12; TEX. CONST. art. I, § 13.

⁵⁶ *Columbia Rio Grande Reg'l Healthcare, L. P. v. Hawley*, 188 S.W.3d 838, 866 (Tex. App. 2006).

⁵⁷ *Lankford*, 416 So. 2d at 1000.

⁵⁸ *Motor Vehicle Mfr. Ass'n of the U. S. v. State of New York*, 550 N.E.2d 919, 920 (1990); *see generally* 1 ADR § 6:16 (3d ed.).

⁵⁹ For a keen analysis of the discussion about the arbitral-like nature of the Illinois external review law, *see* Hunter, *supra* note 3, at 125-27. Hunter observes that although both parties, as well as *amici*, uniformly described the law as “arbitration-like,” as did the four Justices in dissent, the majority’s conclusion of nonpreemption hinged on its rejection of the arbitration analogy, thereby changing the framing of the law as a dispute resolution procedure. Hunter describes this result as arriving at “the right decision for the wrong reason,” suggesting that the Court should instead have reconsidered the provisions of *Pilot Life v. Dedeaux*, 481 U.S. 41, 56 (1987), which, in her opinion, gave ERISA enforcement mechanisms overly-broad reach. Of course, had the Court pursued that path, it might well not have decided *Rush* as it did, for the votes may not have been there for a majority. *See Aetna Health Inc. v. Davila*, 542 U.S. 200, 220 (2004), a unanimous decision by the Court decided shortly after *Rush*, re-emphasized the exclusive remedies available under ERISA.

challenges to the Uniform Arbitration Act⁶⁰ as foreclosing access to courts is worth brief consideration. The statute at issue in *Rush* was not, of course, the UAA; still, consideration of how courts have treated the UAA, and more precisely why they have treated it that way, should provide some suggestion about how they would treat laws giving a binding effect to external review.

Arbitration agreements are a matter of contract, enforceable according to their terms, absent compelling circumstances such as unconscionability.⁶¹ In fact, the UAA itself, although broadly worded, applies to circumstances where there is an agreement to arbitrate, which assumes a meeting of the minds and other conditions necessary to satisfy the constituent elements of a contract (hence the limited review by courts of arbitral decisions, i.e., that there was an agreement and that there was no fraud or duress involved in the process).⁶²

Not all arbitration is the result of an agreement. In some cases, it may be mandated by statute rather than agreed upon by the parties to a dispute. In such circumstances, there are a few cases in which the claim that mandatory arbitration would violate a state's "open courts" constitutional requirement has been recognized. The primary example of this is *State v. Nebraska Ass'n of Pub. Employees*.⁶³ Relying on a history of Nebraska

⁶⁰ The Uniform Arbitration Act ("UAA") was adopted by the National Conference of Commissioners on Uniform Laws in August, 1955, and amended August, 1956. UNIF. ARBITRATION ACT, INTRODUCTION, <http://www.adr.org/si.asp?id=2509> (last visited September 21, 2008). The UAA has been adopted in 35 states, and substantially similar arbitration statutes exist in 14 other jurisdictions. Amy J. Schmitz, *Refreshing Contractual Analysis of ADR Agreements by Curing Bipolar Avoidance of Modern Common Law*, 9 HARV. NEGOT. L. REV. 1, 11 (2004).

⁶¹ See, e.g., *Iwen v. U.S. West Direct*, 977 P.2d 989, 996 (Mont. 1999), where the court refused to enforce a contract term, including an agreement to arbitrate, where the contract is one of adhesion and where the provision was either not within the weaker party's expectation or where the term was unduly oppressive, unconscionable, or against public policy. See also *Ticknor v. Choice Hotels Int'l*, 265 F.3d 931, 939 (9th Cir. 2001), following the *Iwen* logic.

⁶² As a generalization, arbitration involves parties to a dispute voluntarily contracting to select an impartial third party to decide the matter based on arguments and evidence presented to that third party, primarily to avoid the time, expense and uncertainty of litigation. 1 MARTIN DOMKE & GABRIEL M. WILNER, DOMKE ON COMMERCIAL ARBITRATION § 1:1 (rev. ed. 2008). As discussed *infra* p. 20 and n. 66, that voluntary aspect does not apply in external review circumstances, but understanding the issues surrounding the acceptability of statutorily mandated arbitration is of paramount relevance to the weaknesses in such external review laws.

⁶³ 477 N.W.2d 577, 578-79 (1991). The Nebraska constitution was subsequently changed to recognize binding arbitration agreements and allow for their enforcement, NEB.

cases holding arbitration provisions entered into before a dispute to be invalid as ousting courts from their constitutional jurisdiction in violation of the open courts provision, the Nebraska Supreme Court declared invalid the UAA and, as a result, provisions of state employee contracts calling for mandatory binding arbitration.⁶⁴

More frequently, courts find no constitutional conflict between arbitration agreements and a state constitution’s open courts provision.⁶⁵ As discussed below, if there is a qualitative, constitutional difference between voluntary agreements to arbitrate and statutorily mandated arbitration,⁶⁶ it is possible that in the Nebraska case the court, concerned about the legislature dictating the source of adjudication (i.e., calling for mandatory binding arbitration rather than for arbitration based on voluntary agreement), was expressing a concern about separation of powers cloaked in the language of access to courts.

B. SEPARATION OF POWERS

The separation of powers doctrine is, at least in some circumstances, of a piece with constitutional requirements for access to courts: when the capacity to determine individual rights with finality is vested in a non-judicial entity without mutual agreement of the parties to do so, the result is both a lack of access to courts and a delegation of complete judicial authority to an agency or private entity, resulting in the vesting of power in either the executive or in another, nongovernmental agency acting on behalf of the state.

CONST. art. I, § 13. *See also* *Huntington Corp. v. Inwood Construction Co.*, 348 S.W.2d 442, 445 (Tex. Civ. App. 1961).

⁶⁴ *State v. Nebraska Ass’n of Pub. Employees*, 477 N.W.2d 577, 580 (Neb. 1991).

⁶⁵ *See, e.g. Rollings v. Thermodyne Indus., Inc.*, 910 P.2d 1030, 1033, 1036 (Okla. 1996), determining that the open courts provision of the constitution did not bar enforcement of arbitration agreements, and noting that most states considering the question have upheld arbitration in the face of claims of unconstitutionality.

⁶⁶ *Nenno v. Blue Cross & Blue Shield of Western N. Y.*, 757 N.Y.S.2d 165, 168 (2003), *aff’d* 841 N.Y.S.2d 916 (2007), involved, among other things, a claim that the external review process violated New York constitutional requirements relating to access to courts and to separation of powers. One defense raised in that case was that the external review was not different than binding arbitration, a position with which the court disagreed: “Finally, we reject defendant’s contention with respect to appeal No. 2 that the external appeal constitutes a binding arbitration to which the parties agreed in the insurance contract. The insurance contract does not contain an agreement to arbitrate . . . in clear, explicit, and unequivocal language.” *Id.* at 168.

All state constitutions embrace the concept of separation of powers – that there are three branches of government (executive, legislative and judicial) and that each has powers vested in it as a separate magistracy, preventing another branch from encroaching on the powers of another.⁶⁷ Separation of powers calls for courts to possess the entire body of judicial power, and their powers may not be assigned to another branch either by it nor assumed by another branch.⁶⁸ That generality does not mean that such creates independent islands, however. It is well-accepted that some overlap may occur, e.g., through empowering administrative agencies to make quasi-judicial decisions.⁶⁹

The conditions surrounding such an overlap were thoughtfully explored in *Board of Education v. Harrell*.⁷⁰ There, the court considered a statute requiring mandated, binding arbitration of teacher disputes regarding discharge. The statute restricted judicial review of the arbitrator's decision to issues regarding fraud or corruption of the arbitral process. In considering Harrell's claim that this limited the power of the judiciary by vesting an arbitrator with sole authority to determine all issues of fact and law, the New Mexico court considered the rationale underlying the separation of powers principle at length. It observed that the theory of separation of powers is derived from concerns that concentrating judicial, legislative, and executive power into a single entity would create a system with inherent tendencies toward tyranny.⁷¹ The court noted that a hermetic sealing off of the three branches was not contemplated by separation of powers, that the doctrine was not an absolute, that separation of powers does not prohibit every exercise of judicial power by persons outside the judiciary, and observed that rather than maintaining a strict separation, constitutional law requires instead the assurance that adequate checks exist to keep each branch free from the control or coercive influence of the other branches.⁷²

Applying that concept to the exercise of judicial power by quasi-judicial tribunals, the New Mexico court declared that the judiciary must

⁶⁷ 16 AM. JUR. 2D *Constitutional Law* § 8 (1998); 16A AM. JUR. 2D *Constitutional Law* § 246 (1998).

⁶⁸ 16 AM. JUR. 2D *Constitutional Law* § 8 (1998); 16A AM. JUR. 2D *Constitutional Law* § 246 (1998).

⁶⁹ 16 AM. JUR. 2D *Constitutional Law* § 8 (1998); 16A AM. JUR. 2D *Constitutional Law* § 246 (1998).

⁷⁰ 882 P.2d 511, 524 (N.M. 1994).

⁷¹ *Id.* at 514-15, 524.

⁷² *Id.* at 524-25.

maintain “the power of check” over such tribunals’ exercise of the essential attributes of judicial power, defined as “the final authority to render and enforce a judgment.”⁷³ That principle of check, the court said, requires that courts have an opportunity to review decisions of arbitrators in statutorily compelled arbitrations.⁷⁴ In *Harrell*, the statute called for the arbitrator’s decision to be binding and non-appealable except where the decision was procured by corruption, fraud, deception or collusion (and not, the court observed, where the decision was arbitrary or capricious). The court considered Illinois case law regarding the need for judicial review⁷⁵ and concluded that both due process and separation of powers considerations require that parties to statutorily mandated arbitration be offered meaningful review of the arbitrator’s decision.⁷⁶ The court explained that to be meaningful, the review must consist of determinations of whether the litigant received a fair hearing before an impartial tribunal, whether the decision was supported by substantial evidence, and whether the decision is in accordance with the law.⁷⁷ The New Mexico statute at issue, limiting

⁷³ *Id.* at 525.

⁷⁴ *Id.*, citing to *Ky. Comm’n on Human Rights v. Fraser*, 625 S.W.2d 852, 855 (Ky. 1981); *Peick v. Pension Benefit Guar. Corp.*, 724 F.2d 1247, 1277 (7th Cir. 1983); *Republic Indus. Inc. v. Teamsters Joint Council No. 83*, 718 F.2d 628, 640 (4th Cir. 1983); *Bayscene Resident Negotiators v. Bayscene Mobilehome Park*, 18 Cal. Rptr. 2d 626, 634 (1993), among others.

⁷⁵ *City of Waukegan v. Pollution Control Bd.*, 311 N.E.2d 146, 152 (Ill. 1974):

As a general rule, delegation to administrators or agencies of the quasi-judicial power to adjudicate rights or to revoke privileges such as licenses is not invalid so long as there is an opportunity for judicial review of the administrative action. Such judicial review normally permits an aggrieved party to contest the fairness of the procedure used, the constitutionality of the substance of the regulatory statute and implementing rules and regulations, the correctness of the administrator’s interpretation of the statute under which he operates, and whether or not his decision was arbitrary. In short, if the judiciary is given an adequate opportunity to review what has been done, the principle of separation of powers-or due process of law, if you will-is generally satisfied.

(internal citations omitted).

⁷⁶ *Bd. of Educ. v. Harrell*, 882 P.2d 511, 525-26 (N.M. 1994).

⁷⁷ *Id.* at 526.

court review, was thus struck down as both lacking in due process and as an unconstitutional delegation of judicial power.⁷⁸

The *Harrell* court's analysis offers an important distinction about arbitration. Consensual agreements between two parties, it says, are enforceable according to their terms, and raise no constitutional issues, a position consistent with the overwhelming majority of courts that have considered whether arbitration "ousts" the judiciary of its authority in an unconstitutional manner.⁷⁹ On the other hand, and critically, the *Harrell* court recognizes that statutorily mandated arbitration is not an agreement at all, but a determination by the legislature of the adjudicative structure to govern disputes.⁸⁰ Under such a circumstance, just as in circumstances of reference of disputes by the legislature to administrative agencies in the first instance, both separation of powers doctrine and due process considerations require that there be a meaningful review by a court of whether the attributes of due process – a fair hearing involving notice and opportunity to be heard, a decision supported by substantial evidence, and a decision in accordance with the law – are present.⁸¹

The *Harrell* decision is not unique in finding that statutory binding arbitration without a right of judicial review violates a state separation of powers constitutional safeguard. In a Texas case, both landowners and the

⁷⁸ *Id.*

⁷⁹ *Id.* at 516-517.

⁸⁰ *Id.* at 523. *See supra* note 66, at 22, regarding the attitude of the court in *Nenno v. Blue Cross* to a claim that an external review law was a form of arbitration; in the same way, *contra* the comparisons of external review laws to arbitration discussed in *Rush*, external review requirements are a determination by the legislature of the adjudicative structure to govern disputes regarding medical necessity.

⁸¹ *See Harrell*, 882 P.2d at 526. Indeed, as the *Harrell* Court observes:

The similarity between compulsory arbitration and an administrative adjudication thus makes caselaw on the constitutional validity of administrative adjudications instructive in assessing the validity of Section 22-10-17.1. As noted by the New York Court of Appeals, "[T]he device of [sic] arbitration is a substitute for a determination of the dispute by an administrative or regulatory agency. As a substitute device, however, its objective may not be accomplished under lower constitutional standards than would be required of an administrative or regulatory agency."

Id. at 518 (quoting *Mount St. Mary's Hosp. v. Catherwood*, 260 N.E.2d 508, 516 (N.Y. 1970)).

county were required to accept the result of binding arbitration when there was a dispute about valuation of property for tax purposes.⁸² The law provided for such an arbitration award to be enforceable by the district court.⁸³ The county asserted the statute not only violated the separation of powers doctrine but also the state open courts requirement.⁸⁴ The court agreed, noting that the unconstitutionality consisted of denying the reviewing court any meaningful method of ascertaining the lawfulness of the arbitration award the court was expected to enforce.⁸⁵ That expectation exists in some external review laws as well, as noted with respect to Iowa in Part II.⁸⁶

In an extensively-cited article considering the constitutional position of binding arbitration, Jean R. Sternlight identifies eight critical factors necessary for a state-compelled binding arbitration scheme to meet the fair hearing demands of due process.⁸⁷ Although some of those elements may be missing from some external review statutory processes, a discussion of each in the context of the multiple state external review laws is beyond the scope of this paper. The final element she identifies, however, is critical: the right to judicial review. Sternlight observes, “Where arbitration is imposed on parties, either by an explicit statute or by a ‘preference’ enunciated by the courts, the parties are arguable entitled to judicial review of the arbitrator’s decision to ensure that the decision is adequately founded in both law and fact.”⁸⁸ Sternlight notes that while this rule has not been explicitly enunciated by the Supreme Court, it is a logical extension of the Court’s logic in closely-related issues.⁸⁹ Moreover, Sternlight argues that the minimal appellate review required by the Federal Arbitration Act – requiring a court to enforce arbitral awards unless they are shown to be the product of corruption, fraud, or arbitrator misconduct - is constitutionally insufficient. Sternlight asserts that rather than a cursory review of the nonjudicial decision, a more extensive de novo review of the decision

⁸² Hays County Appraisal Dist. v. Mayo Kirby Springs, Inc., 903 S.W.2d 394, 394-395 (Tex. App. 1995).

⁸³ *Id.* at 396.

⁸⁴ *Id.*

⁸⁵ *Id.* at 397.

⁸⁶ See *supra* Part II, at 94-97 (discussing Type 1 Laws).

⁸⁷ Jean R. Sternlight, *Rethinking the Constitutionality of the Supreme Court’s Preference for Binding Arbitration: A Fresh Assessment of Jury Trial, Separation of Powers, and Due Process Concerns*, 72 TUL. L. REV. 1, 87-98 (1997).

⁸⁸ *Id.* at 95.

⁸⁹ *Id.*

under a “weight of the evidence” standard should apply.⁹⁰ Sternlight reasons: “If judicial review is required of decisions by administrative agencies, surely it is required of private arbitration decisions as well, to ensure that such decisions reflect law and not merely whim or bias.”⁹¹

Although Sternlight’s observations are cast in terms of due process, they apply equally, as the *Harrell* court observes,⁹² to the constitutional doctrine of separation of powers. That is, if separation of powers concerns require that a court engage in meaningful review and require that the court is also the final authority to render and enforce a judgment in the case of statutorily-mandated binding arbitration, then both of those concerns apply equally to binding external review processes. There is no principled basis for a distinction that would treat the binding result of decisions of an external review entity any differently than statutory binding arbitration. If that is so – if an external review agency exercises the same power as an administrative agency acting in a quasi-judicial capacity – then the same constitutional considerations should apply to the processes and decisions of state- required external review, including consideration of separation of powers. As one court observed, “[U]nder the separation of powers clause of our state constitution, judicial review must be provided for administrative agency decisions involving the exercise of quasi-judicial powers.”⁹³

It appears from the taxonomy of external review laws discussed above that only a minority provide for any court involvement, other than the ability to enforce the decision of the independent review organization.⁹⁴ Some merely describe the decision of the external review entity as binding, either on the insurer or on the insurer and insured.⁹⁵ At least some expressly describe external review as not being an administrative decision under the state’s particular administrative procedures act,⁹⁶ which appears to foreclose access to courts for subsequent review under state laws governing judicial review of administrative decisions. Those external review laws that allow for court review of the decision of an independent review

⁹⁰ *Id.* at 95-97.

⁹¹ *Id.* at 96.

⁹² Bd. of Educ. v. Harrell, 882 P.2d 511, 526 (N.M. 1994).

⁹³ Meath v. Harmful Substances Comp. Bd., 550 N.W.2d 275, 282 (Minn., 1996) (Anderson, J., concurring specially).

⁹⁴ *See supra* Part II, at 91-97.

⁹⁵ *See supra* Part II, at 93.

⁹⁶ *See* N.H. REV. STAT. ANN. § 420-J:5e (2004) (“The external review process shall not be considered an adjudicative proceeding within the meaning of RSA 541-A, and the external review decision of the independent review organization shall not be subject to rehearing and appeal pursuant to RSA 541.”).

organization, but make that decision binding with respect to the particular insured's benefits, lack any meaningful access to a court. In all three such circumstances, an appropriate initial inquiry would be whether placing the adjudicative power in the hands of a private entity or in the hands of a regulatory official (by calling for an order from the commissioner, for example, adopting or rejecting the external review entity's conclusion) without an opportunity for meaningful appellate review violates the separation of powers doctrine (or the logical consequence of such a violation, the violation of an “open courts” provision). Certainly in such cases the rationale applied in *Harrell* to statutorily-mandated binding arbitration would seem readily to apply.⁹⁷

Even when an external review statute provides for judicial review, state constitutional concerns may still exist, and have been raised in at least one instance in which the external review law explicitly provided for appellate review. Michigan law provides, “A person aggrieved by an external review decision . . . may seek judicial review no later than 60 days from the date of the decision in the circuit court for the county where the covered person resides or in the circuit court of Ingham county.”⁹⁸ In *English v. Blue Cross Blue Shield*,⁹⁹ Blue Cross argued that the independent review act did not provide the insurance commissioner or the independent review organization with standards for reviewing the adverse determination and did not announce a standard for an appellate court to apply to the decision when appealed, violating the insurer's right to substantive due process.¹⁰⁰ The court recharacterized this claim as “one attacking the Legislature's delegation of power to an administrative agency and rooted in the separation of powers doctrine.”¹⁰¹ That is, the court understood the heart of the complaint to be that overly-broad and unconstrained authority had been given to an administrative agency without any judicial check thereon.¹⁰² Reviewing the provisions of the statute, the court concluded that adequate

⁹⁷ See *supra* notes 79-81, at 108 and accompanying text.

⁹⁸ Patient's Right to Independent Review Act, MICH. COMP. LAWS SERV. § 550.1915(1) (Lexis Supp. 2008).

⁹⁹ 688 N.W.2d 523 (Mich. Ct. App. 2004).

¹⁰⁰ *Id.* at 534.

¹⁰¹ *Id.* at 534. The court explained, “When a legislative body chooses to vest an administrative body with the power to regulate public conduct, the legislative body must provide adequate standards to protect the public from the exercise of uncontrolled, arbitrary power.” *Id.* (quoting *Natural Aggregates Corp. v. Brighton Twp.*, 539 N.W.2d 761, 770 (Mich. Ct. App. 1995)). See also *Ross v. Blue Care Network of Michigan*, 722 N.W.2d 223 (Mich. Ct. App. 2006) (elaborating on the standards for judicial review).

¹⁰² *English*, 688 N.W.2d at 534.

standards did, in fact, exist for the exercise of judgment by the commissioner and the independent review organization, and that, while the act was silent on the standard for judicial review, the Michigan constitution adequately specified the standard to be used in review of final agency determinations.¹⁰³

PART IV. THE *RUSH* CONUNDRUM WHEN APPEAL IS AUTHORIZED

In the taxonomy of external review laws noted above, one group would appear to be safe from claims of violation of the separation of powers doctrine or of “open courts” constitutional provisions, those providing for appellate review of the external review decision before it becomes effective. As noted above, New York courts have addressed this issue at least three times.¹⁰⁴ Even though the New York statute described the result of an external review to be binding on the insurer and the insured, the statute was interpreted to mean that appellate review was proper.¹⁰⁵ Under such a circumstance, the potential that an external review law runs afoul of state constitutional concerns is considerably diminished.¹⁰⁶

On the other hand, when judicial review of an external agency decision occurs – when one appeals an external review decision to a state court for review – the court is placed in a position of making a determination regarding a dispute over a claim for benefits. At least one court has seen this as creating a dilemma in light of the *Rush* decision. *Hawaii Management Alliance Association v. Insurance Commissioner*¹⁰⁷ involved

¹⁰³ *Id.* at 535.

¹⁰⁴ See cases cited *supra* note 50.

¹⁰⁵ *Schulman v. Group Health Inc.*, 833 N.Y.S.2d 62, 63 (N.Y. App. Div. 2006). The *Schulman* court described the claim that no appellate review was available thusly: “Defendant’s interpretation provides no mechanism for review of either erroneous or arbitrary determinations by external review agents, a result that is not only inconsistent with the purpose of these statutory provisions, but would be detrimental to both insureds and insurers.” *Id.*

¹⁰⁶ That is not to say that there may not be other state, or even federal, constitutional concerns with the external review procedure, depending on the structure of the law. See *English v. Blue Cross Blue Shield of Mich.*, 688 N.W.2d 523 (Mich. Ct. App. 2004); see also *Bd. of Educ. of Carlsbad v. Harrell*, 882 P.2d 511 (N.M. 1994) (where issues were raised about whether the niceties of due process were met, i.e., whether an in person hearing was required, whether the ability to cross-examine witnesses or challenge the fact-finder for bias existed, and whether the decision was based on a record and used procedures that adequately documented the basis in law and in fact for the decision.)

¹⁰⁷ 100 P.3d 952, 966-67 (Haw. 2004).

the Hawaii Supreme Court considering a lower court affirmation of orders of attorney fees and costs arising out of the successful appeal of the denial of a claim under that state’s external review law. In defending, the appellants asserted that the law was preempted by ERISA, and that hence, the claim for attorney fees and costs was void.¹⁰⁸

The Hawaii statute provided for the insurance commissioner to enter an order affirming, modifying or vacating the decision of the external review panel and incorporated the Hawaii Administrative Procedure Act, which, among other things, provided “[a]ny person aggrieved by a final decision and order in a contested case...is entitled to judicial review thereof...”¹⁰⁹ The court found that this access to court review was fatal to a *Rush*-style claim that the statute was not preempted by ERISA. In its analysis, the court, mindful of *Rush* as well as of *Aetna v. Davila*¹¹⁰ and of *Kentucky Association of Health Plans v. Miller*,¹¹¹ determined that the statute regulated insurance under the test set forth in the latter case and hence was saved from express preemption.¹¹² However, the court did not stop there, but went on to consider in detail the concepts of field preemption and conflict preemption as they related to the Hawaii statutes.¹¹³ ERISA, the court unremarkably concluded, does not impliedly preempt the entire field of HMO regulation – indeed, its express preemption clause coupled with the savings clause makes clear that the preemptive reach of ERISA does not extend to all state laws affecting employee benefit plans.¹¹⁴ On the other hand, merely because Congress did not intend to preempt the entire field of state law affecting employee benefit plans does not mean that some such laws, otherwise saved from preemption as regulation of insurance, may not be preempted if they present a conflict with ERISA’s remedial scheme.¹¹⁵ In observing that, the court pointed to *Aetna Health* in its discussion of conflict preemption:

“[U]nder ordinary principles of conflict pre-emption,...even a state law that can arguably be characterized as ‘regulating insurance’ will be pre-empted if it provides a separate vehicle to

¹⁰⁸ *Id.* at 954.

¹⁰⁹ *Id.* at 966, quoting from HAW. REV. STAT. § 91-14 (1993).

¹¹⁰ 542 U.S. 200 (2004).

¹¹¹ 538 U.S. 329 (2003).

¹¹² *Haw. Mgmt. Alliance Ass’n*, 100 P.3d at 959-960.

¹¹³ *Id.* at 960-67.

¹¹⁴ *Id.* at 961.

¹¹⁵ *Id.* at 962.

assert a claim for benefits outside of, or in addition to, ERISA's remedial scheme."¹¹⁶

Aetna considered the availability of litigation under a Texas statute authorizing claims against health plans for failure to use due care in claims processing. Whether such a claim was preempted by ERISA depended on the remedial scheme in 29 U.S.C. 1132(a).¹¹⁷ Justice Thomas, writing for a unanimous court, emphasized the exclusivity of federal enforcement actions:

The pre-emptive force of ERISA § 502(a) is still stronger. In *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 65-66, 95 L.Ed.2d 55 (1987), the Court determined that the similarity of the language used in the Labor Management Relations Act, 1947 (LMRA), and ERISA, combined with the "clear intention" of Congress "to make § 502(a)(1)(B) suits brought by participants or beneficiaries federal questions for the purposes of federal court jurisdiction in like manner as § 301 of the LMRA," established that ERISA § 502(a)(1)(B)'s pre-emptive force mirrored the pre-emptive force of LMRA § 301. Since LMRA § 301 converts state causes of action into federal ones for purposes of determining the propriety of removal, see *Avco Corp. v. Machinists*, 390 U.S. 557, so too does ERISA § 502(a)(1)(B). Thus, the ERISA civil enforcement mechanism is one of those provisions with such "extraordinary pre-emptive power" that it "converts an ordinary state common law complaint into one stating a federal claim for purposes of the well-pleaded complaint rule." *Metropolitan Life*, 481 U.S. at 65-66, 107 S.Ct 1542. Hence, "causes of action within the scope of the civil enforcement provisions of § 502(a) [are] removable to federal court." *Id.* at 66.

It follows that if an individual brings suit complaining of a denial of coverage for medical care, where the individual is entitled to such coverage only because of the terms of an ERISA-regulated employee benefit plan, and where no legal duty (state or federal) independent of ERISA or the plan terms is violated, then the suit falls "within the scope of" ERISA § 502(a)(1)(B). *Metropolitan Life, supra*, at 66. In other words, if an

¹¹⁶ *Id.*

¹¹⁷ *Id.*

individual, at some point in time, could have brought his claim under ERISA § 502(a)(1)(B), and where there is no other independent legal duty that is implicated by a defendant’s actions, then the individual’s cause of action is completely pre-empted by ERISA § 502(a)(1)(B).¹¹⁸

The *Rush* court recalled its determination in *Metropolitan Life* that Congress had so completely preempted the field of benefits law that an ostensibly state cause of action for benefits was necessarily a creature of federal law removable to federal court,¹¹⁹ and indicated that under the decision in the instant case, enforcement of the medical necessity determination would require a civil action under 29 U.S.C. 1132(a)(1)(B) to recover benefits due the beneficiary or to enforce his rights under the terms of the plan.¹²⁰ The concern of the Hawaiian Supreme Court, then, was that the structure set up under its state law resulted in an enforcement action – an adjudicatory action – not under ERISA but rather in state courts. The *Rush* opinion had considered this: “To be sure, a State might provide for a type of ‘review’ that would so resemble an adjudication as to fall within *Pilot Life*’s categorical bar.”¹²¹

The *Hawaii Management* court considered whether *Rush* survived the strong language of *Aetna* emphasizing the preemptive power of ERISA, concluding that *Aetna* did not overrule *Rush* but allowed the Hawaii legislature to regulate insurance so long as the legislature did not create a “cause of action that duplicates, supplements, or supplants the ERISA civil

¹¹⁸ *Aetna Health Inc*, 542 U.S. at 209-10.

¹¹⁹ *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 378 (2002).

¹²⁰ *Id.* at 380 n.10.

¹²¹ *Id.* at 381. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 52 (1987) had stated:

The Solicitor General, for the United States as *amicus curiae*, argues that Congress clearly expressed an intent that the civil enforcement provisions of ERISA § 502(a) be the exclusive vehicle for actions by ERISA-plan participants and beneficiaries asserting improper processing of a claim for benefits, and that varying state causes of action for claims within the scope of § 502(a) would pose an obstacle to the purposes and objectives of Congress. Brief for United States as *Amicus Curiae* 18-19. We agree. The conclusion that § 502(a) was intended to be exclusive is supported, first, by the language and structure of the civil enforcement provisions, and second, by legislative history in which Congress declared that the pre-emptive force of § 502(a) was modeled on the exclusive remedy provided by § 301 of the Labor Management Relations Act, 1947 (LMRA), 61 Stat. 156, 29 U.S.C. § 185. *Id.*

enforcement remedy.”¹²² Reading the two together, the court determined that the Supreme Court meant to distinguish between state laws that create a state law claim for relief against an employee benefit plan (as in the case of *Aetna*) and state laws that require insurers to provide certain procedural protections to insureds.¹²³ Further, it understood the status of the law to be that a state statute is preempted by ERISA if it provides “a form of ultimate relief in a judicial forum that added to the judicial remedies provided by ERISA” or that “duplicates, supplements, or supplants the ERISA civil enforcement remedy.”¹²⁴

The Hawaii statute, the *Hawaii Management* court observed, is very similar to the Illinois statute at issue in *Rush*: both provide for an independent review of an insurer’s denial of benefits, both require the reviewing entity to consider the medical necessity of the procedure at issue, both allow the reviewer to overturn the insurer’s denial of coverage, and neither creates a claim for relief upon which a beneficiary can file a lawsuit (unlike in *Aetna*) or enlarges a beneficiary’s claim for benefits beyond what the beneficiary could obtain in an action under 29 U.S.C. 1132(a).¹²⁵ However, the court determined that the Hawaii and Illinois statutes have salient differences: first, the Hawaii statute provides for appellate review under the state’s administrative procedures act and sets forth the procedural requirements for contested cases, including, importantly, the availability of judicial review. Second, while the Illinois statute charged the reviewing physician to determine whether the procedure was medically necessary, the Hawaii statute charged the review panel to determine whether the actions of the HMO were “reasonable.”¹²⁶

These distinctions, the court held, were fatal to the survival of the Hawaii law under conflict analysis.¹²⁷ First, since the Hawaii statute did not seek a medical opinion *per se* but instead raised a broader question, i.e., whether the HMO’s actions were reasonable, the nature of the external review itself “more closely resembles ‘contract interpretation or evidentiary litigation before a neutral arbiter’ than ‘a practice (having nothing to do with arbitration) of obtaining another medical opinion.’”¹²⁸

Beyond that and more damaging, according to the court, was the right

¹²² *Haw. Mgmt. Alliance Ass’n*, 100 P.3d at 964.

¹²³ *Id.*

¹²⁴ *Id.* at 965.

¹²⁵ *Id.* at 966.

¹²⁶ *Id.*

¹²⁷ *Id.*

¹²⁸ *Haw. Mgmt. Alliance Ass’n*, 100 P.3d at 966.

of the parties to seek judicial review.¹²⁹ Such review, in the court’s opinion, was precisely the type of adjudication barred by *Pilot Life Ins. Co. v. Dedeaux*, which held that an action under 29 U.S.C. 1132(a) is the exclusive vehicle for actions by ERISA plan participants and beneficiaries asserting improper processing of a claim for benefits.¹³⁰ The creation of a state-level judicial forum for asserting a claim for benefits under an ERISA plan resulted in duplication of ERISA’s civil enforcement scheme.¹³¹

The result of the *Hawaii Management* case taken together with the *Rush / Aetna* analyses is that to avoid preemption, an external review law should not allow for judicial review of the decision of the independent reviewer.¹³² Allowing for court review, *Hawaii Management* says, results in preemption of the external review law.¹³³ On the other hand, not allowing for such review likely violates state constitutional constraints relating to separation of powers. In such a circumstance, the external review law might not be preempted, but it may well be unconstitutional.

PART V. IS THERE A WAY TO CUT THIS GORDIAN KNOT?

If the *Hawaii Management* analysis is correct, but if at the same time lack of integration into legal adjudicatory systems violates separation of powers or “open courts” constitutional protections, the result would seem to be either that an external review system is preempted by ERISA or that it is constitutionally invalid – that there can be no valid state-level external review system applicable to ERISA plans. Of course, that would have been the result had the minority in *Rush* prevailed, and it does not yield an unthinkable or cataclysmic result; rather, it would identify and clarify federal policy choices, legislative action or inaction, in its wake. In the alternative, the Supreme Court could sharpen its diction and its message surrounding what it means when it speaks of exclusive remedies under ERISA. Hunter’s suggestion - that the Court made the right decision for the wrong reason in *Rush*, and that the Court should instead reconsider what she believes to be an overly broad reach of ERISA enforcement

¹²⁹ *Id.*

¹³⁰ *Id.*

¹³¹ *See id.* at 966-67.

¹³² That concern led to the introduction of legislation in Hawaii subsequent to the *Hawaii Management* case that would eliminate judicial review of external review decisions. Zachary Antalis, *Hawaii’s Patients’ Bill of Rights: Saving the Right to External Review*, 28 U. HAW. L. REV. 295, 314 (2005).

¹³³ *Haw. Mgmt. Alliance Ass’n*, 100 P.3d at 966-967.

mechanisms¹³⁴ - is a different approach to the conundrum. Which course is best depends on values and biases. One might believe that uniformity in approaches to claims administration and adjudication is desirable for multi-state employers, a belief that informed the heart of ERISA's preemption provisions to begin with, either on the grounds that such is what the employers bargained for (either in their contracts or, more broadly speaking, in their influence on the legislation, in Posnerian¹³⁵ terms) or on the simpler grounds of efficiency, in which case one would not seek contraction of the "exclusive remedy" concept. Those same persons (or others) might believe that state-enforced external review is unneeded, that markets will punish errant health insurers and HMOs that too often appear to be determining claims to be lacking in medical necessity to the benefit of the insurer or HMO. On the other hand, one might believe that the potential for an insurer or HMO to deny claims too readily is strong enough that it is necessary to have what are, in the end, judgments about medical practice being made by a party not associated with the insurer, and that sufficient structural elements can be built into the identification of external reviewers, the standards to be used for review, and the appellate rights of parties involved to assure fairness to all. It would be an extraordinary waste, given the pressures of health care costs and the fundamental integrity of most insurers and HMOs, if, faced with this dilemma, legislators were to adopt a third approach, one clearly safe from any claim of ERISA preemption in taking the form of a mandated benefit, calling for insurers and HMOs to unquestioningly pay for any service a doctor might provide, order or recommend.

¹³⁴ Hunter, *supra* note 3, at 127.

¹³⁵ Judge Posner of the Seventh Circuit Court of Appeals has described legislation as a bargained-for good among interest groups: "The 'interest group' theory asserts that legislation is a good demanded and supplied much as other goods, so that legislative protection flows to those groups that derive the greatest value from it, regardless of overall social welfare..." Richard A. Posner, *Economics, Politics, and the Reading of Statutes and the Constitution*, 49 U. CHI. L. REV. 263, 265 (1982).

ARE STATE COURT GARNISHMENT ACTIONS AN EFFECTUAL IMPEDIMENT TO FEDERAL DECLARATORY JUDGMENT JURISDICTION: IS TIMING EVERYTHING?

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ABSTRACT

This article discusses the efficacy of state court garnishment actions in comparison with federal declaratory judgments, particularly the issue of timing for such decisions in insurance coverage disputes. Jurisdiction of Constitutional Article III courts are largely governed by precedents found in either the *Brilhart* or *Wilton* analyses, and it is responsible for deciding if garnishment actions are removable to federal courts in such disputes. Federal abstention doctrine is also discussed as a discretionary response to ideas of comity, equity, and federalism under various precedential cases from the mid-twentieth century to the current decade. State court garnishments may serve as impediments to federal jurisdiction, and removability for insurance cases is in dispute. Such uncertainties present difficulties for insurers. Abstention doctrine therefore pushes insurers to take declaratory judgment filing actions early in the two situations of removable or non-removable garnishment actions.

The abstention doctrine provides the backdrop for a recurring juridical controversy that arises out of insurance coverage disputes. An insurance claim can produce two nascent suits: one in state and one in federal court.¹

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¹ There have been historical exceptions to the dueling state and federal suits. Prior to 1964, a discrete number of states (most notably Louisiana) had legislation permitting an injured person to bring suit directly against a liability insurer without joining the insured. This made it possible for a state citizen who had been injured by a citizen of that same state to litigate his or her suit in federal court if the state-citizen tortfeasor was insured by an out-

Typically, an injured plaintiff will bring suit against the tortfeasor and litigate liability and damages in state court. At the conclusion of the liability lawsuit through judgment, the plaintiff creditor will initiate a state court garnishment action. Where coverage has been declined, the insurance company, seeking the benefits of federal forum,² will bring a separate declaratory judgment action in federal court. Oftentimes, the insurance company will initiate a federal declaratory judgment action as the state court liability proceedings conclude. Once judgment is entered, the state court plaintiff will bring a second state court action seeking a writ of garnishment against the insurer. The unfortunate insurer then finds itself at an intersection of jurisdictional complications and doctrinal contradictions. The varied courts' holdings on abstention provide that a federal court may decline to exercise federal jurisdiction in a declaratory judgment action any

of-state insurer. *See, e.g.,* *Lumbermen's Mut. Cas. Co. v. Elbert*, 348 U.S. 48 (1954). An overwhelming number of suits were brought in federal court until 1964 when Congress amended 28 U.S.C. § 1332(c) to allow federal jurisdiction only when the insurer defendant in a direct action was a citizen of the insured's state as well as its own. *See* Donald T. Weckstein, *The 1964 Diversity Amendment: Congressional Indirect Action Against State "Direct Action" Laws*, 1965 WIS. L. REV. 268 (1965) (criticizing Congress's amendment of the statute).

² It is commonly recognized that plaintiffs prefer to litigate in state court, whereas defendants prefer federal court. This preference is said to result, in part, from the overburdened federal docket and federal judges' alleged preference for early case dispositions. *See* Abner J. Mikva, *It's Time to "Unfix" the Criminal Justice System*, 20 HASTINGS CONST. L.Q. 825, 829-830 (1993) (the so-called war on drugs has so overburdened the federal judiciary such that getting a civil case tried in federal courts is almost impossible). One commentator has noted that federal judges, in order to reduce their compressed dockets, have increasingly engaged in stringent control of discovery, have aggressively encouraged settlement, and have more frequently granted summary judgment. *See* Jonathan T. Molot, *An Old Judicial Role for a New Litigation Era*, 113 YALE L.J. 27, 39-41 (2003). Federal court is also perceived as more expensive and time consuming. *See* Gregory M. Cesarano and Daniel R. Vega, *So You Thought a Remand was Imminent? Post-Removal Litigation and the Waiver of the Right to Seek Remand Ground on Removal Defects*, 74 FLA. B. J. 22, 23-24 (2000).

Moreover, the forum for litigation may in fact impact the plaintiff's chance for success. Two Cornell law professors authored a study in 1998 which concluded that the plaintiff win rate in removed federal civil cases was 36.7% compared to the overall win rate in federal civil cases generally 57.9%. *See* Kevin M. Clermont & Theodore Eisenberg, *Do Case Outcomes Really Reveal Anything About the Legal System? Win Rates and Removal Jurisdiction*, 83 CORNELL L. REV. 581, 593 (1998). The win statistics in diversity cases is more startling. The win rate in original diversity cases was 71% compared to a 34% win rate in removed cases. *Id.* This disparity may be the result of forum impact. Generally, "removed plaintiffs fare relatively worse before judges than before juries." *Id.* at 601.

time there is a parallel state court proceeding;³ and, a non-forum defendant cannot remove an action to federal court if it is supplemental or ancillary to another action.⁴ Thus, the question insurance companies and the courts must both wrestle is: can a garnishment suit – a derivative of a concluded state court liability and damages claim – be removed to federal court attendant with a federal declaratory judgment action? Or, can a state court garnishment effectively impede litigation of coverage questions in federal court because an Article III court will be compelled to exercise its discretion and decline jurisdiction in lieu of the state court garnishment action?

Effective procedural impediments may exist which preclude removal of the state garnishment action to federal court to unify both the garnishment and federal declaratory judgment proceedings. In this situation, the United State Supreme Court's decision in *Brillhart v. Excess Insurance Company of America*,⁵ provides the analysis to be applied by the federal courts in exercising their discretion to deny jurisdiction where concurrent state and federal cases exist. Invariably, the defense to the garnishment proceedings rests upon the insurance company's ability to establish that it is not a debtor because its insurance policy does not provide coverage for the events which produced the garnishable judgment. Where the garnishment action is non-removable, the insurance company's declaratory judgment action is in jeopardy under federal abstention principles. Where the garnishment action is properly removable, it is unclear whether federal abstention can be avoided. The Supreme Court in *Wilton v. Seven Falls Co.*⁶ failed to delineate the outer boundaries of district court discretion to abstain in cases in which there are no parallel state proceedings. Can a state garnishment action, properly removed to federal court, be used as a basis for a federal

³ See, e.g., *Huth v. Hartford Ins. Co. of the Midwest*, 298 F.3d 800, 803-804 (9th Cir. 2002) (refusing removal when the possibility exists that the insured may bring an analogous declaratory judgment action in state court).

⁴ Unless federal question jurisdiction can be invoked, an action cannot be removed if any named defendant is a citizen of the forum state.

Any civil action of which the district courts have original jurisdiction founded on a claim or right arising under the Constitution, treaties or laws of the United States shall be removable without regard to the citizenship or residence of the parties. Any other such action shall be removable only if none of the parties in interest properly joined and served as defendants is a citizen of the State in which such action is brought.

28 U.S.C. § 1441(b).

⁵ 316 U.S. 491, 495-96 (1942).

⁶ 515 U.S. 277, 290 (1995).

district court judge to abstain from the exercise of jurisdiction under the discretionary Federal Declaratory Judgment Act?

This article will proceed in four parts. Part I will recount the abstruse history of the jurisdiction of Article III courts. Part II will trace the evolution of the variegated iterations of the abstention doctrine. Part III will examine the procedural and substantive characterization of state garnishment actions to assess whether the garnishment action is removable. Where the state garnishment action is not removable, the *Brillhart* analysis will prevail. Where the state garnishment action is removable, the silence of the *Wilton* court on the question of abstention when there is no parallel state court proceeding will be brought into focus. Part IV will analyze the application of federal abstention in cases involving state garnishment actions.

I. THE JURISDICTIONAL HISTORY OF ARTICLE III COURTS

Article III of the United States Constitution vests the judicial power of the United States in the Supreme Court “and in such inferior courts as the Congress may from time to time ordain and establish.”⁷ This devolution of discretion to Congress, resulting from the Madisonian compromise,⁸ has been interpreted as affording Congress authority to not only create or decline to create inferior federal tribunals, but to define the contours of the jurisdiction the lower federal courts will enjoy.⁹ “All federal courts, other than the Supreme Court, derive their jurisdiction wholly from the exercise of the authority to ‘ordain and establish’ inferior courts”¹⁰ Congress’s power to create lower federal courts therefore includes the “power ‘of

⁷ U.S. CONST. art. III, § 1.

⁸ Steven G. Calabresi & Gary Lawson, *The Unitary Executive, Jurisdiction Stripping, and the Hamdan Opinions: A Textualist Response to Justice Scalia*, 107 COLUM. L. REV. 1002, 1033 (2007) (describing the “Tribunals Clause” as a “huge grant of power to Congress, made necessary by the Madisonian compromise.”); John Eidsmoe, *The Article III Exceptions Clause: Any Exceptions to the Power of Congress to Make Exceptions?*, 19 REGENT U. L. REV. 95, 134 (2007) (noting that Madison’s *Notes*, which were released in 1837 demonstrate that Article III, Section 2 was a “Madisonian compromise” to give Congress the choice of creating inferior federal courts.).

⁹ Congress cannot, however, confer upon the lower federal courts jurisdiction greater than that contemplated in the Constitution. In *Seminole Tribe of Fla. v. Florida*, the Supreme Court held Congress was limited by, *inter alia*, the Eleventh Amendment. 517 U.S. 44, 65 (1996) (stating it is “fundamental that Congress could not expand the jurisdiction of the federal courts beyond the bounds of Article III”).

¹⁰ *Lockerty v. Phillips*, 319 U.S. 182 (1943) (Chief Justice Stone writing for a unanimous court).

withholding jurisdiction from them in the exact degrees and character which to Congress may seem proper for the public good.”¹¹

Congress has never deemed it “proper for the public good” to grant to the Article III courts jurisdiction coterminous with that permitted by the Constitution. Rather, every grant of jurisdiction to the lower federal courts has been a gift wrestled from the hands of Congress. The Judiciary Act of 1789,¹² for example, did not provide for federal jurisdiction in cases “arising under [the] Constitution, the laws of the United States, and treaties made....”¹³ Rather, federal question cases had to fall under a more specialized grant of jurisdiction or be litigated in a state court, subject to review in the United States Supreme Court.¹⁴ It was not until 1875 that a Reconstruction Congress provided an enduring grant of general federal question jurisdiction.¹⁵ One commentator referred to the post Civil War broadening of federal judicial power as the greatest expansion in history, stating: “In crabbed and obscure jurisdictional statues a hundred years old we may trace out great shifts of power, shifts that left the nation supreme over the states....”¹⁶ In spite of the magnanimous realignment of power that occurred in 1875, however, limits on federal question jurisdiction remain. Under § 1331,¹⁷ a federal court cannot exercise jurisdiction over a case presenting a federal question unless the federal question appears on the face of the plaintiff’s well-pleaded complaint.¹⁸

¹¹ *Id.*

¹² Judiciary Act of 1789, ch. 20, §§ 9, 11, 1 Stat. 73, 76-78 (1789).

¹³ U.S. CONST. art. III, § 2.

¹⁴ The “Midnight Judges” Bill did provide for federal jurisdiction in cases presenting federal questions. *See* Act of Feb. 13, 1801, § 2, 2 Stat. 89 (repealed 1802). *See, e.g.*, *Bankers Trust Co. v. Texas & Pac. Ry. Co.*, 241 U.S. 295, 303, 305 (1916); *Knights of Pythias v. Kalinski*, 163 U.S. 289, 290 (1896); *Pacific R.R. Removal Cases*, 115 U.S. 1, 10-12 (1885).

¹⁵ Act of March 3, 1875, ch. 137, § 1, 18 Stat. 470 (1875).

¹⁶ William M. Wiecek, *The Reconstruction of Federal Judicial Power, 1863-1875*, 13 AM. J. LEGAL HIST. 333, 333 (1969).

¹⁷ 28 U.S.C.A. § 1331 (2006).

¹⁸ Federal Question Jurisdictional Amendments Act of 1980, Pub L. No. 96-486 § 1, 94 Stat. 2369 (1981) (amending U.S.C. § 1331); *Husvar v. Rapoport*, 430 F.3d 777, 781 (6th Cir 2005) (recognizing that “the plaintiff is the master of the complaint, that the federal question must appear on the face of the complaint, and that the plaintiff may, by eschewing claims based on federal law, choose to have the cause heard in state court”); *Cal. ex rel. Lockyer v. Dynegy, Inc.*, 375 F.3d 831, 838 (9th Cir. 2004) (“well-pleaded complaint” rule...provides that federal jurisdiction exists only when federal question is presented on the face of plaintiff’s properly pleaded complaint).

Article III courts were granted federal diversity jurisdiction in the Judiciary Act of 1789,¹⁹ however, the authority of the lower federal courts to hear cases in which there is diversity of citizenship is still, by no means, unlimited. Despite the constitutional mandate that the federal judiciary power extend to all cases “between citizens of different states,”²⁰ federal diversity jurisdiction cannot be exercised by an Article III court unless the case meets the ever-increasing “amount in controversy” requirement²¹ and there exists *full* diversity among the parties.²² Still, federal diversity jurisdiction has been deemed necessary to provide a neutral forum for out-of-state defendants against perceived local bias by state courts.²³ As Chief Justice John Marshall stated in *Bank of the U.S. v. Deveaux*:

However, true the fact may be, that the tribunals of the states will administer justice as impartially as those of the nation, to parties of every description, it is not less true that the constitution itself either entertains apprehensions on this subject, or views with such indulgence the possible fears and apprehensions of suitors, that it has established national tribunals

¹⁹ Judiciary Act of 1789, ch. 20, § 11, 1 Stat. 73, 78 (1789).

²⁰ U.S. CONST. art. III, § 2. *See also*, THE FEDERALIST NO. 80, at 305 (Alexander Hamilton McLean ed., 1787) (noting “[t]he power of determining causes between two states, between one state and the citizens of another, and between the citizens of different states, is perhaps not less essential to the peace of the union than what has just been examined.”).

²¹ The Judiciary Act of 1789 set the amount in controversy at \$500.00. Judiciary Act of 1789, ch. 20, 1 Stat. 79. In 1887 it was raised to \$2000. *See* The Judiciary Act of 1887, ch. 373, 24 Stat. 552. And in 1911 it was raised to \$3000. *See* The Judiciary Act of 1911, ch. 231, § 24, 36 Stat. 1091. In 1958 the jurisdictional threshold was raised to \$10,000. *See* The Judiciary Act of 1958, PUB. L. NO. 85-554, 72 Stat. 415. In 1988, the amount was raised a final time to \$50,000. *See* The Judiciary Act of 1988, PUB. L. NO. 100-702, 102 Stat. 4646, before reaching the current requirement of \$75,000. *See* The Judiciary Act of 1996, PUB. L. NO. 104-317, 110 Stat. 3847).

²² *Strawbridge v. Curtiss* held that in federal diversity cases, it is insufficient for merely some of the opposing parties to be from different states. Rather, no plaintiff may be from the same state as any defendant. 7 U.S. (3 Cranch) 267, 267-268 (1806). Moreover, Section 1441 of Chapter 28 of the United States Code prohibits removal of an action if a named defendant is a citizen of the forum state, thereby further divesting the federal courts of jurisdiction that would otherwise exist under federal diversity. 28 U.S.C. § 1441 (2000).

²³ *See generally* Patrick J. Borchers, *The Origins of Diversity Jurisdiction, The Rise of Legal Positivism, and a Brave New World for Erie and Klaxon*, 72 TEX. L. REV. 79, 82 (1993) (identifying the historical justifications for federal diversity jurisdiction); *see also* Henry J. Friendly, *The Historic Basis of Diversity Jurisdiction*, 41 HARV. L. REV. 483, 492-93 (1928) (vulnerability of state courts to local pressure was initial justification for federal diversity jurisdiction).

for the decisions of controversies between aliens and a citizen, or between citizens of different states.²⁴

Like federal question and federal diversity jurisdiction, the grant of declaratory judgment jurisdiction to the federal courts was not secured without substantial effort. Passage of the Federal Declaratory Judgment Act (“FDJA”) of 1934²⁵ marked the end of a long-waged campaign for legal reform.²⁶ Advocates for passage of the FDJA viewed traditional common law remedies – awards of damages or injunctive relief – as inadequate.²⁷

Reformers argued social equilibrium can be disturbed not only by direct violations of rights, but also by actions that leave persons in ‘grave doubt and uncertainty’ about their legal positions. In their view, the existing remedial structure failed in three ways. First, it failed to address the plight of a person embroiled in a dispute who, limited by traditional remedies, could not have the controversy adjudicated because the opposing party had the sole claim to traditional relief and chose not to use it. Second, the traditional system of remedies harmed parties by forcing them to wait an unnecessarily long time before seeking relief. Third, the reformers criticized the harshness of damage and injunctive awards. Even when they could be invoked, they were thought to hamper litigants who did not need or desire coercive relief. For the reformers the declaratory judgment was the procedural innovation that would solve these problems.²⁸

However, in spite of widespread support for the FDJA, Congress was concerned that authorizing the federal courts to entertain suits for declaratory judgment was tantamount to allowing prohibited advisory opinions.²⁹ Congressional concerns were quelled when the United States

²⁴ 9 U.S. (5 Cranch), 61, 87 (1809).

²⁵ 28 U.S.C. §§ 2201-02 (2000).

²⁶ Donald L. Doernberg & Michael B. Mushlin, *The Trojan Horse: How the Declaratory Judgment Act Created a Cause of Action and Expanded the Federal Judiciary While the Supreme Court Wasn't Looking*, 36 UCLA L. REV. 529 (1988-1989).

²⁷ *Id.* at 551, 552-53.

²⁸ *Id.* at 551-553.

²⁹ The United States Constitution extends the judicial power only to “cases” and “controversies.” U.S. CONST., art. III, § 2. *See also*, *Pub. Serv. Comm'n v. Wycoff, Co.*, 344 U.S. 237, 244 (1952) (“The disagreement [underlying the declaratory relief action] must not be nebulous or contingent but must have taken on a fixed and final shape so that a court can see what legal issues it is deciding, what effect its decision will have on the adversaries, and some useful purpose to be achieved in deciding them.”); *Old Colony Trust Co. v. Comm’r of Internal Revenue*, 279 U.S. 716, 722 (1929) (considering whether “the proceedings before the Circuit Courts of Appeals or District Courts of Appeals on a petition to review are and can not be judicial, for they involve ‘no case or controversy,’ and without

Supreme Court first reviewed a suit brought under a state declaratory judgment provision³⁰ and when it later upheld the federal act.³¹

The constitutionality of the FDJA was examined in *Aetna Life Ins. Co. of Hartford, Conn. v. Haworth*,³² where the Supreme Court recognized, “[t]he Declaratory Judgment Act of 1934, in its limitation to ‘cases of actual controversy,’ manifestly has regard to the constitutional provision and is operative only in respect to controversies which are such in the constitutional sense.”³³ The *Aetna* court explained that the operation of the FDJA was procedural only, and in providing remedies and defining procedure, Congress was exercising its authority over the jurisdiction of the federal courts.³⁴ In exercising this authority, Congress is not limited to traditional forms of relief or remedy. “The judiciary clause of the Constitution ‘did not crystallize into changeless form the procedure of 1789 as the only possible means for presenting a case or controversy otherwise cognizable by the federal courts.’”³⁵

The *Aetna* court examined what “controversy” meant in the context of the FDJA, holding the controversy must be “justiceable,” meaning it must not be “a difference or dispute of a hypothetical or abstract character” or “academic or moot.”³⁶ Rather, the controversy must be “definite and concrete, touching the legal relations of the parties having adverse legal interests.”³⁷ “It must be a real and substantial controversy admitting of specific relief through a decree of a conclusive character, as distinguished from an opinion advising what the law would be upon a hypothetical state of facts.”³⁸ Thus, the Supreme Court held constitutional the FDJA’s authorization for the federal courts to issue declaratory judgment “in a case

this a Circuit Court of Appeals, which is a constitutional court, is incapable of exercising its judicial function.”); *Muskat v. U.S.*, 219 U.S. 346,356 (1911) (recognizing the federal judicial power is “limited to require an application of the judicial power to cases and controversies.”); *In re Pacific Railway Commission Ry Comm’n*, 32 F. 241, 255 (1887) (recognizing the Eleventh Amendment’s modification of Article III, Section 2 of the Constitution and the requirement of a “case or controversy.”); *Chisholm v. Georgia*, 2 U.S. 419, 431-32 (1793) (discussing the relationship between criminal cases and the “case or controversy” requirement of Article III, Section 2.).

³⁰ *Nashville, Chattanooga & St. Louis R. Co. v. Wallace*, 288 U.S. 249,258 (1933).

³¹ *Aetna Life Ins. Co. v. Haworth*, 300 U.S. 227, 239-240 (1937).

³² *Id.*

³³ *Id.*

³⁴ *Id.* at 240.

³⁵ *Haworth*, 300 U.S. at 240.

³⁶ *Id.*

³⁷ *Id.* at 240-241.

³⁸ *Id.* at 241 (citations omitted).

of actual controversy *within its jurisdiction*.”³⁹ The jurisdictional qualifier incorporated into Congress’s grant of declaratory judgment jurisdiction raises the question: when is it proper for a federal court to abstain from entertaining an action that falls within the literal terms of a Congressional grant of jurisdiction? This question was addressed by the United States Supreme Court in *Fair Assessment in Real Estate Assn., Inc. v. McNary*⁴⁰ and *Great Lakes Dredge & Dock Co. v. Huffman*,⁴¹ and has been answered, in part, by a number of juridical doctrines that provide the federal courts with procedural mechanisms whereby they may refrain from exercising their Congressionally-ordained jurisdiction. These doctrines include the concepts of justiciability,⁴² ripeness,⁴³ *forum non conveniens*,⁴⁴ and exhaustion of remedies,⁴⁵ and the rules restricting the exercise of federal

³⁹ *Id.*

⁴⁰ 454 U.S. 100, 102, 104-105 (1981).

⁴¹ 319 U.S. 293, 296-297 (1943).

⁴² The concept of justiciability allows the court to directly abstain. A federal court may find its determination regarding abstention in the related doctrines of standing and mootness. The Supreme Court has recognized that the doctrine of standing has both a constitutional and a prudential aspect. *See, e.g., Craig v. Boren*, 429 U.S. 190, 193-94 (1996) (recognizing prudential objectives served by *jus tertii* limitations on standing); *Phillips Petroleum Co. v. Shutts*, 472 U.S. 797, 804 (1985) (recognizing the prudential limitation that a “litigant must normally assert his own legal interest rather than those of third parties”); *Warth v. Seldin*, 422 U.S. 490, 500 (1975) (court addressed the prudential limitations that were “closely related to Article III concerns but essentially matters of judicial self-governance”).

⁴³ Discretionary abstention is also reflected in the doctrine of ripeness. A comparison of *Poe v. Ullman*, 367 U.S. 497 (1961) and *Epperson v. Arkansas*, 393 U.S. 97 (1968) makes it difficult to discern whether a particular result rests upon the court’s view of constitutional necessity or on prudential choice. *See, e.g., United Pub. Workers v. Mitchell*, 330 U.S. 75, 89-90 (1947) (challenges to the Hatch Act unripe with the intimation that the result was constitutionally mandated.) Mootness is an intentionally open-ended concept of justiciability. In an action for equitable relief, for example, the reasonable expectation of repetition cannot render the matter moot despite a defendant’s voluntary discontinuance of a challenged practice. *See, e.g., United States v. W. T. Grant Co.*, 345 U.S. 629, 632-33 (1953).

⁴⁴ Another aspect of indirect abstention comes in the form of *forum non conveniens*. *See e.g., Gulf Oil Corp. v. Gilbert*, 330 U.S. 501, 507 (1947) (noting that “the principle of *forum non conveniens* is simply that a court may resist imposition upon its jurisdiction even when jurisdiction is authorized by the letter of a general venue statute.”).

⁴⁵ The federal courts may abstain when a plaintiff has not exhausted alternative routes of relief before seeking a federal forum. As an example, “[a] refusal to enjoin a state criminal proceeding is, in effect, a holding that a federal court will consider the federal claim only on direct review or on habeas corpus, after the state proceeding has come to an end. And *Pullman* abstention represents a decision that a federal court will not consider the constitutionality of a state statute until the plaintiff has sought a clarification of state law . . .

jurisdiction in probate and domestic relations matters.⁴⁶ The federal courts have embraced with ever-increasing latitude, the judicially created doctrine of abstention,⁴⁷ as a basis for declining jurisdiction.

Application of the abstention doctrine was traditionally restricted to cases arising in equity;⁴⁸ however, the doctrine has distended through application and is now applied to “all cases in which a federal court is asked to provide some form of discretionary relief.”⁴⁹ And the federal courts have, over the years, amassed a collection of jurisprudential defenses from which a federal judge may select a predicate for his or her decision to abstain. These include “equitable discretion, federalism and comity,

from a state court.” David L. Shapiro, *Jurisdiction and Discretion*, 60 N.Y.U. L. REV. 543, 558 (1985). See also *Ex Parte Royall*, 117 U.S. 241, 245 (1886) (a prisoner, about ready to be tried in a state court, sought federal habeas corpus relief on the ground that the state statute was unconstitutional). *Id.* at 245. In the opinion, Justice Harlan, observed that the federal court had jurisdiction over the case and that in special circumstances it might be appropriate for a court to grant relief before the conclusion of the state proceedings. *Id.* at 245-50. However, the court held that the state court should typically be permitted to proceed without federal interference so long as the state court was competent to consider the federal claim at involved. *Id.* at 251.

⁴⁶ The view that Article III excludes jurisdiction in domestic relations cases was originally supported by the assertion that certain matters were beyond the historical scope of law and equity. In *Fontain v. Ravenel*, Chief Justice Taney argues in his dissent that the federal courts lacked power to enforce a charitable bequest, as the “chancery jurisdiction” of the federal courts conferred by Article III extended only to matters of which chancery had jurisdiction “in its judicial character as a court of equity,” and not the “prerogative powers, which the king, as *parens patriae*, in England, exercised through the courts,” which remained with the sovereign states. 58 U.S. (17 How.) 369, 391-93 (1854). Taney’s analogy to the chancery courts was subsequently attacked by Judge Weinstein, who, in *Spindel v. Spindel*, criticized the development of the federal domestic relations exception. 283 F.Supp. 797, 802 (E.D.N.Y. 1968). Judge Weinstein challenged the historical premise, noting that matrimonial matters were handled by the ecclesiastical courts and not in chancery acting in its judicial capacity. In *Ankenbrandt v. Richards*, Justice White eschews any mention of the historical arguments about the scope of chancery jurisdiction, instead relying on judicial precedent and Congress’s failure to object to them. 504 U.S. 689, 700-01 (1992).

⁴⁷ *Quackenbush v. Allstate Ins. Co.*, 517 U.S. 706, 716-18, 722 (noting the “abstention doctrine is of a distinct historical pedigree . . .”).

⁴⁸ *Id.* at 717. The *Quackenbush* court stated that “it has long been established that a federal court has the authority to decline to exercise its jurisdiction when it ‘is asked to employ its historic powers as a court of equity.’” *Id.*

⁴⁹ *Id.* at 730. The abstention doctrine is oft used in spite of Justice O’Connor’s notation in *Quackenbush*, that it requires “rare circumstances” for the federal courts to “relinquish their jurisdiction in favor of another forum.” *Id.* at 722. See, e.g., *Great Lakes Dredge & Dock Co. v. Huffman*, 319 U.S. 293, 297 (1943); *Samuels v. Mackell*, 401 U.S. 66, 69-70, 72-73 (1971).

separation of powers, and judicial administration.”⁵⁰ Regardless of the doctrinal justification invoked in a given case, the propriety of an Article III court’s voluntary divestiture of the jurisdiction conferred by Congress is a matter of broad debate.

One side of the debate has ostensible origins in Chief Justice John Marshall’s opinion in *Cohen v. Virginia*,⁵¹ in which Justice Marshall stated, “[w]e have no more right to decline the exercise of a jurisdiction which is given than to usurp that which is not given. The one or the other would be treason to the constitution.”⁵² This is the position championed by Professor Martin H. Redish of Northwestern University School of Law. Professor Redish views a federal court’s invocation of the abstention doctrine as an usurpation of congressional power to define the jurisdiction of the federal courts, which is fundamentally incompatible with basic premises of constitutional democracy.⁵³ Redish argues:

“[t]he fact that Congress theoretically could delegate to the court the power to modify otherwise unlimited legislation [] does not mean that Congress has actually done so. It is this improper leap from theoretical possibilities to assumed fact that ultimately undermines any defense of the [] abstention model from a separation-of-powers attack.”⁵⁴

In *The Federalist No. 80*, however, Alexander Hamilton, writing on the extent of the power of the judiciary outlined in Article III, stated, “[i]f there are such things as political axioms, the propriety of the judicial power of a government being co-extensive with its legislative, may be ranked among

⁵⁰ Shapiro, *supra* note 45, at 579. See also, Gene R. Shreve, *Pragmatism without Politics – A Half Measure of Authority for Jurisdictional Common Law*, 1991 B.Y.U. L. REV. 767, 768, 797, 803 (1991) (arguing abstention is appropriate when based on concerns about judicial administration, but not when based on matters requiring “political choices”).

⁵¹ 19 U.S. (6 Wheat.) 264, 404 (1821).

⁵² *Id.* at 404.

⁵³ Martin H. Redish, *Abstention, Separation of Powers, and the Limits of the Judicial Function*, 94 YALE L.J. 71, 77-79 (1984). See also, Anthony J. Dennis, *The Illegitimate Foundations of the Younger Abstention Doctrine*, 10 U. BRIDGEPORT L. REV. 311, 312 (1990); Donald L. Doernberg, “You can Lead a Horse to Water . . .”: *The Supreme Court’s Refusal to Allow the Exercise of Original Jurisdiction Conferred by Congress*, 40 CASE W. RES. L. REV. 999, 1000-02 (1989-1990).

⁵⁴ MARTIN H. REDISH, *THE FEDERAL COURTS IN THE POLITICAL ORDER: JUDICIAL JURISDICTION AND AMERICAN POLITICAL THEORY* 59-60 (1991).

the number.”⁵⁵ Indeed, the federal jurisdiction decisions seem to suggest that the Supreme Court plays at least as great a role as Congress in defining boundaries of jurisdictional authority.⁵⁶ Legal commentators who address the issue have described the process as a “dialogic process of congressional enactment and judicial response.”⁵⁷ “[A]s experience and tradition teach, the question whether a court must exercise jurisdiction and resolve a controversy on its merits is difficult, if not impossible, to answer in gross. And the courts are functionally better adapted to engage in the necessary fine tuning than is the legislature.”⁵⁸

While opinions on the propriety of abstention proliferate, the federal courts continue to utilize the doctrine as a weir constructed to regulate their case loads. In doing so, the federal courts have sullied the litigation process with an ever-increasing number of externally inconsistent and internally under-justified opinions in which discretionary abstention is exercised.

II. EVOLUTION OF THE ABSTENTION DOCTRINE

The abstention doctrine is a byproduct of the coherence of principles of comity and federalism.⁵⁹ The abstention doctrine may also be surmised as a judicial effort to balance conflicting goals: militating on one side is the desire to eschew premature constitutional determinations, to defer to state

⁵⁵ THE FEDERALIST NO. 80 (Alexander Hamilton).

⁵⁶ See, e.g., *Rose v. Lundy*, 455 U.S. 509, 519-20 (1982) (adopting a “total” exhaustion rule); *Wainwright v. Sykes*, 433 U.S. 72, 85, 90-91 (1977) (changing procedural default test from “deliberate bypass” to “cause and prejudice” without any evidence of changed Congressional intent); *Kuhlmann v. Wilson*, 477 U.S. 436, 449-52 (1986) (discussing Congressional adoption of judicially crafted “ends of justice” standard).

⁵⁷ Barry Friedman, *A Different Dialogue: The Supreme Court, Congress and Federal Jurisdiction*, 85 NW. U. L. REV. 1, 2 (1990).

⁵⁸ Shapiro, *supra* note 45 at 574. See also Richard A. Matasar & Gregory S. Bruch, *Procedural Common Law, Federal Jurisdictional Policy, and Abandonment of the Adequate and Independent State Grounds Doctrine*, 86 COLUM. L. REV. 1291, 1337-38 (1986) (arguing that, at best, abstention can be seen as fine tuning the implicit intent of Congress that is reflected in jurisdictional grants).

⁵⁹ See 17A CHARLES ALAN WRIGHT, ET AL., FEDERAL PRACTICE AND PROCEDURE § 4241 (3d ed. 2007), for a brief comparison of abstention doctrine. In justifying federal abstention, the Supreme Court has expressed concern for comity and federalism interests. The relationships between coordinate state and federal judicial systems is often referred to as “comity.” The relationships between state and federal sovereigns is often referred to as federalism. See also, Randall P. Bezanson, *Abstention: The Supreme Court and Allocation of Judicial Power*, 27 VAND. L. REV. 1107, 1151 (1974) (asserting abstention is the highest form of cooperative judicial federalism).

courts on state law questions, to avoid duplicative proceedings, and to interfere as little as possible with state processes.⁶⁰ Competing interests include upholding a litigant's choice of a federal forum, respecting the policies of the jurisdictional grants, and effectuating timely vindication of federal rights.⁶¹

While there are many types of abstention,⁶² the principle variants are *Pullman* abstention, to allow resolution of unsettled questions of state law;⁶³ *Burford* abstention, exercised in deference to state sovereignty and policies;⁶⁴ and *Younger* abstention, which avoids interference with state criminal proceedings.⁶⁵ These types of abstention “are not rigid pigeonholes into which federal courts must try to fit cases. Rather, they reflect a complex of considerations designed to soften the tensions inherent in a system that contemplates parallel judicial processes.”⁶⁶ The *Pullman*, *Burford*, and *Younger* doctrines are, however, supplemented by a more general requirement that the federal courts yield discretionary jurisdiction when judicial economy demands.⁶⁷

⁶⁰ See 17A CHARLES ALAN WRIGHT ET AL., FEDERAL PRACTICE AND PROCEDURE 3d § 4241 (2007).

⁶¹ The federal court's application of the abstention doctrine has, in some cases, prevented the federal issue from ever being heard. In *United States v. Leiter Minerals, Inc.*, for example, the federal court abstained from hearing the federal issue in deference to state authority, and then dismissed the matter as moot when it returned to the federal court eight years after the abstention doctrine was originally invoked. 381 U.S. 413 (1965).

⁶² Many concepts can be labeled as part of the abstention doctrine. A case in point is exemplified by so-called *Rooker-Feldman* abstention which originated from *Rooker v. Fidelity Trust Co.*, 263 U.S. 413 (1923) and *D.C. Court of Appeals v. Feldman*, 460 U.S. 462 (1983). Under *Rooker-Feldman* abstention, the court recognizes that Congress has conferred original jurisdiction and not appellate jurisdiction on the federal district courts. *Rooker*, 263 U.S. at 415; *Feldman*, 460 U.S. at 486. *Rooker-Feldman* abstention prevents a state court party from having two bites at the apple: one through the state courts with a petition to the U.S. Supreme Court and the other through a subsequent collateral attack originating in the federal courts. *Rooker*, 263 U.S. at 415; *Feldman*, 460 U.S. at 486. Where a party begins litigating a constitutional matter in state court and stops short of petitioning the U.S. Supreme Court, and then initiates litigation in federal court regarding the same constitutional matter, the federal district court can abstain. *Rooker-Feldman* abstention essentially holds that the federal district court does not have appellate jurisdiction over the state court. The state court party should continue through the state court proceeding up through the U.S. Supreme Court.

⁶³ See *R.R. Comm'n of Tex. v. Pullman Co.*, 312 U.S. 496, 501 (1941).

⁶⁴ See *Burford v. Sun Oil Co.*, 319 U.S. 315, 319 (1943).

⁶⁵ See *Younger v. Harris*, 401 U.S. 37, 53 (1971).

⁶⁶ *Pennzoil Co. v. Texaco Inc.*, 481 U.S. 1, 11 n.9 (1987).

⁶⁷ See, e.g., *Brillhart v. Excess Ins. Co. of Am.*, 316 U.S. 491, 495 (1942) (discussing abstention based on concerns of judicial economy and federalism); *Will v.*

A. *PULLMAN* ABSTENTION

The *Pullman* abstention doctrine⁶⁸ arose out of the Supreme Court's decision in *Railroad Comm'n of Texas v. Pullman Co.*⁶⁹ It is to be applied by the federal courts in cases presenting federal constitutional issues and questions of state law, provided that the federal court finds that the federal question presented may be made moot or will otherwise be substantively implicated by a state court determination of the relevant state law question involved in the case.⁷⁰ "When a federal constitutional claim is premised on an unsettled question of state law, the federal court should stay its hand in order to provide the state courts an opportunity to settle the underlying state-law question and thus avoid the possibility of unnecessarily deciding a constitutional question."⁷¹ Thus, the *Pullman* abstention doctrine has traditionally been touted as a reflection of the Supreme Court's doctrinal goal of constitutional avoidance.⁷² *Pullman* abstention may, however, be

Calvert Fire Ins. Co., 437 U.S. 655, 663-64 (1978) (endorsing the *Brillhart* reasoning in a federal declaratory judgment action).

⁶⁸ See, e.g., *Arizonans for Official English v. Arizona*, 520 U.S. 43, 75-76 (1997); *Haw. Hous. Auth. v. Midkiff*, 467 U.S. 229, 236 (1984); *Moses H. Cone Mem'l Hosp. v. Mercury Constr. Corp.*, 460 U.S. 1, 9 (1983); *Moore v. Sims*, 442 U.S. 415, 427-28 (1979); *Ohio Bureau of Employment Servs. v. Hodory*, 431 U.S. 471, 477 (1977); *Harris County Comm'rs Court v. Moore*, 420 U.S. 77, 83 (1975); but cf. *Grove v. Emison*, 507 U.S. 25, 32 n.1 (1993) (stating that while the *Pullman* doctrine is referred to as a form of abstention, "[t]o bring out more clearly, however, the distinction between those circumstances that require dismissal of a suit and those that require postponing consideration of its merits, it would be preferable to speak of *Pullman* 'deferral.' *Pullman* deferral recognizes that federal courts should not prematurely resolve the constitutionality of a state statute...").

⁶⁹ 312 U.S. 496 (1941).

⁷⁰ *Colo. River Water Conservation Dist. v. United States*, 424 U.S. 800, 814 (1976) (quoting *County of Allegheny v. Frank Mashuda Co.*, 360 U.S. 185, 189 (1959)).

⁷¹ *Orr v. Orr*, 440 U.S. 268, 285 (1979) (Powell, J., dissenting). See also *Sims*, 442 U.S. at 427-28 (stating "that a federal action should be stayed pending determination in state court of state-law issues central to the constitutional dispute."); *Elkins v. Moreno*, 435 U.S. 647, 662 (1978); *Hodory*, 431 U.S. at 477 (stating that *Pullman* abstention "involves an inquiry focused on the possibility that the state courts may interpret a challenged state statute so as to eliminate or at least to alter materially, the constitutional question presented."); *Boehning v. Ind. State Employees Ass'n., Inc.*, 423 U.S. 6, 8 (1975); *Askew v. Hargrave*, 401 U.S. 476, 478-79 (1971); *Reetz v. Bozanich*, 397 U.S. 82, 87 (1970); *Dresner v. City of Tallahassee*, 375 U.S. 136, 136-38 (1964); *Clay v. Sun Ins. Office, Ltd.*, 363 U.S. 207, 211-12 (1960); *City of Meridian v. S. Bell Tel. & Tel. Co.*, 358 U.S. 639, 640 (1959); *Spector Motor Serv., Inc. v. McLaughlin*, 323 U.S. 101, 105 (1944); *R.R. Comm'n v. Pullman Co.*, 312 U.S. 496, 499-501 (1941).

⁷² See, e.g., *Cincinnati v. Vester*, 281 U.S. 439, 448-49 (1930) (constitutional questions will not be decided unnecessarily). The roots of *Pullman* abstention cannot be

founded more on concerns relating to the preservation of federalism than on constitutional avoidance. By its own statement, the *Pullman* holding was crafted with the intent to avoid “‘needless friction’ between federal pronouncements and state policies.”⁷³

fully understood without reference to the historical context in which the opinion was issued. Justice Frankfurter suggests in the *Pullman* opinion that the constitutional question “‘touche[d] on a sensitive area of social policy.” *Pullman*, 312 U.S. 498 (1941) (emphasis added). The “sensitive” area to which Justice Frankfurter refers is the same divisive issue that at one time threatened to dissolve the union of the United States. As Professor Resnik points out:

The testimony [in the record] in *Pullman* is filled with discussion of how white women feel ‘a little bit safer ... with a white man conductor in charge of that car’ * * * Further, in an effort to prop up the porters’ claims, the record also includes testimony aimed at distinguishing ‘the Pullman porter[s]’ as ‘pretty high-classed colored men,’ from those other kids of ‘colored men.’

In 1941 it was [] not obvious how federal constitutional law would decide [the equal protection] question [that *Pullman* presented]. It was not easy because national norms did not readily trump local customs and prejudices, indeed because national norms may well have shared such prejudices. Thus the case was ‘sensitive,’ the engagement between federal and state law fraught with anxiety, and if some other point of law could determine the outcome without having to consider announcing federal constitutional rules about discrimination based on race, more the better.

Judith Resnik, *Rereading “The Federal Courts”*: *Revising the Domain of Federal Court Jurisprudence at the End of the Twentieth Century*, 47 VAND. L. REV. 1021, 1039 (1994). It often goes unnoted that *Pullman*’s predecessor, *Siler v. Louisville & Nashville R.R. Co.*, held that if a controverted question of state law was presented in an action that also presented a federal constitutional question, the federal district court should decide the state question first. The doctrine of *Pullman* abstention, therefore, may have been a result of the judiciary’s unwillingness to interfere in race relations in the southern states. *See, e.g.*, *Plessy v. Ferguson*, 163 U.S. 537 (1896) (affirming Louisiana statute providing separate railway carriages for “the white and colored races,” thereby establishing “separate but equal” requirement); *Cumming v. Richmond County Bd. of Educ.*, 175 U.S. 528 (1899) (refusing to interfere in state operation of segregated high schools); *Berea College v. Kentucky*, 211 U.S. 45 (1908) (affirming conviction of private college that violated Kentucky law requiring separation of the races); *Gong Lum v. Rice*, 275 U.S. 78 (1927) (allowing Mississippi to exclude a child of Chinese ancestry from attending school reserved for whites).

⁷³ *Reetz v. Bozanich*, 397 U.S. 82, 87 (1970) (citing *Pullman*, 312 U.S. at 500).

Pullman abstention is an equitable doctrine⁷⁴ and, therefore, cannot be formulaically applied.⁷⁵ Rather, the court must make a *sui generis* determination as to whether the proper combination of elements exist in a given controversy.⁷⁶ In order to exercise *Pullman* abstention, a case must present two conjunctive⁷⁷ elements or “special circumstances.”⁷⁸ There must be an unanswered question of state law⁷⁹ and the unsettled question of state law must be susceptible⁸⁰ to a construction that will moot, limit, or

⁷⁴ Despite the doctrine’s equitable foundations, the court has applied the doctrine, without discussion, to actions at law in several significant cases. See *Fornaris v. Ridge Tool Co.*, 400 U.S. 41, 44 (1970); *United Gas Pipe Line Co. v. Ideal Cement Co.*, 369 U.S. 134, 135-36 (1962); *Clay v. Sun Ins. Office, Ltd.*, 363 U.S. 207, 212 (1960).

⁷⁵ See *Gonzales v. Gonzales*, 536 F.2d 453, 457 (1st Cir. 1976); *Ahrensfeld v. Stephens*, 528 F.2d 193, 196-97 (7th Cir. 1975) (stating abstention is a discretionary, judge-made doctrine to be applied on a case-by-case basis only where special circumstances exist); *Muskegon Theaters, Inc. v. City of Muskegon*, 507 F.2d 199, 201 (6th Cir. 1974) (abstention is equitable doctrine turning on case-by-case facts).

⁷⁶ *Baggett v. Bullitt*, 377 U.S. 360, 375 (1964).

⁷⁷ See, e.g., *Id.* at 375-76 (1964) (abstention not automatic merely because doubtful issue of state law exists); and *Meredith v. City of Winter Haven*, 320 U.S. 228, 234 (1943) (absent a potential limiting of a constitutional issue, abstention is inappropriate because a challenged state law is difficult or uncertain).

⁷⁸ See *Meredith*, 320 U.S. at 234 (describing the two constituent elements as “exceptional circumstances”). The Supreme Court has not been consistent in its determination of when the special circumstances warranting *Pullman* Abstention are present. Compare *Wisconsin v. Constantineau*, 400 U.S. 433, 439 (abstention inappropriate because no ambiguity existed in state statute), with *Reetz*, 397 U.S. 82, 86-87 (abstention appropriate because it was “conceivable” that a state court would interpret the state statute at issue contrary to its clear import, thus avoiding a constitutional question).

⁷⁹ Federal courts should avoid making forecasts of state law. *R.R. Comm’n of Tex. v. Pullman Co.*, 312 U.S. 496, 499-500 (1941). The court in *Baggett* noted that *Pullman* abstention was generally appropriate only when state law issues are complex, unsettled, or unclear. *Baggett*, 377 U.S. at 375 (citing *Propper v. Clark*, 337 U.S. 472, 492 (1949)) (when federal court has been granted jurisdiction, abstention should not impede normal course of action). Under *Baggett*, the federal courts pre-abstention analysis should take into consideration the nature of the unsettled question.

⁸⁰ Similar inconsistencies exist in the Courts’ articulation of whether an unsettled state law question is subject to a limiting construction which is dispositive of the federal question. One articulation requires a challenged statute to be “obviously susceptible to a limiting construction.” *Zwickler v. Koota*, 389 U.S. 241, 251 n.14 (1967) (where state statute not obviously susceptible of a limiting construction, abstention is inappropriate). A different articulation focuses on whether the state statute is “fairly” susceptible to such a construction. See, e.g., *Harman v. Forsinius*, 380 U.S. 528, 534-35 (1965) (where state statute not fairly susceptible to limiting construction, abstention inappropriate). A third articulation finds abstention appropriate where it is “conceivable” that the challenged state statute is amenable to a limiting construction. *Fornaris v. Ridge Tool Co.*, 400 U.S. 41, 43-44 (1970) (abstention appropriate where “conceivable” that phrase in state statute amenable

otherwise alter the consideration the federal court will give to the federal question.⁸¹

While the federal courts may have enjoyed application of *Pullman* abstention at the outset, the Court's enthusiasm for the doctrine seemed to wane once the judiciary was faced with the reality of the resultant delay caused by the prescribed procedure.⁸² Critics argue for abolition of the doctrine on that basis.⁸³ The viability and value of abstention as a judicial construct has ever been criticized by members of the Supreme Court whose reasoning gave form to the doctrine.⁸⁴ The *Pullman* abstention doctrine

to limiting construction). The Court has suggested that these articulations of susceptibility are interchangeable. *See* *Haw. Hous. Auth. v. Midkiff*, 467 U.S. 229 (1984).

⁸¹ *Pullman*, 312 U.S. at 499-501. *See also* *Harris County Comm'rs v. Moore*, 420 U.S. 77, 84 (1975) (where resolution of unclear state law question would avoid or significantly modify the federal constitutional question, abstention is appropriate); *Kusper v. Pontikes*, 414 U.S. 51, 54-55 (1973) (where state statute is susceptible of a construction by the state judiciary that would avoid or modify necessity of reaching a federal constitutional question, abstention is appropriate).

⁸² *See, e.g., Spector Motor Serv., Inc. v. O'Connor*, 340 U.S. 602 (1951) (eight year delay in federal court's adjudication of issue); *United States v. Leiter Minerals, Inc.*, 381 U.S. 413 (1965) (dismissed as moot eight years after abstention was ordered).

The delay associated with *Pullman* abstention merits particular consideration where a state statute is challenged on grounds that it inhibits first amendment freedoms. *Baggett*, 377 U.S. at 378-379. Because the delay from abstention would seriously inhibit the realization of first amendment rights, these claims are exempt from *Pullman* abstention. *See, e.g., Zwickler v. Koota*, 389 U.S. 241, 251-252 (1967). *See also* *Procurier v. Martinez*, 416 U.S. 396, 404 (1974) (where first amendment challenge involved, abstention was inappropriate). *Cf. Babbitt v. United Farm Workers Nat'l Union*, 442 U.S. 289, 308-09 (1979) (Court abstained from deciding first amendment challenge to an ambiguous state law limiting deceptive union publicity aimed at consumers of agricultural products). The Court's concern over the heightened cost of abstention involving first amendment rights has also been expressed in cases involving basic civil liberties. *See, e.g., Harman*, 380 U.S. at 537.

⁸³ *See, e.g., Philip P. Kurland, Toward a Cooperative Judicial Federalism: The Federal Court Abstention Doctrine*, 24 F.R.D. 481, 488-491 (1959); Marth A. Field, *The Abstention Doctrine Today*, 125 U. PA. L. REV. 590, 605-606 (1976-1977); David P. Currie, *The Federal Courts and the American Law Institute*, Part II, 36 U. CHI. L. REV. 268, 317 (1969).

⁸⁴ *See, e.g., England v. La. State Bd. Of Med. Exam'rs*, 375 U.S. 411, 425 (1964) (Douglas, J. concurring), Justice Douglas urged reconsideration of the doctrine:

I was a member of the Court that launched *Pullman* and sent it on its way. But if I had realized the creature it was to become, my doubts would have been far deeper than they were.

Pullman from the start seemed to have some qualities of a legal research luxury. As I said in *Clay v. Sun Ins.*

enjoyed a healthy resurgence, however, under the Burger Court.⁸⁵ In fact, in 1970, the Supreme Court arguably expanded *Pullman* abstention in *Reetz v. Bozanich*⁸⁶ where the Court addressed whether constitutional challenges to state law were appropriately decided by state or federal courts.⁸⁷

Office, 363 U.S. 207, 228, 80 S.Ct. 1222, 1234, 4 L.Ed.2d 1170 (dissenting opinion):

‘Some litigants have long purses. Many, however, can hardly afford one lawsuit, let alone two. Shuttling the parties between state and federal tribunals is a sure way of defeating the ends of justice. The pursuit of justice is not an academic exercise. There are no foundations to finance the resolution of nice state law questions involved in federal court litigation. The parties are entitled-absent unique and rare situations-to adjudication of their rights in the tribunals which Congress has empowered to act.’

As recently stated by the late Judge Charles E. Clark of the Second Circuit Court of Appeals, ‘As a result of this doctrine, individual litigants have been shuffled back and forth between state and federal courts, and cases have been dragged out over eight- and ten-year periods.’ *Federal Procedural Reform and States’ Rights*, 40 TEX. L. REV. 211, 221 (1961).

Professor Charles A. Wright described the results that occurred when this doctrine was applied to a suit to enjoin the enforcement of a state statute restricting the rights of state employees to join unions: ‘* * * after five years of litigation, including two trips to the Supreme Court of the United States and two to the highest state court, the parties still had failed to obtain a decision on the merits of the statute.’ *The Abstention Doctrine Reconsidered*, 37 TEX. L. REV. 815, 818 (1959).

Id.

⁸⁵ Chief Justice Warren Earl Burger served as chief justice from 1969 to 1986. *See, e.g.,* *Babbitt v. United Farm Workers Nat. Union*, 442 U.S. 289 (1979); *Harris County Com’rs Court v. Moore*, 420 U.S. 77 (1975); *Lake Carriers’ Ass’n v. MacMullan*, 406 U.S. 498 (1972).

⁸⁶ 397 U.S. 82, 85 (1970). In *Wisconsin v. Constantineau*, however, the Court upheld the decision of a lower federal court which invalidated a Wisconsin statute providing for public posting, without notice or hearing to the person affected, the name of any person whose excessive drinking produced specified social problems. 400 U.S. 433 (1971). The statute “forbid the sale or gift of intoxicating liquors to one who ‘by excessive drinking’ produces described conditions or exhibits specified traits, such as exposing himself or family ‘to want’ or becoming ‘dangerous to the peace’ of the community.” *Id.* at 434. It was argued that the statute violated both state and federal law. *Id.* Upon review, the United States Supreme Court declined to abstain, stating, “the naked question, uncomplicated by an unresolved state law, is whether that Act on its face is unconstitutional.” *Id.* at 439.

The Supreme Court attempted to reconcile the *Reetz* and *Constantineau* decisions in *Harris County Commissioners Office v. Moore*, in which the high Court ordered a federal court in Texas to abstain in order to allow a Texas state court to construe relevant provisions of the Texas Constitution. 420 U.S. 77 (1975). In *Moore*, a number of displaced justices of the peace and constables, along with voters who had lived in their precincts, brought an action for injunctive relief based on claim that the Texas statute pursuant to which they had been removed violated due process and equal protection clauses of Fourteenth Amendment. *Id.* The Texas statute provided for removal of justices of the peace and constables when boundaries are changed and, as a result, more than the allotted number of justices or constables reside within a changed district. *Id.* The *Moore* court noted that in *Constantineau*, it had declined to order abstention because the “the federal due process claim was not complicated by an unresolved state-law question, even though the plaintiffs might have sought relief under a similar provision of the state constitution.” *Id.* at 85 n.8. However, the Court continued, “where the challenged statute is part of an integrated scheme of related constitutional provisions, statutes, and regulations, and where the scheme as a whole calls for clarifying interpretation by the state courts, we have regularly required the district courts to abstain.” *Id.* (citing *Reetz*).

⁸⁷ *Reetz*, 397 U.S. at 85. Federal litigants are not prohibited from litigating constitutional claims in state court. The litigant who submits the claims to state court will be bound by the state court decision and will not be able to avoid a contrary decision by re-litigating the claims in federal court. *England v. La. Bd. of Med. Exam'rs*, 375 U.S. 411, 419 (1960).

Commentators have criticized this procedure because the “shuttling” of cases between federal and state courts exacerbates the potential for delay already inherent in *Pullman* abstention. See CHARLES ALAN WRIGHT, LAW OF FEDERAL COURTS § 52 at 305-06 (4th ed. 1983); Martha A. Field, *Abstention in Constitutional Cases: The Scope of the Pullman Abstention Doctrine*, 122 U. PA. L. REV. 1071, 1085 (1974) (where author observes that substantial delay occurs due to “shuttling” between federal and state court). However, the Court in *England* justified this delay because the federal plaintiff had the option of avoiding the delay by submitting all issues to the state court. 375 U.S. at 418 (plaintiff may waive the right to federal court and submit his entire case to the state courts, thus avoiding much of the delay and expense associated with the abstention process).

Reetz involved a federal suit for declaratory judgment regarding the constitutionality of Alaska fishing laws and regulations, which limited eligibility to receive certain commercial fishing licenses. 397 U.S. at 83. The *Reetz* plaintiffs argued these regulations violated the Fourteenth Amendment of the Federal Constitution as well as provisions of the Alaska Constitution – one reserving fishing rights to the people and the other proscribing exclusive fishing rights. *Id.* at 84. The case was decided by a federal three-judge court, from which there was direct review by the U.S. Supreme Court. *Id.* at 85. On appeal, the Supreme Court vacated and remanded to the federal court with directions to abstain. *Id.* at 87. The *Reetz* Court cited *Pullman*'s doctrinal aim of avoiding “needless friction” between federal pronouncements and state policies. *Id.* The Court stated, “[t]he instant case is the classic case in that tradition, for here the nub of the whole controversy may be the state constitution. *Id.* The constitutional provisions relate to fish resources, an asset unique in its abundance in Alaska. *Id.* The statute and regulations relate to that same unique resource, the management of which is a matter of great state concern.” *Id.* Certification of unsettled state law issues to the state's highest court may be effective alternative to *Pullman* Abstention. See *Bellotti v. Baird*, 428 U.S. 132, 150-51 (1976)

B. *BURFORD* AND *THIBODAUX* ABSTENTION

In its paradigmatic application, the *Pullman* doctrine involves challenges to state action in which resolution of an unsettled question of state law may eliminate or narrow a corresponding federal question. *Burford v. Sun Oil Co.*,⁸⁸ and *Louisiana Power & Light Co. v. City of Thibodaux*⁸⁹ establish an alternative theory of abstention, sometimes referred to as “administrative” abstention. *Burford* abstention recognizes and gives deference to the sovereignty of state governments in carrying out domestic policy, and endeavors to preempt conflict between state and federal judiciaries.⁹⁰ *Burford* abstention is intended to facilitate the federal courts giving “proper regard for the rightful independence of state governments in carrying out their domestic policy.”⁹¹

(certification saves time, energy and resources and aids in developing cooperative judicial federalism).

⁸⁸ 319 U.S. 315 (1943).

⁸⁹ 360 U.S. 25 (1959).

⁹⁰ *Quackenbush v. Allstate Ins. Co.*, 517 U.S. 706, 727-28 (1991).

⁹¹ *Burford*, 319 U.S. at 318 (quoting *Pennsylvania v. Williams*, 294 U.S. 176, 185 (1935)). The Supreme Court applied *Burford* abstention, rather than *Pullman*, in *Ala. Pub. Serv. Comm. v. Southern R.R.*, and in doing so, provided the first glimpse of the doctrinal juggernaut abstention would become. 341 U.S. 341 (1951). Chief Justice Vinson, writing for the Court, conceded that there was no unsettled question of state law and there was no facial challenge to the constitutionality of a state statute; however, he reasoned:

This Court has held that regulation of intrastate railroad service is ‘primarily the concern of the state.’ . . . Statutory appeal from an order of the Commission is an integral part of the regulatory process under the Alabama Code. . . . And, whatever the scope of review of Commission findings when an alleged denial of constitutional rights is in issue, it is now settled that a utility has no right to relitigate factual questions on the ground that constitutional rights are involved. . . . As adequate state court review of an administrative order based upon predominantly local factors is available to appellee, intervention of a federal court is not necessary for the protection of federal rights. Equitable relief may be granted only when the District Court, in its sound discretion exercised with the ‘scrupulous regard for the rightful independence of state governments which should at all times actuate the federal courts,’ is convinced that the asserted federal right cannot be preserved except by granting the ‘extraordinary relief of an injunction in the federal courts’

Thibodaux involved a proceeding by the City of Thibodaux to take the property of Louisiana Power & Light by eminent domain.⁹² Louisiana Power & Light removed the case to federal court on the basis of diversity

Id. at 346-50. The Supreme Court has not, however, invoked the *Burford* abstention doctrine since *Southern Railroad*. In *McNeese v. Bd. of Educ.*, for example, the Court refused to abstain in a school desegregation case in which the state presented evidence of an administrative procedure available to handle the dispute. 373 U.S. 668, 673-674 (1963). The majority opinion distinguished *McNeese* from *Burford*, stating the federal right at issue was not “in any way entangled in a skein of state law that must be untangled before the federal case can proceed.” *Id.* at 674. Moreover, the Court held, “it is immaterial whether respondents’ conduct is legal or illegal as a matter of state law”. *Id.* Since *Southern Railroad*, the Court’s continued recognition of the *Burford* abstention doctrine is limited to discussion of the doctrine each time it eschews its application. *See, e.g.*, *Colo. River Water Conservation Dist. v. United States*, 424 U.S. 800, 815-16 (1976) (finding *Burford* abstention inappropriate because the state law was settled and although a federal decision might conflict with that of a state tribunal, it would not impermissibly impair state water policy); *Ankenbrandt v. Richards*, 504 U.S. 689, 705-06 (1992) (recognizing that *Burford* abstention would be appropriately applied in a domestic dispute that presents “difficult question of state law bearing on the policy problems of substantial import whose importance transcends the result in the case then at bar,” but holding this is not that case); *New Orleans Pub. Serv., Inc. v. Council of New Orleans*, 491 U.S. 350, 362 (1989) (refusing to apply *Burford* abstention and holding, “[w]hile *Burford* is concerned with protecting complex state administrative processes from undue federal interference, it does not require abstention whenever there exists such a process, or even in all cases where there is a ‘potential for conflict’ with state regulatory law or policy.”); *Quackenbush*, 517 U.S. at 731 (1996) (overturning Ninth Circuit’s application of *Burford*, stating “federal courts have the power to dismiss or remand cases based on abstention principles only where the relief being sought is equitable or otherwise discretionary. Because this was a damages action, we conclude that the District Court’s remand order was an unwarranted application of the *Burford* doctrine.”).

⁹² 360 U.S. 25.

of citizenship.⁹³ The core issue addressed in the case was whether, as a matter of Louisiana law, municipalities had authority to condemn public utility properties.⁹⁴ The action was stayed by the federal district court pending a state declaratory judgment action and a decision by the Louisiana Supreme Court.⁹⁵ The Fifth Circuit Court of Appeals reversed the district court, but was in turn reversed by the United States Supreme Court.⁹⁶

While the Supreme Court's opinion in *Thibodaux* dedicates some time to discussing competing views on the propriety of federal abstention,⁹⁷ the Court's holding is foreshadowed in the opening lines of the opinion, which incorporate a quote from Justice Holmes.⁹⁸ "The fundamental fact is that eminent domain is a prerogative of the state, which on the one hand, may be exercised in any way that the state thinks fit, and, on the other, may not be exercised except by an authority which the state confers."⁹⁹ Justice Holmes words are no less than an oracle, for the Supreme Court directs the lower federal courts to abstain, and the majority opinion concludes extolling the wisdom of the district court judge who saw fit to stay the matter.¹⁰⁰ The Court's holdings in *Thibodaux* and *Burford*, as well as those later cases in which *Burford* abstention was not applied,¹⁰¹ reveal how unpredictably the doctrine can be invoked.

⁹³ *Id.* at 25.

⁹⁴ *Id.* at 26.

⁹⁵ *Id.* at 30.

⁹⁶ *Id.*

⁹⁷ The Court notes, "[w]e have increasingly recognized the wisdom of staying actions in the federal courts pending determination by a state court of decisive issues of state law." *Id.* at 27. However, the Court also recognizes, "that the mere difficulty of state law does not justify a federal court's relinquishment of jurisdiction in favor of state court action." *Id.*

⁹⁸ *La. Power & Light Co. v. City of Thibodaux*, 360 U.S. 25, 26 (1959).

⁹⁹ *Id.* (quoting *Madisonville Traction Co. v. St. Bernard Mining Co.*, 196 U.S. 239, 257 (1905)).

¹⁰⁰ Caught between the language of an old but uninterpreted statute and the pronouncement of the Attorney General of Louisiana, the district judge determined to solve his conscientious perplexity by directing utilization of the legal resources of Louisiana for a prompt ascertainment of meaning through the only tribunal whose interpretation could be controlling—the Supreme Court of Louisiana. The District Court was thus exercising a fair and well-considered judicial discretion in staying proceedings pending the institution of a declaratory judgment action and subsequent decision by the Supreme Court of Louisiana. *See id.* at 30.

¹⁰¹ *See, e.g., Quackenbush v. Allstate Ins. Co.*, 517 U.S. 706, 731 (1996); *Ankenbrandt v. Richards*, 504 U.S. 689, 706 (1992); *New Orleans Pub. Serv., Inc. v. Council of New Orleans*, 491 U.S. 350, 364 (1989); *Colo. River Water Conservation Dist. v. United States*, 424 U.S. 800, 815 (1976).

Regardless of the consistency in application, however, the ambition of the abstention doctrine crafted in *Burford* and *Thibodaux* is a laudable one. The doctrine seeks to secure the sovereignty of the states from federal intrusion.¹⁰² A federalist system that mediates the dual sovereignty of the state and federal governments is a defining feature of our system of government.¹⁰³ The concurrent sovereignty of the states is only limited by the supremacy clause of the Constitution,¹⁰⁴ and the federal government is, by constitutional grant, a government of limited powers.¹⁰⁵ Thus, the states

¹⁰² See *La. Power & Light Co. v. City of Thibodaux*, 360 U.S. 25, 33 (1959); *Burford v. Sun Oil Co.*, 319 U.S. 315, 332 (1943).

¹⁰³ *Gregory v. Ashcroft*, 501 U.S. 452, 457 (1991). For the advantages and disadvantages of the dual sovereignty system see generally Michael W. McConnell, *Federalism: Evaluating the Founders' Design*, 54 U. CHI. L. REV. 1484, 1491 (1987); Deborah Jones Merritt, *The Guarantee Clause and State Autonomy: Federalism for a Third Century*, 88 COLUM. L. REV. 1, 3-10 (1988).

Originally, under the Articles of Confederation, Congress could not directly legislate the American people; it could only do so with the approval of the states. *New York v. United States*, 505 U.S. 144, 163 (1992) (“Congress could not directly tax or legislate upon individuals; it had no explicit ‘legislative’ or ‘governmental’ power to make binding ‘law’ enforceable as such.”) (citing Akhil Reed Amar, *Of Sovereignty & Federalism*, 96 YALE L.J. 1425, 1447 (1987)). The inadequacy of the federal government to directly legislate was responsible in part for the Constitution Convention. *Id.* The Constitutional Convention sought to restructure Congress and give it the power to legislate without the need of state legislatures. Alexander Hamilton addressed this issue in *The Federalist No. 16* by stating:

[the new national government] must carry its agency to the persons of the citizens. It must stand in need of no intermediate legislations ... the government of the Union, like that of each State, must be able to address itself immediately to the hopes and fears of individuals.

THE FEDERALIST NO. 16 at 116 (Alexander Hamilton) (Clinton Rossiter ed., 1961). During the Constitutional Convention, delegates debated two different plans – the Virginia and New Jersey Plans – by which the federal government could exercise its powers. *New York*, 505 U.S. at 164. Under the Virginia Plan, Congress could exercise legislative authority directly without employing the states as intermediaries. *Id.* The New Jersey Plan mirrored the status quo and Congress would continue to require the approval of the states before legislating. *Id.* A repeated objection to the New Jersey Plan was that it might require Congress to coerce the states into implementing legislation. *Id.* Consequently, the Convention adopted a constitution in which Congress would exercise its legislative authority directly over individuals, rather than over states. *Id.* at 165. One reason for adopting the Virginia Plan was to avoid coercing states as separate sovereign entities. Instead, Congress would be able to legally coerce individuals. *Id.*

¹⁰⁴ U.S. CONST., art. VI, cl. 2.

¹⁰⁵ U.S. CONST., amend. X.

concede their sovereign authority only where the Constitution recognizes the supremacy of federal authority.¹⁰⁶

In essence, *Burford* abstention acknowledges that the state court systems have been created by independent state legislatures as an integral part of an administrative system that regulates activities of substantial interest to the many states.¹⁰⁷ State courts are given broad discretion to participate in the development of regulatory policy,¹⁰⁸ and *Burford* abstention gives due recognition to this discretion by limiting federal participation in any case in which exercise of federal jurisdiction may interfere with a state's development of a consistent regulatory policy.¹⁰⁹

C. *YOUNGER* ABSTENTION: EQUITABLE RESTRAINT

The doctrine of equitable restraint established in *Younger v. Harris*¹¹⁰ has its origins in the English Courts of Chancery.¹¹¹ It was a venerable maxim of the Chancery Courts that equity will not enjoin a criminal prosecution.¹¹² The Chancery Courts also embraced the notion that equity will not provide relief unless there is no adequate remedy at law and the

¹⁰⁶ See *Gregory*, 501 U.S. at 457.

¹⁰⁷ See Peter M. Shane, *Interbranch Accountability in State Government and the Constitutional Requirement of Judicial Independence*, 61 LAW & CONTEMP. PROBS. 21, 42-43 (1998) (discussing separation of powers issues raised by the administrative code of state courts).

¹⁰⁸ See *id.* Oftentimes state legislatures make the state courts an integral part of an administrative system that regulates activities of substantial interest to the state. When states grant regulatory power to their courts they grant two forms of discretion. First, they grant discretion to devise remedies that are appropriate given the particular facts at issue. Second, they vest in the courts the discretion to decide whether to grant relief at all.

¹⁰⁹ Courts are divided on whether *Burford* abstention must be premised upon the existence of prior state administrative agency action. Compare *Quackenbush v. Allstate Insurance Co.*, 517 U.S. 706, 733 (1996) (Kennedy J. concurring) (“[t]he fact that a state court rather than an agency was chosen to implement California scheme provided more reason, not less, for the Federal Court to stay its hand.”); *Nelson v. Murphy*, 44 F.3d 497, 500-01 (7th Cir. 1995) (agencies role in dispute was not essential to *Burford* abstention) and *Friedman v. Revenue Mgmt.*, 38 F.3d 668, 671 (2d Cir. 1994) (*Burford* abstention appropriate in absence of agency action) with *St. Paul Ins. Co. v. Trejo*, 39 F.3d 585, 589 (5th Cir. 1994) (“[t]he concerns of governing the *Burford* abstention doctrine are not present in the instant case. St. Paul’s lawsuit does not involve a state administrative proceeding.”).

¹¹⁰ 401 U.S. 37 (1971).

¹¹¹ *Id.* at 44.

¹¹² Shapiro, *supra* note 50, at 550 n. 37.

plaintiff is threatened with irreparable injury.¹¹³ These principles were adopted in the states in the First Judiciary Act, which stated, “suits in equity shall not be sustained in ... the courts of United States, in any case where plain, adequate, and complete remedy may be had at law.”¹¹⁴ This provision, however, precluded equitable relief only if the remedy was available in law in a federal court; it did not alter a criminal defendant’s right to a federal forum.¹¹⁵

The doctrine of *Younger* abstention¹¹⁶ holds, “a federal court should not enjoin a state criminal prosecution begun prior to the institution of the federal suit except in very unusual situations, where necessary to prevent immediate irreparable injury.”¹¹⁷ The *Younger* doctrine speaks to the relationship between the courts of the United States and those of its former

¹¹³ Whitten, *Federal Declaratory and Injunctive Interference with State Court Proceedings: The Supreme Court and the Judicial Discretion*, 53 N.C. L. REV. 591, 598.

¹¹⁴ Judiciary Act of 1789, ch. 20 § 16, 1 STAT. 82 (1789).

¹¹⁵ *Atlas Life Ins. Co. v. W.I. Southern, Inc.*, 306 U.S. 563, 569 (1939).

¹¹⁶ *See generally Ankenbrandt*, 504 U.S. at 689; *New Orleans Pub. Serv., Inc.*, 491 U.S. 350 (1989); *Deakins v. Monaghan*, 484 U.S. 193 (1988). The *Younger* doctrine has been criticized by scholars. *See, e.g.*, Owen W. Fiss, *Dombrowski*, 86 YALE L.J. 1103, 1117-1120 (1977); Judge Gibbons, *Our Federalism*, 12 SUFFOLK U. L. REV. 1087, 1087-1088 (1978); Douglas Laycock, *Federal Interference with State Prosecutions: The Need for Prospective Relief*, 1977 SUP. CT. REV. 193, 194; Aviam Soifer & Hugh C. MacGill, *The Younger Doctrine: Reconstructing Reconstruction*, 55 TEX. L. REV. 1141, 1141-1143 (1977).

¹¹⁷ *Samuels v. Mackell*, 401 U.S. 66, 68 (1971). *See also Colo. River Water Conservation Dist.*, 424 U.S. at 816 (1976) (observing that “abstention is inappropriate where, absent bad faith, harassment, or a patently invalid state statute, federal jurisdiction has been invoked for the purpose of restraining state criminal proceedings.”). Although the *Younger* doctrine has equitable origins, the Supreme Court has, in large part, abandoned the equitable foundation in cases subsequent to *Younger*. *See* George D. Brown, *When Federalism and Separation of Powers Collide – Rethinking the Younger Abstention* 59 GEO. WASH. L. REV. 114, 120 n.56 (1990) (post *Younger* cases have strayed from the equitable rationale); Howard B. Stravitz, *Younger Abstention Reaches a Civil Maturity: Pennzoil Co., v. Texaco Inc.*, 57 FORDHAM L. REV. 997, 1007 (1989) (*Younger*’s progeny toppled the equitable pillar in favor of federalism and comity); Larry W. Yackle, *Explaining Habeus Corpus*, 60 N.Y.U. L. REV. 991, 1042 (1985) (arguing that the Supreme Court has eroded the equitable foundation to the doctrine). Numerous lower court cases have addressed *Younger* as a case based on comity and federalism as opposed to equity. *See, e.g.* *Warmus v. Melahn*, 62 F.3d 252, 255 (8th Cir. 1995) (*Younger* vacated 116 S. Ct. 2493 (1996) (*Younger* Abstention has its roots in comity and federalism); *Schilling v. White*, 58 F.3d 1081, 1084 n.3 (6th Cir. 1995) (*Younger* doctrine is founded in federalism and comity); *Gwyned Properties v. Lower Gwyned Township*, 970 F.2d 1195, 1199-2000 (3d Cir. 1992) (*Younger* abstention arose primarily from the notion of comity).

colonial master. It is also yet another iteration of the federal courts mantra to avoid “undue interference” with state court proceedings.¹¹⁸

The Supreme Court subsequently extended the application of *Younger* abstention to “civil enforcement proceedings,¹¹⁹ [including] civil proceedings involving certain orders that are uniquely in furtherance of the state courts’ ability to perform their judicial functions.”¹²⁰ The Supreme Court, in *Middlesex County Ethics Committee v. Garden State Bar Ass’n*,¹²¹ articulated a three part test for *Younger*’s application: (1) the proceedings must be ongoing;¹²² (2) the proceedings must implicate important state interests;¹²³ and (3) there must be an adequate opportunity in the state court proceeding to raise constitutional challenges.¹²⁴

Prior to the Court’s decision in *Quackenbush v. Allstate Insurance Co.*,¹²⁵ there existed, however, a question as to whether *Younger* abstention was appropriate when a state court defendant sought legal relief.¹²⁶ Before

¹¹⁸ Several federal courts have concluded that adjudication of damages actions does not “unduly” interfere with state proceedings to a level contemplated by the Supreme Court. See, e.g., *Alexander v. Ieyoub*, 62 F.3d 709, 713 (5th Cir. 1995).

¹¹⁹ *New Orleans Pub. Serv., Inc. v. Council of New Orleans*, 491 U.S. 350, 368 (1989) (citing *Huffman v. Pursue, Ltd.*, 420 U.S. 592, 604 (1975)); *Trainor v. Hernandez*, 431 U.S. 434, 444 (1977); *Moore v. Sims*, 442 U.S. 415, 423 (1979). In *Huffman v. Pursue Ltd.* the court expanded *Younger* to encompass quasi-criminal cases. 420 U.S. 592, 607 (1975). In *Moore v. Simms* the court applied *Younger* to a Texas child welfare agency case involving the loss of custody of a child based on allegations of child abuse. 442 U.S. 415, 431 (1979). See also, *Trainor v. Hernandez*, 431 U.S. 434, 447 (1977) (applying *Younger* to attachment proceedings); *Juidice v. Vail*, 430 U.S. 327, 338-39 (1977) (applying *Younger* to appeals of contempt of court and judgment creditor actions). *Younger* has also been applied to non-judicial cases. See, e.g., *Ohio Civil Rights Comm’n v. Dayton Christian Sch., Inc.*, 477 U.S. 619, 622 (1986); *Haw. Hous. Auth. v. Midkiff*, 467 U.S. 229, 237-38 (1984).

¹²⁰ *New Orleans Pub. Serv.*, 491 U.S. at 368 (citing *Juidice v. Vail*, 430 U.S. 327, 336, n.12 (1977) (civil contempt order); *Pennzoil*, 481 U.S. at 13 (1987) (requirement for the posting of bond pending appeal).

¹²¹ 457 U.S. 423 (1982).

¹²² *Id.* at 432.

¹²³ *Id.*

¹²⁴ *Id.*; see also *Ohio Civil Rights Comm’n v. Dayton Christian Sch. Inc.*, 477 U.S. 619, 619-620, 628-629 (1986) (holding that even if complainants in an administrative hearing could not raise First Amendment objections, it was sufficient that the objections could be raised in judicial review of the administrative hearings by the state courts).

¹²⁵ 517 U.S. 706 (1996).

¹²⁶ *Id.* at 719 (citing *Deakins v. Monaghan*, 484 U.S. 193, 202, & n.6 (1988) (reserving the question whether *Younger* requires abstention in an action for damages)); see also Jeremy D. Sosna, Comment, *Quackenbush v. Allstate Insurance Co.: The Continuing Saga of the Younger Doctrine*, 82 IOWA L. REV. 275, 277-78 (1996).

Quackenbush was decided, a considerable number of federal district courts were applying the *Younger* doctrine and abstaining from hearing a matter when legal relief was being sought by the federal court plaintiff.¹²⁷ A unanimous court in *Quackenbush* held that a federal district court does not have the authority to abstain when the district court plaintiff seeks only non-discretionary relief.¹²⁸ While the *Quackenbush* decision only expressly spoke in relation to *Burford* abstention, the context of and equitable justifications for *Younger* abstention, support an argument that *Quackenbush* may also constrain a federal court's power to invoke the principles of *Younger* in cases at law.¹²⁹

D. *BRILLHART V. EXCESS INSURANCE COMPANY*

The exercise of federal jurisdiction under the FDJA is discretionary.¹³⁰ It is not surprising then that the question of whether a federal court should

¹²⁷ See, e.g., *Schilling v. White*, 58 F.3d 1081, 1083-84 n.3 (6th Cir. 1995) (electing to stay proceedings rather than adjudicate a §1983 damages action), *Simpson v. Rowan*, 73 F.3d 134, 137-39 (7th Cir. 1995) (holding that the *Younger* doctrine authorizes the court to stay the damages action pending the outcome of state court proceedings while not directly permitting abstention); *Kyricopoulos v. Town of Orleans*, 967 F.2d 14, 15-16 (1st Cir. 1992) (dictum) (inferring that dismissal of a damages action pursuant to *Younger* was proper; however, the court did not address the issue because the parties waived application of the abstention doctrine), *Traverso v. Penn.*, 874 F.2d 209, 213 (4th Cir. 1989) (staying the federal damages action), *Williams v. Hepting*, 844 F.2d 138, 144-45 (3d Cir. 1988) (also staying federal damages action), *Mann v. Jett*, 781 F.2d 1448, 1449 (9th Cir. 1986) (where damages action would "have a substantially disruptive effect upon ongoing state proceedings *Younger* abstention may be appropriate"), *Giulini v. Blessing*, 654 F.2d 189, 193-194 (2d Cir. 1981) (staying a damages action pursuant to the *Younger* doctrine), *Parkhurst v. Wyoming*, 641 F.2d 775, 777-78 (10th Cir. 1981) (also staying a damages action); *McCurry v. Allen*, 606 F.2d 795, 799 (8th Cir. 1979) *rev'd on other grounds*, 449 U.S. 90 (1980) (staying a damages action).

¹²⁸ In *Quackenbush*, the court did not delineate between broad categories of "equitable" or legal relief. 517 U.S. 706, 730. The court also reviewed various abstention doctrines as a function of "the historic discretion exercised by federal courts 'sitting in equity.'" *Id.* at 716-718. After distinguishing all authority to the contrary, the court held that abstention in damages actions contravened the principles of abstention. *Id.* at 720-21.

¹²⁹ See *Sosna v. Iowa*, 419 U.S. 393, 396-97 n.3 (1975).

¹³⁰ Under the FDJA, a federal court "may declare the rights and other legal relations of any interested party." 28 U.S.C. § 2201 (2001) (emphasis added). Federal jurisdiction in *Pullman* abstention cases is not discretionary; jurisdiction exists over federal questions pursuant to the 1875 Judiciary Act. Judiciary Act of 1875, ch. 137, 18 Stat. 470. Federal jurisdiction in *Burford* abstention cases likely arises through diversity of citizenship; jurisdiction in federal diversity cases was granted to the federal courts in the Judiciary Act of 1789. Judiciary Act of 1789, ch. 20, 1 Stat. 79. Federal jurisdiction in *Younger*

abstain from exercising its jurisdiction in suits brought under the FDJA generated yet another test for application of the abstention doctrine.¹³¹ The question of whether a federal court should abstain from hearing a claim brought under the FDJA most commonly arises when a parallel case is pending in state court at the time the federal court is presented with the declaratory judgment suit.¹³² *Brillhart v. Excess Insurance Co. of America* sets forth the analysis to be applied by the federal courts in exercising their discretion to deny jurisdiction in these concurrent federal cases.¹³³

In fact, *Brillhart* itself involved a request for declaratory judgment brought by Excess Insurance Company of America in federal court while a state suit was pending. Excess asked the federal court to define the extent and nature of Excess's obligations in the pending state court proceeding.¹³⁴ The *Brillhart* court found that it would "ordinarily be uneconomical as well as vexatious for a federal court to proceed in a declaratory judgment suit where another suit is pending in a state court presenting the same issues, not governed by federal law, between the same parties."¹³⁵

The *Brillhart* analysis is designed for consideration of issues of comity, judicial economy, and federalism.¹³⁶ These issues arise when a petition for declaratory judgment is filed in federal court pursuant to the FDJA, and over which the federal court has discretionary jurisdiction, when there is a separate pending state court case that involves additional state law issues.¹³⁷ This is particularly true if the state action includes non-removable state court claims or a forum defendant is named in the state action, precluding its removal pursuant to 28 U.S.C. § 1441(b).

The *Brillhart* Court declined to establish a test for the exercise of federal jurisdiction, however, the lower federal courts have developed from the holding a three-pronged test for determining whether jurisdiction is

abstention cases arises from the grant in the First Judiciary Act. Judiciary Act of 1789, ch. 20, 1 Stat. 82.

¹³¹ In *Quackenbush v. Allstate Insurance Co.*, the Supreme Court found that the various forms of the abstention doctrine had been extended to "certain classes of declaratory judgments..., the granting of which is generally committed to the court's discretion." 517 U.S. at 718. It is interesting to note that in *Great Lakes Co. v. Huffman*, 319 U.S. 293, 297-298 (1943) and *Samuels v. Mackell*, 401 U.S. 66, 69, 72-73 (1971) the Supreme Court recognized that the actions were brought pursuant to the FDJA but did not exercise discretion under this statute; rather, it applied a different form of the abstention doctrine.

¹³² *Maryland Casualty Co. v. Knight*, 96 F.3d 1284, 1288 (9th Cir. 1996).

¹³³ 316 U.S. 491, 495-96 (1942).

¹³⁴ *Id.* at 492-93.

¹³⁵ *Id.* at 495.

¹³⁶ *Gov't Employees Ins. Co. v. Dizol*, 133 F.3d, 1220 1225-26 (9th Cir. 1998).

¹³⁷ *See id.* at 1224.

appropriately exercised. The lower federal courts have identified some variation of the following three factors: (1) a district court should avoid needless determination of state law issues; (2) it should discourage litigants from filing declaratory judgment actions as a means of forum shopping;¹³⁸

¹³⁸ This factor really asks whether the parties are “forum shopping.” The term “forum shopping” typically refers to a party’s act of seeking the most advantageous venue in which to try a particular case. See Lynn M. LoPucki & William C. Whiteford, *Venue Choice and Forum Shopping in the Bankruptcy Reorganization of Large, Publicly Held Companies*, 1991 WIS. L. REV. 11, 14 (1991) (attempting to have a case heard in a forum where it has the greatest chance of success is commonly defined as “forum shopping”); see also Kimberly Jade Norwood, *Shopping for a Venue: The Need for More Limits on Choice*, 50 U. MIAMI L. REV. 267, 268 (1996) (when a party attempts to have its action tried in a particular court or jurisdiction where the most favorable judgment or verdict may be rendered is “forum shopping”). Although “forum shopping” has a pejorative connotation, various courts have recognized the place of forum shopping as part of potential sound litigation strategy. See, e.g., *Goad v. Celotex Corp.*, 831 F.2d 508, 512 n.12 (4th Cir. 1987) (“there is nothing inherently evil about forum shopping”). The court in *Celotex* called forum shopping a “spectre, or ... strawman depending on whose ox is being gored.” *Id.* at 512. Indeed, Justice Rehnquist in *Keeton v. Hustler Magazine Inc.*, 465 U.S. 770, 779 (1984), approvingly refers to the forum shopping strategy, calling it “no different from the litigation strategy of countless plaintiffs who seek a forum with favorable substantive or procedural rules for sympathetic, local populations.” See generally Douglas G. Baird, *Loss Distribution, Forum Shopping and Bankruptcy: A Reply to Warren*, 54 U. CHI. L. REV. 815, 825-26 (1987) (recognizing that once two different courts are available in which to litigate disputes, there is an incentive to forum shop). Indeed, selecting a forum is part of the social fabric. See, e.g., Michael Bradley & Cindy A. Schipani, *The Relevancy of the Duty of Care Standard and Corporate Governance*, 75 IOWA L. REV. 1, 65-66 (1990) (documenting the reincorporation of many firms in Delaware to seek the protection of a new statute limiting directors’ liability). Convenience of counsel may be a strong motivator in the choice of forums. See Neal Miller, *An Empirical Study of Forum Choices in Removal Cases Under Diversity and Federal Question Jurisdiction*, 41 AM. U. L. REV. 369, 400 (1992).

Commentators have written about the abuse of forum shopping. See Kevin M. Clermont & Theodore Isenberg, *Exorcising the Evil of Forum Shopping*, 80 CORNELL L. REV. 1507, 1508 n.1 (1995) (discussing examples of plaintiffs seeking venues in certain south Texas counties where judges are sympathetic and juries are generous). See also *Coast Mfg. Co., Inc. v. Keylon*, 600 F. Supp. 696 (S.D.N.Y. 1985). In that case, the court refused Rule 11 sanctions against plaintiffs’ forum shopping efforts:

[I]t is understandable that litigants will do a small amount of artful conniving to gain access to the diversity jurisdiction of the federal courts, and for a long time such efforts have been tolerated. It is our duty to protect the diversity jurisdiction from abuses of the sort attempted here. In doing so, we need not become punitive.

Id. at 698.

and (3) its should avoid duplicative litigation.¹³⁹ These factors are not, however, exhaustive. An Article III court may also consider, for example, whether a subsequent declaratory judgment action (either in federal or state court) is filed merely for the purposes of procedural fencing.¹⁴⁰

E. *COLORADO RIVER WATER CONSERVATION DISTRICT V. UNITED STATES*

The validity of the *Brillhart* analysis was called into question in *Colorado River Water Conservation District v. United States*, in which the *Pullman*, *Burford*, and *Younger* abstention doctrines were summarized by the Court.¹⁴¹ The Court there identified three situations in which it was appropriate for a federal court to abstain from exercising jurisdiction, which correspond to the three abstention doctrines discussed above:

(a) Abstention is appropriate ‘in cases presenting a federal constitutional issue which might be mooted or presented in a different posture by a state court determination of pertinent state law.’

(b) Abstention is also appropriate where there have been presented difficult questions of state law bearing on policy problems of substantial public import whose importance transcends the result in the case then at bar.

c) Finally, abstention is appropriate where, absent bad faith, harassment, or a patently invalid state statute, federal jurisdiction has been invoked for the purpose of restraining state criminal proceedings, state nuisance proceedings antecedent to a criminal prosecution which are directed at obtaining the closure of places exhibiting obscene films, or collection of state taxes.¹⁴² (citations omitted).

The *Colorado River* court held that abstaining from exercising federal jurisdiction is the exception, not the rule. The court stated that “[a]bdication of the obligation to decide cases can be justified under [the abstention] doctrine only in the exceptional circumstances where the order

¹³⁹ *Dizol*, 133 F.3d at 1225.

¹⁴⁰ *Id.* at 1225 n.5.

¹⁴¹ 424 U.S. 800 (1976).

¹⁴² *Id.* at 814-16.

to the parties to repair to the State court would clearly serve an important countervailing interest.”¹⁴³ The court went on to identify the “exceptional circumstances” that would justify federal abstention as those that exist when there are concurrent proceedings in the state and federal courts and considerations of “wise judicial administration, giving regard to conservation of judicial resources and comprehensive disposition of litigation” suggest that the federal court should abstain.¹⁴⁴

The “exceptional circumstances” test set forth in *Colorado River* was subsequently affirmed and expanded in *Moses H. Cone Memorial Hospital v. Mercury Construction Corp.*¹⁴⁵ The *Moses H. Cone* court formulated two additional factors for the “exceptional circumstances” test: (1) the determination of which forum’s substantive law would govern the merits of the litigation; and (2) the adequacy of the state forum to protect the rights of the parties.¹⁴⁶ The Court emphasized the federal courts’ “virtually unflagging obligation” to exercise the jurisdiction given to them.¹⁴⁷ In spite

¹⁴³ *Id.* at 813.

¹⁴⁴ *Id.* at 817-18.

¹⁴⁵ 460 U.S. 1 (1983).

¹⁴⁶ *Id.* at 23-27. Five justices in *Will v. Calvert Fire Insurance Co.* (Blackmun, J., concurring and four dissenters) supported the consideration of controlling state law as a new factor. 437 U.S. 665, 667-68 (Blackmun, J. concurring); *Id.* at 668-677 (Brennan, J., dissenting).

¹⁴⁷ *Moses H. Cone Memorial Hosp. v. Mercury Const. Corp.*, 460 U.S. 1, 15 (1983). After *Moses H. Cone*, the circuit courts were divided over which standard governed a district court’s decision to stay or dismiss a declaratory judgment action where there were parallel state proceedings. The Third, Fourth, Fifth and Ninth circuits applied the discretionary standard articulated in *Brillhart v. Excess Ins. Co. of America*, 316 U.S. 491, 497-98 (1942) and *Calvert*, 319 U.S. at 663. *See, e.g.*, *Travelers Ins. Co. v. La. Farm Bureau Fed’n Inc.*, 996 F.2d 774, 778 n.12 (5th Cir. 1993) (holding *Colorado River* and *Moses H. Cone* inapplicable in declaratory judgment actions); *Mitcheson v. Harris*, 955 F.2d 235, 237-38 (4th Cir. 1992) (also holding the “exceptional circumstances” test of *Colorado River* and *Moses H. Cone* inapplicable in declaratory judgment actions); *Terra Nova Ins. Co. v. 900 Bar, Inc.*, 887 F.2d 1213, 1223 n.12 (3d Cir. 1989); *Cont’l Cas. Co. v. Robsac Indus.*, 947 F.2d 1367, 1369-70 (9th Cir. 1991); *Chamberlain v. Allstate Ins. Co.*, 931 F.2d 1361, 1366 (9th Cir. 1991) (*Colorado River* test does not apply to declaratory relief actions because they have “special status”).

However, other circuit courts applied the narrow exceptional circumstances test developed in *Colorado River Water Conservation District v. United States*, 424 U.S. 800, 813 (1976), and expanded in *Moses H. Cone*, 460 U.S. 15-16. *See, e.g.*, *Employers Ins. of Wausau v. Mo. Elec. Works*, 23 F.3d 1372, 1374 n.2 (8th Cir. 1994) (following *Colorado River* and *Moses H. Cone*, the district court was not justified in staying or dismissing a declaratory relief action absent “exceptional circumstances”); *Lumbermens Mut. Cas. Co. v. Conn. Bank & Trust Co.*, 806 F.2d 411, 413 (2d Cir. 1986) (also holding that district court should have considered *Colorado River* and *Moses H. Cone* applicable). A middle ground

of the Court's reiteration of this directive, the proposition *Colorado River*¹⁴⁸ stands for is: if the case does not fall within the narrow holdings of *Pullman*, *Burford* and *Younger*, there are other principles which may also be invoked so as to result in the federal court's abstention.¹⁴⁹

F. *WILTON V. SEVEN FALLS COMPANY*

The disparate standards set forth in *Colorado River* and *Brillhart* resulted in a split in the federal courts regarding the proper test for abstention in a federal declaratory judgment action.¹⁵⁰ The Supreme Court granted certiorari in the case of *Wilton v. Seven Falls Company* expressly for the purpose of "resolv[ing] Circuit conflicts concerning the standard governing a district court's decision to stay a declaratory judgment action in favor of parallel state litigation and the applicable standard for an appellate court's review of a district court's decision to stay a declaratory judgment action."¹⁵¹

In determining that *Brillhart* properly governs the abstention question in causes of action brought under the FDJA, the Supreme Court noted the difficulty of reconciling the jurisdictional mandate inherent in the *Colorado River* "exceptional circumstances" requirement with the discretionary nature of federal declaratory judgment jurisdiction.¹⁵² The Court reiterated with approval Professor Borchard's observation that "[t]here is ... nothing

between these two positions can be found. See, e.g., *Fuller Co. v. Ramon I. Gil, Inc.*, 782 F.2d 306, 308-11 (1st Cir. 1986) (where the state court has expended significant resources through the adjudicatory process of the state law claims, federal courts may decline to exercise jurisdiction over a declaratory judgment action).

¹⁴⁸ *Colorado River*, 424 U.S. at 814-17.

¹⁴⁹ *Id.* at 817 (stating that "[a]lthough this case falls within none of the abstention categories, there are principles unrelated to considerations of proper constitutional adjudication and regard for federal-state relations which govern in situations involving the contemporaneous exercise of concurrent jurisdictions, either by federal courts or by state and federal courts.").

¹⁵⁰ Compare *Employers Ins. of Wausau*, 23 F.3d at 1374, n.2 (applying "exceptional circumstances" test of *Colorado River* and *Moses H. Cone*), and *Lumbermens*, 806 F.2d at 413 (2d Cir. 1986) (also applying *Colorado River* and *Moses H. Cone*), with *La. Farm Bureau*, 996 F.2d at 778 n.12 (the "exceptional circumstances" test of *Colorado River* and *Moses H. Cone* is inapplicable in declaratory judgment actions), and *Mitcheson*, 955 F.2d at 237-238 (also holding that there are no reasons to apply *Colorado River* in declaratory judgment cases).

¹⁵¹ 515 U.S. 277, 281 (1995) (citations omitted).

¹⁵² *Id.* at 286-89.

automatic or obligatory about the assumption of ‘jurisdiction’ by a federal court”¹⁵³ to hear a declaratory judgment action. Rather, the Court declared:

By the Declaratory Judgment Act, Congress sought to place a remedial arrow in the district court’s quiver; it created an opportunity, rather than a duty, to grant a new form of relief to qualifying litigants. Consistent with the nonobligatory nature of the remedy, a district court is authorized, in the sound exercise of its discretion, to stay or to dismiss an action seeking a declaratory judgment before trial or after all arguments have drawn to a close. In the declaratory judgment context, the normal principle that federal courts should adjudicate claims within their jurisdiction yields to considerations of practicality and wise judicial administration.¹⁵⁴

Thus, the *Wilton* court concluded that the principles of comity, judicial economy, and federalism incorporated into the *Brillhart* test are those that are determinative of the federal courts’ exercise of jurisdiction in declaratory judgment actions.¹⁵⁵

The *Wilton* Court left open, however, an important question of jurisdictional procedure. The Court specifically narrowed application of its holding, stating, “[w]e do not attempt at this time to delineate the outer boundaries of that discretion in other cases, for example, cases raising issues of federal law or cases in which there are no parallel state proceedings.”¹⁵⁶ Relevant to the insurance coverage context is the question of abstention when an insurer has brought a federal suit for declaratory judgment while the injured plaintiff litigates the defendant tortfeasor’s liability in an underlying state court suit. On the face of it, two such cases do not meet requirements of *Brillhart*, that is, they do not “present[] the same issues ... between the same parties.”¹⁵⁷ *Brillhart*’s application to an insurance coverage issue becomes slightly more convoluted, however, once the liability and damages claim is concluded and the injured state court plaintiff files an action for garnishment against the insurer.¹⁵⁸

G. FEDERAL CIRCUIT DECISIONS POST-*WILTON*

Federal circuit court decisions answering the *Wilton* question have yielded inconsistent results. On the one hand, there is a disheartening trend

¹⁵³ *Id.* at 288.

¹⁵⁴ *Id.*

¹⁵⁵ *Id.* at 289-90.

¹⁵⁶ *Id.* at 290.

¹⁵⁷ *Wilton v. Seven Falls Co.*, 515 U.S. 277, 282 (5th Cir. 1995).

¹⁵⁸ *Id.*

among the circuit courts to inflate the boundaries of *Brillhart* abstention in insurance coverage actions and to view the “parallel state proceeding” as only a factor to be considered in applying *Wilton*, rather than a predicate to *Wilton*’s application.¹⁵⁹ The circuit courts’ movement toward unjustified and mechanical invocation of the abstention doctrine is most poignantly reflected in the recent decisions of the Sixth Circuit Court of Appeal in *Travelers Indemnity Company v. Bowling Green Professional Associates, P.L.C.*¹⁶⁰ The *Bowling Green* decision demonstrates that, in practice, some federal courts have moved so far from the origins of the abstention doctrine that the juridical policies once mirrored in the doctrine are now reflected only as a tarnished doubt as to the propriety of the federal courts’ actions.

There are, however, other federal decisions to consider. There are opinions out of the Eighth,¹⁶¹ Tenth,¹⁶² and Fourth¹⁶³ circuits that mitigate the impact of decisions like *Bowling Green*. These courts recognize that

¹⁵⁹ See, e.g., *Aetna Cas. & Sur. Co. v. Ind-Com Elec. Co.*, 139 F.3d 419, 423 (4th Cir. 1998) (holding “[t]here is no requirement that a parallel proceeding be pending in state court before a federal court should decline to exercise jurisdiction over a declaratory judgment action ... the existence or nonexistence of a state court action is simply one consideration relevant to whether to grant declaratory relief.”); *Polido v. State Farm Mut. Auto. Ins. Co.*, 110 F.3d 1418, 1423 (9th Cir. 1997) (“[T]he dispositive question is not whether the pending state proceeding is ‘parallel,’ but rather, whether there was a procedural vehicle available to the insurance company in state court to resolve the issues raised in the action filed in federal court.”); *Golden Eagle Ins. Co. v. Travelers Cos.*, 95 F.3d 807, 810 (9th Cir. 1996) (stating that the existence of a parallel state court proceeding is a “major factor” in the determination, but “the absence of a parallel state proceeding is not necessarily dispositive; the potential for such a proceeding may suffice.”); *Employers Reins. Corp. v. Karussos*, 65 F.3d 796, 799-801 (9th Cir. 1995) (finding that district court erred in accepting jurisdiction in insurance coverage declaratory judgment action on duties to defend and indemnify state court suit, where the state court action was purely a tort action and did not involve issues of coverage). *Polido*, *Golden Eagle*, and *Karussos* have all been overruled on other grounds by *Gov’t Employees Ins. Co. v. Dizol*, 133 F.3d 1220, 1227 (9th Cir. 1998) (holding that when district court has constitutional and statutory jurisdiction to hear case under the Declaratory Judgment Act, district court may entertain action without *sua sponte* addressing whether jurisdiction should be declined). See also *Sherwin-Williams Co. v. Holmes County*, 343 F.3d 383, 394 (5th Cir. 2003) (“This court finds that a *per se* rule requiring a district court to hear a declaratory judgment action is inconsistent with the discretionary *Brillhart* and *Wilton* standard.... The lack of a pending parallel state proceeding should not automatically require a district court to decide a declaratory judgment action, just as the presence of a related state proceeding does not automatically require a district court to dismiss a federal declaratory judgment action.”).

¹⁶⁰ 495 F.3d 266 (6th Cir. 2007).

¹⁶¹ *Scottsdale v. Detco Indus., Inc.*, 426 F.3d 994, 997 (8th Cir. 2005).

¹⁶² *United States v. City of Las Cruces*, 289 F.3d 1170, 1180-81 (10th Cir. 2002).

¹⁶³ *Aetna Cas. & Sur. Co. v. Ind-Com Elec. Co.*, 139 F.3d 419, 422 (4th Cir. 1998).

the parallel state court proceeding is a prerequisite to application of the broad discretionary standard of *Wilton*.¹⁶⁴ These courts hold that, in the absence of a parallel state court proceeding, an alternative analysis has to be applied to determine whether the federal court should exercise or abstain from exercising its jurisdiction.¹⁶⁵ Emblematic of these courts reasoning is the Eighth Circuit's holding in *Scottsdale v. Detco Indus., Inc.*¹⁶⁶

1. *Bowling Green*

Bowling Green involved a Kentucky state court suit for wrongful death and an action for declaratory judgment brought in the Kentucky District Court.¹⁶⁷ The state court suit for liability and damages was brought against Bowling Green Professional Associates, an out-patient drug treatment facility in Kentucky, after Bowling Green allowed one of its patients, Jonas Wampler, to drive after receiving a methadone treatment.¹⁶⁸ Mr. Wampler navigated his vehicle into the oncoming traffic lane and collided head on with another vehicle, driven by Stephanie Caudill, causing the death of both Mr. Wampler and Ms. Caudill.¹⁶⁹ Both Mr. Wampler and Ms. Caudill brought a wrongful death action against Bowling Green.¹⁷⁰ The federal declaratory judgment action was brought by Bowling Green's insurer, Travelers Indemnity Company.¹⁷¹ Bowling Green's other insurer, Evanston Insurance Company, cross-claimed, seeking declaratory

¹⁶⁴ *Scottsdale*, 426 F.3d at 996-998 (broad discretion granted in *Wilton* does not apply when there are no parallel state court proceedings); *Las Cruces*, 289 F.3d at 1182-84 (requirement that district courts first determine whether the federal and state proceedings are parallel before considering *Colorado River* abstention analysis is consistent with the narrowness of the doctrine); *Aetna Casualty*, 139 F.3d at 423 (noting the existence of a parallel state court proceeding should be a significant factor in the district court's determination).

¹⁶⁵ *Scottsdale*, 426 F.3d at 998 (applying a six factor test to determine whether abstention by the district court would be appropriate in a declaratory judgment action in which there are no parallel state court proceedings); *Las Cruces*, 289 F.3d. at 1183 (applying *Mhoon* five factor analysis in absence of parallel proceedings); *Aetna Casualty*, 139 F.3d at 423 (holding that even in the absence of a state court proceeding, the criteria outlined in *Quarles*, as well as the considerations of federalism, continue to be factors which the district court should balance when determining to assert jurisdiction over a declaratory judgment action).

¹⁶⁶ 426 F.3d 994 (2005).

¹⁶⁷ 495 F.3d 266, 268 (6th Cir. 2007).

¹⁶⁸ *Id.*

¹⁶⁹ *Id.*

¹⁷⁰ *Id.*

¹⁷¹ *Id.* at 269.

judgment on the coverage issue as well.¹⁷² The Kentucky District Court granted the insurers' motions for declaratory judgment and Bowling Green appealed.¹⁷³ On appeal, the Sixth Circuit Court of Appeals *sua sponte* raised the issue of subject matter jurisdiction.¹⁷⁴

In considering whether the federal district court abused its discretion in exercising jurisdiction under the FDJA, the *Bowling Green* court considered the five factors enumerated in *Grand Truck W. R.R. Co. v. Consol Rail Co.*¹⁷⁵ Namely:

- (1) whether the declaratory action would settle the controversy;
- (2) whether the declaratory action would serve a useful purpose in clarifying the legal relations in issue;
- (3) whether the declaratory remedy is being used merely for the purpose of "procedural fencing" or "to provide an arena for a race for *res judicata*;"
- (4) whether the use of a declaratory action would increase friction between our federal and state courts and improperly encroach on state jurisdiction; and
- (5) whether there is an alternative remedy which is better or more effective.¹⁷⁶

The Sixth Circuit supplemented its analysis with three additional factors it previously recognized in *Scottsdale Insurance Company v. Rumph*.¹⁷⁷ These include:

- (1) whether the underlying factual issues are important to an informed resolution of the case;
- (2) whether the state trial court is in a better position to evaluate those factual issues than is the federal court; and
- (3) whether there is a close nexus between the underlying factual and legal issues and state law and/or public policy, or whether federal common law or statutory law dictates a resolution of the declaratory judgment action.¹⁷⁸

¹⁷² *Id.*

¹⁷³ *Travelers Indem. Co. v. Bowling Green Prof'l Assoc.*, 495 F.3d 266, 269 (6th Cir. 2007).

¹⁷⁴ *Id.* at 271.

¹⁷⁵ *Id.* (citing *Grand Truck W. R.R. Co. v. Consol Rail Co.*, 746 F.2d 326 (6th Cir. 1984)).

¹⁷⁶ *Id.* at 271.

¹⁷⁷ *Id.* (citing *Scottsdale Ins. Co. v. Rumph*, 211 F.3d 964, 967 (6th Cir. 2000)).

¹⁷⁸ *Id.*

As to the first two factors, the Sixth Circuit took exception to the District Court's finding that these factors favored an exercise of jurisdiction, holding instead that because the "district court's decision could not settle the controversy in the underlying state court litigation," these factors weighed in favor of abstention.¹⁷⁹

The appellate court recognized that the declaratory judgment action would clarify the legal obligations of the two insurers, however, it held that the declaratory judgment action did nothing to settle the controversy or clarify the legal relationship between the other parties.¹⁸⁰ As to the third

¹⁷⁹ *Travelers Indem. Co. v. Bowling Green Prof'l Assoc.*, 495 F.3d 266, 269 (6th Cir. 2007).

¹⁸⁰ *Id.* at 272. The court noted that the two individuals that had brought wrongful death suits against *Bowling Green*, Mr. Wampler and Ms. Caudill, were not named as defendants in the declaratory judgment action, and as non-parties, they would not be bound by the entry of declaratory judgment. *Id.*

However, had the claims of Mr. Wampler and Ms. Caudill been consolidated with the declaratory judgment action, they could have been heard in federal court. *Id.* The doctrine of pendent jurisdiction allows federal courts to hear state law claims brought jointly with a federal claim in federal court wherein a case is removed to federal court, even though the state law claims could not have been brought separately in federal court because by themselves they do not have an independent basis in federal jurisdiction. See Richard D. Freer, *A Principled Statutory Approach to Supplemental Jurisdiction*, 1987 DUKE L.J. 34, 34 (1987); Arthur R. Miller, *Ancillary and Pendent Jurisdiction*, 26 S. TEXAS L.J. 1, 1 (1985); Note, *Problems of Judicial Power and Discretion in Federal Pendent Jurisdiction Cases*, 7 WM. MITCHELL L. REV. 689, 690 (1981). In *United Mine Workers v. Gibbs*, 383 U.S. 715, 725-27 (1966), the Supreme Court constructed a two prong test for pendent jurisdiction. The state law claims must be closely related to the action which is within the court's statutory jurisdiction. First, "power" exists to hear the state claim brought with the federal claim if both claims derive from a "common nucleus of operative facts: and the claims are such that plaintiff would ordinarily be expected to try them all in one judicial proceeding" *Id.* at 725. This power need not be exercised in every case because its justification lied in considerations of judicial economy, convenience and fairness to litigants; if these are not present a federal court should dismiss the claims without prejudice. *Id.* at 726-27. An intermediate part of the test was added after *Gibbs* which requires the court to determine whether the exercise of jurisdiction would violate a particular federal policy or whether it is an attempt by plaintiff to manufacture federal jurisdiction when it is otherwise foreclosed by statute. *Ambromovage v. United Mine Workers*, 726 F.2d 972, 989-90 (3d Cir. 1984). Both pendent and ancillary jurisdiction are judicial doctrines that permit a Federal Court to exercise jurisdiction over a party or claim normally not within the scope of federal judicial power. Bradford Gram Swing, *Federal Common Law Power to Remand a Properly Removed Case*, 136 U.P.A. L. REV. 583, 584 n.9 (1987). Pendent jurisdiction concerns the resolution of a plaintiff's federal and state law claims against a single defendant in one action while ancillary jurisdiction, on the other hand, typically involves claims by a defending party hauled into court against his will, or by another person whose rights might be irretrievably lost unless he can assert them in an ongoing action in a federal court. Owen

factor, both courts agreed that there was no evidence that the declaratory judgment action brought by the insurers was an attempt at “procedural fencing” or a “race to judgment.”¹⁸¹

As to the fourth factor, the Court of Appeals once again took issue with the District Court’s holding, concluding instead that the Kentucky state court was in a better position to evaluate the terms and exclusions in the insurance contracts because they involved pure questions of state law.¹⁸² In particular, the Court of Appeals held that Kentucky law would govern the determination of whether Bowling Green’s act of allowing Mr. Wampler to leave the facility and drive his car was part of Mr. Wampler’s medical treatment and therefore constituted “medical negligence.”¹⁸³ The Court of Appeals held, “[n]egligence questions are largely reserved to the states,” and “[h]ere, it appears that the issue has not been squarely resolved under Kentucky law.”¹⁸⁴

The Sixth Circuit further explained that the fourth factor did not fall in favor of exercising federal jurisdiction because “insurance contract interpretation are questions of state law with which the Kentucky state courts are more familiar and, therefore, better able to resolve.”¹⁸⁵ In a statement that is reminiscent of the United States Supreme Court’s holdings in *Burford* and *Thibodaux*, the appellate court noted, “states regulate insurance companies for the protection of their residents, and state courts are best situated to identify and enforce the public policies that form the foundation of such regulation.”¹⁸⁶

Equipment Co. v. Kroger, 437 U.S. 365, 370, 376 (1977). Ancillary jurisdiction often arises in the context of counterclaims, cross-claims, third-party claims and interpleaders. *Id.* at 375.

¹⁸¹ Travelers Indem. Co. v. Bowling Green Prof’l Assoc., 495 F.3d 266, 272 (6th Cir. 2007).

¹⁸² *Id.*

¹⁸³ *Id.*

¹⁸⁴ *Id.*

¹⁸⁵ *Id.* at 273.

¹⁸⁶ *Id.*; See *Scottsdale Ins. Co. v. Rounph*, 211 F.3d 964, 968-69 (6th Cir. 2000); *Employers’ Fire Ins. Co. v. Danis Bldg. Constr. Co.*, No. 99-3987, 2000 WL 1234321, at *2 (6th Cir. Aug. 22, 2000); *Omaha Prop. & Cas. Ins. Co. v. Johnson*, 923 F.2d 446, 448 (6th Cir. 1991); *Allstate Ins. Co. v. Mercier*, 913 F.2d 273, 277 (6th Cir. 1990); *Am. Home Assurance Co. v. Evans*, 791 F.2d 61, 63 (6th Cir. 1986); *Manley, Bennett, McDonald & Co. v. St. Paul Fire & Marine Ins. Co.*, 791 F.2d 460, 462 (6th Cir. 1986). *But see*, *Gov’t Employees Ins. Co. v. Dizol*, 133 F.3d 1220, 1225 (9th Cir. 1998) (holding that “there is no presumption in favor of abstention in declaratory actions generally, nor in insurance coverage cases specifically.”).

The court further noted that the “lack of clearly-settled Kentucky precedent on the issue is compounded by the lack of a factual record.”¹⁸⁷ It then compressed its analysis of the supplemental *Roumph* factors into a brief consideration of the fourth factor articulated in *Grand Truck*.¹⁸⁸ The court noted that the fifth factor weighed in favor of state court jurisdiction, and then concluded by vacating the District Court’s judgment and remanding¹⁸⁹ the matter with instructions to dismiss for lack of jurisdiction.¹⁹⁰

As the *Bowling Green* court’s analysis demonstrates, if a federal court is inclined to decline jurisdiction by invoking the abstention doctrine, the abstention analysis is fluid enough to allow it to do so.¹⁹¹ The *Bowling Green* court predicated its decision to abstain on 1) the existence of a dispute regarding the proper interpretation of the insurance contract and 2) a question of negligence, both of which the Court held were appropriately reserved for the states.¹⁹² The existence of a dispute regarding insurance contract interpretation is, however, the *sine qua non* of this genus of declaratory judgment action. And, the coverage dispute that involves some question of negligence is by no means a legal anomaly. If these are appropriate grounds for federal abstention, it is difficult to imagine a declaratory judgment action that would be appropriately heard by a federal court. The Kentucky District Court simply did not reach very far into its reserve before selecting an excuse upon which to base its decision to abstain. This type of irresponsible invocation of abstention is what makes the doctrine such a juridical vice.

¹⁸⁷ *Travelers Indem. Co. v. Bowling Green Assoc.*, 495 F.3d 266, 273 (6th Cir. 2007).

¹⁸⁸ *Id.*

¹⁸⁹ *Id.* Orders denying remand are interlocutory in nature and, thus, are not reviewable except as part of an appeal from final judgment. *See Cervantez v. Bexar County Civil Serv. Comm’n*, 99 F.3d 730, 732 (5th Cir. 1996) (reviewing denial of remand as part of review of final judgment).

“An order remanding a case to the State Court from which it was removed is not reviewable on appeal or otherwise” 28 U.S.C. §1447(d) (1994). The span on appellate review is limited to remand based on the two grounds enumerated in §1447(c). *See Things Remembered, Inc. v. Petrarca*, 516 U.S. 124, 127 (1975) (“section 1447(d) must be read in *pari materiai* with section 1447(c) . . .”).

¹⁹⁰ *Bowling Green*, 495 F.3d at 273-74. Abstention results in either a stay or dismissal of the federal actions. *See, e.g., La. Power and Light Co. v. Thibodaux*, 360 U.S. 25, 30-31 (1959) (stay); *Harris County Comm’r Court v. Moore*, 420 U.S. 77, 88-89 (1975) (dismissal).

¹⁹¹ *Bowling Green*, 495 F.3d at 271-74.

¹⁹² *Id.* at 272-73.

2. *Scottsdale v. Detco Indus., Inc.*

Detco Industries, Inc., which was insured by Scottsdale Insurance Company, was named as a defendant in multiple class action lawsuits in Arkansas state court stemming from a 2004 explosion at its facility in Conway, Arkansas.¹⁹³ Subsequent to the commencement of the state court actions, Scottsdale sought a federal declaratory judgment from the Arkansas District Court that it was not obligated to indemnify or defend Detco in the state court actions.¹⁹⁴ Detco argued for federal abstention, and the District Court granted Detco's motion. Scottsdale appealed the matter to the Eighth Circuit Court of Appeals.¹⁹⁵

The Eighth Circuit's opinion opens with citation to the "exceptional circumstances" mandate set forth by the Supreme Court in *Colorado River*.¹⁹⁶ The Court noted, however, that in *Wilton*, the Supreme Court held that "a federal district court has much broader discretion in determining whether to exercise jurisdiction in a declaratory judgment action during the pendency of parallel state court proceedings."¹⁹⁷ The Court of Appeals recognized that *Wilton* expressly left unanswered the question of whether abstention was appropriate in cases in which there is no parallel state proceeding.¹⁹⁸

The threshold question the court turned to then was whether there was a parallel proceeding pending in state court at the time Scottsdale brought its action for federal declaratory judgment.¹⁹⁹ The Eighth Circuit answered that question in the negative, relying in large part on the requirement that the parallel suit involve the "same issues . . . between the same parties," as set forth by the Supreme Court in *Brillhart* and later reiterated by the Fourth Circuit in *New Beckley Mining Corp. v. Int'l Union, United Mine Workers of America*.²⁰⁰ The court noted that Scottsdale was not a defendant in the state court suit and the state court matters did not involve the same issues as the declaratory judgment action, which was limited to a determination of coverage.²⁰¹

¹⁹³ *Scottsdale Ins. Co. v. Detco Indus., Inc.*, 426 F.3d 994, 996 (8th Cir. 2005).

¹⁹⁴ *Id.*

¹⁹⁵ *Id.*

¹⁹⁶ *Id.*

¹⁹⁷ *Id.*

¹⁹⁸ *Id.*

¹⁹⁹ *Scottsdale*, 426 F.3d at 997.

²⁰⁰ 946 F.2d 1072, 1073 (4th Cir. 1991); *Scottsdale v. Detco Indus. Inc.*, 426 F.3d 994, 997 (8th Cir. 2005).

²⁰¹ *Scottsdale*, 426 F.3d at 997.

Having determined there was no parallel state proceeding, the court then inquired into whether abstention may be appropriately exercised by a federal court entertaining jurisdiction under the FDJA.²⁰² The Court of Appeals read *Wilton* as granting the federal courts greater latitude in exercising or abstaining from exercising their jurisdiction only when there is a parallel state proceeding.²⁰³ While the court declined to return to the “exceptional circumstances” standard of *Colorado River* when no parallel proceeding exists, it did hold that the considerations of practicality and wise judicial administration that allow a district court to exercise greater discretion than otherwise granted by the FDJA were diminished and abstention would, accordingly, be inappropriate.²⁰⁴ Thus, the court struck a balance between the standard of *Colorado River* and *Wilton* by “allowing the federal district court some, but not complete, discretion in determining whether to dismiss or stay declaratory judgment actions when there are no parallel state court proceedings.”²⁰⁵

²⁰² *Id.*

²⁰³ *Id.*

²⁰⁴ *Id.* at 999. As the Court notes in *Scottsdale*, the holding concurs with the holdings of a number of other circuit court holdings. See, e.g., *United States v. City of Las Cruces*, 289 F.3d 1170, 1188 (10th Cir. 2002) (establishing a five factor test for cases in which there is no pending parallel state action: (1) whether a declaratory action would settle the controversy; (2) whether it would serve a useful purpose in clarifying the legal relations at issue; (3) whether the declaratory remedy is being used merely for the purpose of procedural fencing or to provide an arena for a race to *res judicata*; (4) whether use of declaratory action would increase friction between our federal and state courts and improperly encroach upon state jurisdiction; and (5) whether there is an alternative remedy which is better or more effective); *Scottsdale*, 211 F.3d at 968 (examining the question of federal abstention when there is no parallel state proceeding under the same factors as articulated by the court in *Las Cruces*); *Aetna Cas. & Surety Co. v. Ind-Com Electric Co.*, 139 F.3d 419, 422 (4th Cir. 1998) (*per curiam*) (defining a six part test for cases in which there is no parallel state court proceeding: (1) whether the declaratory judgment sought “will serve a useful purpose in clarifying and settling the legal relations in issue”; (2) whether the declaratory judgment “will terminate and afford relief from the uncertainty, insecurity, and controversy giving rise to the [federal] proceeding”; (3) “the strength of the state’s interest in having the issues raised in the federal declaratory judgment action decided in the state courts”; (4) “whether the issues raised in the federal action can more efficiently be resolved in the court in which the state action is pending”; (5) “whether permitting the federal action to go forward would result in unnecessary ‘entanglement’ between the federal and state court systems, because of the presence of ‘overlapping issues of fact or law’ “; and (6) “whether the declaratory judgment action is being used merely as a device for ‘procedural fencing’—that is, ‘to provide another forum in a race for *res judicata*’ or ‘to achiev[e] a federal hearing in a case otherwise not removable.’”).

²⁰⁵ *Scottsdale*, 426 F.3d at 998.

The Eighth Circuit then applied the six-factor test articulated by the Fourth Circuit in *Aetna Casualty & Surety Co. v. Ind-Com Electric Company*²⁰⁶ – in substance, the same test that the Sixth Circuit applied in *Bowling Green*. That test considers: (1) whether the declaratory judgment sought “will serve a useful purpose in clarifying and settling the legal relations in issue”; (2) whether the declaratory judgment “will terminate and afford relief from the uncertainty, insecurity, and controversy giving rise to the [federal] proceeding”; (3) “the strength of the state’s interest in having the issues raised in the federal declaratory judgment action decided in the state courts”; (4) “whether the issues raised in the federal action can more efficiently be resolved in the court in which the state action is pending”; (5) “whether permitting the federal action to go forward would result in unnecessary ‘entanglement’ between the federal and state court systems, because of the presence of ‘overlapping issues of fact or law’”; and (6) “whether the declaratory judgment action is being used merely as a device for ‘procedural fencing’-that is, ‘to provide another forum in a race for *res judicata*’ or ‘to achiev[e] a federal hearing in a case otherwise not removable.’”²⁰⁷

The appellate court quickly found the first, second, third, and fourth factors weighed in favor of exercising federal jurisdiction.²⁰⁸ The court determined that the declaratory judgment action would “clarify and settle the legal relations at issue and would afford relief from the uncertainty, insecurity, and controversy between Scottsdale and Detco.”²⁰⁹ The court further held that the record does not reflect any particular state interest in having the issues decided in state court, and that judicial economy would be served by having the coverage issues decided in federal court – the only court in which the matters had been raised for resolution.²¹⁰

The court looked more critically at the fifth factor – whether the federal action would result in any unnecessary entanglement between the federal and state court systems.²¹¹ Here, the Eighth Circuit recognized a distinction that the Sixth Circuit Court of Appeals could not seem to find.²¹² The Eighth Circuit carefully delineated between the factual determinations that were necessary for resolution of the state court tort action against Detco

²⁰⁶ 139 F.3d at 422.

²⁰⁷ *Scottsdale*, 426 F.3d at 998.

²⁰⁸ *Id.* at 999.

²⁰⁹ *Id.*

²¹⁰ *Id.*

²¹¹ *Id.* at 999-1000.

²¹² *Id.*

and the factual determinations required in deciding the coverage issue.²¹³ The Eighth Circuit importantly recognized that the coverage issue was properly resolved based on the allegations on the face of the complaint, not on the judicial determinations made as to the validity of those allegations.²¹⁴ Thus, the court held the fifth factor also weighed in favor of the federal district court exercising its discretionary jurisdiction.²¹⁵ As to the sixth factor, the *Scottsdale* court was unable to glean any improper motive from Scottsdale's federal filing.²¹⁶ Accordingly, the decision of the district court was overturned and the matter remanded to federal court.²¹⁷

III. CAN A STATE COURT GARNISHMENT SUIT SERVE AS AN EFFECTIVE IMPEDIMENT TO FDJA JURISDICTION?

Section 1441 of Chapter 28 of the United States Code, Subsection (a) allows any civil action over which there is federal jurisdiction to be removed from state to federal court.²¹⁸ A suit which is merely ancillary or supplemental to another action, however, cannot be removed to federal court under this statute.²¹⁹ The federal courts are divided on the question of whether a garnishment proceeding is an ancillary proceeding or an independent civil action.²²⁰ According to one district court "the prevailing standard among the circuits is to permit removal of a garnishment action."²²¹ There are, however, a number of district and circuit courts that

²¹³ *Scottsdale*, 426 F.3d at 999-1000.

²¹⁴ *Id.*

²¹⁵ *Id.* at 1000.

²¹⁶ *Id.*

²¹⁷ *Id.*

²¹⁸ 28 U.S.C. § 1441(a) (2000).

²¹⁹ *Fed. Savings & Loan Ins. Corp. v. Quinn*, 419 F.2d 1014, 1018 (7th Cir. 1969) (recognizing that "[u]nder the general removal statute, 28 U.S.C. § 1441, only independent suits are removable."); *Adriaenssens v. Allstate Ins. Co.*, 258 F.2d 888, 890 (10th Cir. 1958) (addressing challenge to removal based on argument that garnishment action was supplemental to the suit determining liability).

²²⁰ *See, e.g.*, *Richmond v. Allstate Ins. Co.*, 624 F. Supp. 235, 236 (E.D. Pa. 1985) (noting "[t]here is no controlling precedent or consensus among the federal courts on the question of whether garnishment actions should be treated as ancillary or independent civil actions."); *Bridges v. Bentley*, 716 F. Supp. 1389, 1391 (D. Kan. 1989) (recognizing that the federal courts are divided on the question of whether a garnishment action is independent or ancillary to the primary action.).

²²¹ *Wausau Ins. Cos. v. Koal Indus. Int'l, Inc.*, 811 F. Supp. 399, 400 (S.D. Ind. 1991).

have adopted the opposing view.²²² As the Pennsylvania District Court noted in *International Organization Masters, Mates & Pilots of America, Local No. 2 v. International Organization Masters, Mates and Pilots of America, Inc.*, “[t]he garnishment cases constitut[e] the most numerous category of ‘ancillariness’ decisions ... [and] the courts are hopelessly divided in their results and reasoning.”²²³

In answering the question of whether a garnishment action is removable, the federal courts are confronted with a separate and related question on which they are also divided – whether the nature of a garnishment proceeding should be determined by state or federal law.²²⁴ Those courts that hold the state characterization of the garnishment action is determinative base their position on the United States Supreme Court’s decision in *Erie R. Co. v. Tompkins*.²²⁵ The *Erie* doctrine from which it derived, provides that the substantive law of the state is to be applied when the claim is brought in federal court based diversity of citizenship and amount in controversy.²²⁶ The question of whether state or federal law governs the characterization of a proceeding is in some sense determinative of the answer to whether a garnishment proceeding is ancillary or independent. Accordingly, the courts’ holdings on whether state or federal

²²² Compare, e.g., *Barry v. McLemore*, 795 F.2d 452, 455 (5th Cir. 1986); *Butler v. Polk*, 592 F.2d 1293, 1295 (5th Cir. 1979); *Swanson v. Liberty Nat. Ins. Co.*, 353 F.2d 12, 13 (9th Cir. 1965); *Randolph v. Employers Mut. Liab. Ins. Co. of Wis.*, 260 F.2d 461, 464 (8th Cir. 1958); *Adriaenssens v. Allstate Ins. Co.*, 258 F.2d 888, 889-90 (10th Cir. 1958); *Stoll v. Hawkeye Cas. Co. of Des Moines*, 185 F.2d 96, 99 (8th Cir. 1950); *Smotherman v. Caswell*, 755 F. Supp. 346, 348 (D. Kan. 1990) (garnishment is an independent civil action and removable) with *Am. Auto Ins. Co. v. Freundt*, 103 F.2d 613, 616-17 (7th Cir. 1939); *Murray v. Murray*, 621 F.2d 103 (5th Cir. 1980); *W. Med. Prop. Corp. v. Denver Opportunity, Inc.*, 482 F. Supp. 1205, 1207 (D. Colo. 1980); *Overman v. Overman*, 412 F. Supp. 411, 412 (E.D. Tenn. 1976); *Hoagland v. Rost*, 126 F. Supp. 232, 234 (W.D. Mo. 1954); *Toney v. Md. Cas. Co.*, 29 F. Supp. 785, 786 (W.D. Va. 1939); *Oppenheim v. Cir. Ct. of Eleventh Jud. Cir.*, 438 N.E.2d 176, 179 (Ill. 1982) (garnishment is ancillary to the original judgment and non-removable).

²²³ 342 F. Supp. 212, 214 (E.D. Pa. 1972).

²²⁴ Compare, e.g., *Richmond v. Allstate Ins. Co.*, 624 F. Supp. 235, 237 (E.D. Pa. 1985); *Chicago, Rock Island & Pac. R.R. Co. v. Stude*, 346 U.S. 574, 580 (1953); *Graef v. Graef*, 633 F. Supp. 450, 452; *Swanson*, 353 F.2d 12, 13; *Bridges*, 716 F. Supp. at 1391 (character of garnishment to be determined by federal law) with *Overman*, 412 F. Supp. at 412; *Toney*, 29 F. Supp. 785, 786; *Oppenheim*, 438 N.E.2d at 179 (applying state law to determine whether garnishment action is independent or ancillary).

²²⁵ 304 U.S. 64 (1938).

²²⁶ *Id.* See *Swanson v. Sharp*, 224 F. Supp. 850, 851 (D. Alaska 1963) (noting application of *Erie* doctrine to removal of garnishment actions).

law governs the characterization of a garnishment action will be discussed first.

A. SHOULD STATE OR FEDERAL LAW GOVERN THE CHARACTERIZATION OF A GARNISHMENT ACTION?

The Supreme Court has held that the right of removal under the federal statutes is to be determined under federal law by the federal courts, and that classification by the state courts can neither limit nor enlarge that right.²²⁷ This is the position that has been adopted by a majority of the federal courts.²²⁸ In *Swanson v. Liberty Nat. Ins. Co.*, for example, the Ninth Circuit held that “separability, so far as it affects removal, is in the end a federal question.”²²⁹ In *Swanson*, the Ninth Circuit noted that, while the state court’s characterization of a garnishment proceeding should “be entitled to great weight,” the Ninth Circuit subscribes to the view that the removal issue is a matter of federal law.²³⁰ Similarly, in *Randoph*, the Eighth Circuit Court of Appeals stated, “[t]he question of whether a civil action is removable and has been properly removed is one for the consideration of the federal court and is not controlled by State law.”²³¹

In spite of the Supreme Court’s holding in *Chicago, Rock Island & Pacific Railroad v. Stude*,²³² and the federal court holdings that followed, a discrete minority of federal and state courts still apply state law in determining whether a garnishment action is independent of or ancillary to another proceeding. Some courts that allow state law characterization of a garnishment action to control removal turn to the applicable state statute, recognizing that “if a state characterizes its garnishment as a distinct ‘civil action,’ it is removable, but if the state fashions the proceeding as just supplemental to the underlying cause of action, then it is not removable under 1441(a).”²³³ The Tenth Circuit, for example, has looked to Oklahoma’s garnishment statute in order to determine whether a

²²⁷ See, e.g., *Stude*, 346 U.S. at 580; *Shamrock Oil & Gas Corp. v. Sheets*, 313 U.S. 100, 104 (1941); *Comm’rs of Rd. Improvement Dist. v. St. Louis S.W. Ry. Co.*, 257 U.S. 547, 548 (1922); *Harrison v. St. Louis & S. F. R.R.*, 232 U.S. 318, 319 (1914).

²²⁸ See, e.g., *Randoph v. Employers Mut. Liab. Ins. Co.*, 260 F.2d 461, 464 (8th Cir. 1958); *Paxton v. Weaver*, 553 F.2d 936, 940-41 (5th Cir. 1977); *Federal Savings and Loan Ins. Co. v. Quinn*, 419 F.2d 1014, 1019 (7th Cir. 1969).

²²⁹ 353 F.2d 12, 13 (9th Cir. 1965).

²³⁰ *Id.*

²³¹ 260 F.2d at 463.

²³² 346 U.S. 574 (1953).

²³³ *Graef v. Graef*, 633 F. Supp., 450, 452 (E.D. Pa. 1986).

garnishment action is a separate or ancillary proceeding.²³⁴ The courts of Colorado,²³⁵ Maryland,²³⁶ and Tennessee²³⁷ have, similarly, examined the governing statutes of their respective states in making the characterization determination. Elsewhere, courts applying the state law characterization have done so based on application of an “ancillariness” test.²³⁸ These courts have considered “(1) whether a separate issue of fact might be raised in the garnishment proceeding, and (2) whether the proceeding was adversarial, calling for judgment independent of the underlying cause.”²³⁹

A number of courts, however, have eschewed the question of whether state or federal law governs all together by simply developing an “ancillariness” test and applying it to the garnishment action in question. In *Scanlin v. Utica First Ins. Co.*, for example, the court posed three questions to determine whether the garnishment action at issue there was removable: (1) whether the garnishment proceeding was substantially a continuation of the prior state court suit; (2) whether the issue in the garnishment action was completely separate from the central issue in the state court proceeding; and (3) whether the “true” defendant was the same in the garnishment action.²⁴⁰ This three part test was also adopted by the Pennsylvania federal court in *Haines by Midlantic Bank, N.A. v. Donn’s Inc.*²⁴¹

In *Connecticut Bank of Commerce v. Republic of Congo*, the Delaware federal court set forth four considerations in making its determination that a

²³⁴ *Fleeger v. Gen. Ins. Co. of Am.*, 453 F.2d 530, 532 (10th Cir. 1972) (looking to Oklahoma law to determine the nature of a garnishment action); *London & Lancashire Indem. Co. of Am. v. Courtney*, 106 F.2d 277, 281 (10th Cir. 1939) (used Oklahoma law to resolve a garnishment action).

²³⁵ *W. Medical Prop. Corp. v. Denver Opportunity, Inc.*, 482 F. Supp., 1205, 1207 (D. Colo. 1980); *Zurich Ins. Co. v. Bonebrake*, 320 P.2d 975, 976 (Colo. 1958); *Wright v. Nelson*, 242 P.2d 243, 247-48 (Colo. 1952).

²³⁶ *Toney v. Md. Cas. Co.*, 29 F. Supp., 785, 786 (W.D. Va. 1939).

²³⁷ *Overman v. Overman*, 412 F. Supp. 411, 412 (E.D. Tenn. 1976); *Rowland v. Quarles*, 100 S.W.2d 991, 994 (Tenn. Ct. App. 1936).

²³⁸ *See Scanlin v. Utica First Ins. Co.*, 426 F. Supp. 2d 243, 249–50 (M.D. Penn. 2006); *Conn. Bank of Commerce v. Rep. of Congo*, 440 F. Supp. 2d 346, 350 (D. Del. 2006); *Silverman v. China Nat’l. Native Produce & Animal By-Products Imp. & Exp. Corp.*, No. 06cv1710, 2007 WL 518605, at *6 (W.D.Pa. Feb. 12, 2007); *Nat’l Ass’n. of Reg. Util. Comm’rs v. F.C.C.*, 533 F.2d 601, 615 (D.C. Cir. 1976).

²³⁹ *Moore v. Sentry Ins. Co.*, 399 F. Supp. 929, 930 (S.D. Miss. 1975); *Smotherman v. Caswell*, 755 F. Supp. 346, 349 (D. Kan. 1990); *Graef v. Graef*, 633 F. Supp., 450, 452 (1986).

²⁴⁰ *Scanlin v. Utica First Ins. Co.*, 426 F. Supp. 2d 243, 249 (M.D.Pa. 2006).

²⁴¹ No. 95-1025, 1995 WL 262534, at *2 (E.D. Pa. April 27, 1995).

state court garnishment action was a separate and independent civil action.²⁴² In particular the Delaware Court considered (1) whether Delaware garnishment proceedings present a “separate process to which the original debtor is not a party and the purpose of which is to determine the legality of the attachment”; (2) whether the garnishment action present substantive “issues for resolution that are distinct from the original state action”; (3) whether the “true” defendant in the garnishment action was the garnishee; and (4) whether the federal court would have to engage in any “duplicate” function of the state court in adjudicating the garnishment action.²⁴³

B. CAN A STATE COURT GARNISHMENT ACTION BE REMOVED TO FEDERAL COURT IF A FEDERAL ACTION RELATING TO THE LIABILITY UNDERLYING THE GARNISHMENT IS PENDING?

While there is no consensus among the courts regarding whether a garnishment proceeding is in fact removable or whether state or federal law appropriately governs the issue of characterization, there are some strong trends with respect to the question of removal. The most pronounced of these by far seems to be the removal of garnishment actions brought against an insurer after the underlying issues of the defendant tortfeasor’s liability and damages have been litigated in state court. There are a number of federal court opinions addressing this recurring issue. Regardless of whether state or federal law or an “ancillarity” test is applied to the characterization issue, the courts have found, with rare exception, the garnishment action is independent and the proceeding is, therefore, properly removed to federal court.

In *Swanson v. Liberty Nat. Ins. Co.*, the Ninth Circuit Court of Appeals held that a garnishment action against an insurer is an independent civil action, and therefore removable.²⁴⁴ In that case, the Ninth Circuit affirmed the judgment of the United States District Court for the District of Alaska, which denied a request for remand after a garnishment action brought against an insurance company was removed to federal court.²⁴⁵ The Ninth Circuit rested its holding on the fact that the only parties in the case were the insurance company and the judgment creditor.²⁴⁶ The court noted,

²⁴² 440 F. Supp. 2d 346, 351-352 (D. Del. 2006).

²⁴³ *Id.*

²⁴⁴ 353 F.2d 12, 13 (9th Cir 1965).

²⁴⁵ *Id.*

²⁴⁶ *Id.* at 12-13.

however, “[w]e may get some interesting problems in diversity when the judgment defendant debtor stays on, seeks in, or is brought into the garnishment proceedings.”²⁴⁷

The Fifth, Eighth, and Tenth circuits have made similar holdings. In *Butler v. Polk*, the Fifth Circuit reasoned that a garnishment action brought by a judgment creditor against the judgment debtor’s liability insurer was properly removed to federal court because “garnishment actions against third-parties are generally construed as independent suits, as least in relation to the primary action.”²⁴⁸ In *Randolph*, the Eighth Circuit Court of Appeals held a garnishment action against an insurance company was separable from the underlying liability action.²⁴⁹ The Eighth Circuit reasoned, “[t]he only issue is the liability of the garnishee on its insurance contract.”²⁵⁰ If the garnishee is liable, the amount of such liability has been established by the judgment against [the insured] in the state court action.²⁵¹ Likewise, in *Adriaenssens*, the Tenth Circuit held a garnishment action against an insurer was removable, relying on that Court’s earlier holding in *London & Lancashire*.²⁵² The court noted that the action in question was an “original and independent actions between the holders of the judgments and the insurer.”²⁵³ Because the requisite diversity of citizenship and amount in controversy was present, the matters were, accordingly, open to removal.²⁵⁴

In *Scanlin*, discussed above, the Pennsylvania District Court held that a garnishment action brought against an insurer was properly removed.²⁵⁵ The *Scanlin* court found that the issue to be resolved in the garnishment action - whether the defendant’s parents’ insurance policy would provide coverage for their son’s judgment - was distinct from the issues of the defendant’s liability in the initial personal injury action.²⁵⁶ The court further found that the tortfeasor defendant in the personal injury suit was no

²⁴⁷ *Id.* at 13.

²⁴⁸ 592 F.2d 1293, 1295-1296 (5th Cir. 1979) (citing *Swanson v. Liberty Nat. Ins. Co.*, 353 F.2d 12 (9th Cir. 1965); *Randolph v. Employers Mut. Liability Ins. Co.*, 260 F.2d 461 (8th Cir. 1958); *Adriaenssens v. Allstate Ins. Co.*, 258 F.2d 888 (10th Cir. 1958); and *Stoll v. Hawkeye Cas. Co.*, 185 F.2d 96 (8th Cir. 1950)).

²⁴⁹ 260 F.2d 461, 464-465 (8th Cir. 1958).

²⁵⁰ *Id.* at 464.

²⁵¹ *Id.*

²⁵² 258 F.2d 888, 890 (1958).

²⁵³ *Id.*

²⁵⁴ *Id.*

²⁵⁵ 426 F. Supp. 2d 243, 250 (M.D. Pa. 2006).

²⁵⁶ *Id.*

longer a party in the garnishment litigation; only the garnishee, Utica First Insurance Company, was a named party, and the tortfeasor defendant had assigned his rights against Utica to the garnishment plaintiff.²⁵⁷

The court therefore concluded that the garnishment action, as an independent civil action, was appropriately removed.²⁵⁸ The *Scanlin* decision is consistent with the result set forth by the Pennsylvania District Court in *Graef* as well.²⁵⁹ The *Graef* court made observations similar to those made by the *Scanlin* court: “the only issue is the liability of the garnishee on its insurance contract ... Moreover, in the present controversy we have only one defendant, the garnishee....”²⁶⁰

In a case involving a garnishment action and allegations of bad faith, the federal court in Kansas held that, under federal law, the garnishment action brought against the insurer was separate and distinct from the underlying liability claim.²⁶¹ The *Smotherman* court rested its holding on the fact that:

“[t]he issues in the garnishment action are whether [the insurance company] acted negligently or in bad faith in refusing to settle within the limits of the policy prior to trial and exposing its insured [] to an excess judgment, and whether because of its negligence or bad faith the [insurance company] is liable to the plaintiff for the entire judgment and not just the policy limits.”²⁶²

The Pennsylvania courts reached a like conclusion in *Shearer v. Reed*,²⁶³ and the Kansas District Court denied a motion to remand in *Bridges for Bridges* based on a similar analysis.²⁶⁴

Garnishment actions against an insurer have not, however, always been granted.²⁶⁵ In *Richmond*, for example, the federal district court considered whether it would be called upon to re-examine in the garnishment action

²⁵⁷ *Id.*

²⁵⁸ *Id.* at 251

²⁵⁹ *Graef v. Graef*, 633 F. Supp. 450, 454 (E.D. Pa. 1986).

²⁶⁰ *Id.* at 453.

²⁶¹ *Smotherman v. Caswell*, 755 F. Supp. 346, 348 (D. Kan. 1990).

²⁶² *Id.*

²⁶³ 428 A.2d 635, 640 (Pa. 1981) (the garnishment action subsequent to a tort judgment permitted a new claim for bad faith against the defendant’s insurer).

²⁶⁴ *Bridges v. Bentley*, 716 F. Supp. 1389, 1389 (D. Kan. 1989).

²⁶⁵ *Toney v. Maryland Cas. Co.*, 29 F. Supp. 785, 787 (W.D. Va. 1939) (A garnishment action brought against an insurer subsequent to a liability suit was also dismissed).

issues of fact contested in and “inseparably tied to” the initial state action.²⁶⁶ In remanding the matter back to state court, the court addressed several policy concerns, including (1) the federal court having to re-litigate the same issues of fact as those litigated by the state court, (2) unnecessarily bifurcating the trial by allowing execution of the judgment to take place in a different court, (3) wasting federal resources in executing the judgment of a state court’s action, and (4) burdening the federal court with “minor” matters.²⁶⁷ The court concluded that the garnishment action against the tortfeasor defendant’s insurer was supplemental to the original personal injury action because the insurer had raised the issue of payment in the state action, and it would be a “duplication of the function performed by the state court” to further determine whether defendant’s insurer had previously paid the full proceeds permitted by defendant’s policy.²⁶⁸ In addition, the *Richmond* court foresaw that it would be called upon to determine the facts giving rise to the defendant’s liability in order to ascertain the extent of coverage.²⁶⁹ Therefore, the court determined that the garnishment action was not a distinct civil action.²⁷⁰

C. THE INSURER’S DILEMMA: ENJOY THE BENEFITS OF
LITIGATING IN FEDERAL COURT OR THE CONSTITUTIONAL
RIGHT OF DUE PROCESS

The holding of the Pennsylvania District Court in *Richmond* reflects the quandary the insurer faces. If the insurer raises any defense in the state court action, it hazards a subsequent finding by the federal court that the garnishment action is supplemental to the personal injury action and cannot, therefore, be removed.²⁷¹ The *Richmond* court also predicated its decision on the concern that within the context of the federal declaratory judgment action, the court would be required to make a determination on the liability issue – an issue within the province of the state court.²⁷² There is, however, a reciprocal jurisdictional intrusion that has yet to be recognized by a court addressing the issue. In granting the injured plaintiff’s request for garnishment against the insurer, unless the insurer is

²⁶⁶ *Richmond v. Allstate Ins. Co.*, 624 F. Supp. 235, 238 (E.D. Pa. 1985).

²⁶⁷ *Id.* at 237.

²⁶⁸ *Id.* at 237-38.

²⁶⁹ *Id.* at 237.

²⁷⁰ *Id.* at 238.

²⁷¹ *Id.* at 236-37.

²⁷² *Richmond v. Allstate Ins. Co.*, 624 F. Supp. 235, 237-38 (E.D. Pa. 1985).

afforded the right to challenge the extent of its liability within the garnishment action, the state court is making a *de facto* finding of coverage. The garnishment assigns financial liability to the insurer without full hearing on whether the insurer actually owes a duty of indemnification to the state court defendant tortfeasor.

While it has long been recognized that issuance of a pre-judgment writ of garnishment that does not afford notice and hearing violates fundamental principles of due process,²⁷³ the Supreme Court did not rule until some eighty-four years ago on the constitutionality of post-judgment garnishment actions.²⁷⁴ In *Endicott-Johnson v. Encyclopedia Press*, the high court held due process did not require notice and an opportunity to be heard before the issuance of a writ to garnish a judgment-debtor's property.²⁷⁵ The Court reasoned that the judgment debtor, who "has had his day in court" in the action on the merits must "take notice of what will follow."²⁷⁶ An insurer against which garnishment is sought while a federal declaratory judgment action is still pending has not, however, had its "day in court."²⁷⁷ The underlying state suit for liability and damages may have afforded the insured the required notice and opportunity, but when the issue of coverage

²⁷³ See, e.g., *North Georgia Finishing, Inc. v. Di-Chem, Inc.*, 419 U.S. 601, 602-03 (1975) (Georgia garnishment statute permitting writ of garnishment to be issued in pending suits by court clerk without participation by judge on affidavit of plaintiff or his attorney containing only conclusory allegations deprived garnishee due process of law); *Sniadach v. Family Finance Corp. of Bay View*, 395 U.S. 337, 338-39 (1969) (holding Wisconsin statute that "sets in motion the machinery whereby wages are frozen" before trial and without any opportunity for the garnishee to be heard or otherwise tender any defense he might have violates due process); *Finberg v. Sullivan*, 634 F.2d 50, 59-60 (3rd Cir. 1980) (Pennsylvania post-judgment garnishment procedure did not require hearing with sufficient promptness to satisfy requirements of due process); *Davis v. Paschall*, 640 F. Supp. 198, 203 (E.D. Ark. 1986) (Arkansas post-judgment garnishment procedure did not contain sufficient procedural safeguards to satisfy due process); *Scott v. Danaher*, 343 F. Supp. 1272, 1278 (N.D. Ill. 1972) (Illinois garnishment statute violates due process of law because statute fails to provide a means of determining whether or not the particular debtor knowingly and intelligently executed the judgment note waiving right to hearing).

²⁷⁴ *Endicott-Johnson Corp. v. Encyclopedia Press, Inc.*, 266 U.S. 285, 290 (1924).

²⁷⁵ *Id.*

²⁷⁶ *Id.* at 288.

²⁷⁷ See *Crist v. Hunan Palace, Inc.*, 89 P.3d 573, 581 (Kan. 2004) (upholding garnishment against insurer, noting insurer "had the means by which it could have protected itself. It chose not to enter the fray in defense of the [insured tortfeasor] or to file a declaratory judgment action to define its contractual obligations"); *Baldrige v. Kirkpatrick*, 63 P.3d 568, 572 (Okla. Civ. App. 2002) (refusing to enter judgment against insurer which had no opportunity to present a defense).

has yet to be determined, that notice and opportunity does not necessarily transfer to the insurer.²⁷⁸

There are a number of states that insure due process by allowing, pursuant to state statute, an insurer to test the validity of the judgment in a garnishment action.²⁷⁹ Interestingly, the Supreme Court in *Brillhart* suggested it would have been stratified with the proceedings below had the District Court considered whether “under applicable local law, the claims sought to be adjudicated by the respondent in th[e] suit for a declaratory judgment had either been foreclosed by Missouri law or could adequately be tested in the garnishment proceeding pending in the Missouri state court.”²⁸⁰ Despite the Supreme Court’s comfort with such a determination, however, it alone does not resolve the issue for the insurer. The insurer’s dilemma remains because the states that allow the insurer to test the validity of the judgment in the garnishment action also consider the garnishment action to be an ancillary or auxiliary proceeding.²⁸¹

Insurers seeking judicial determination of coverage issues are, therefore, faced with bleak alternatives. If the insurer fails to act in the state court action, either by defending the insured or asserting defenses to coverage, such as the insured’s failure to pay the premium,²⁸² then the insurer may be found to have forfeited its only opportunity to secure due process of law.²⁸³ However, if the insurer acts in the state court action, then

²⁷⁸ *Crist*, 89 P.3d at 581.

²⁷⁹ *Standard Acc. Ins. Co. v. Leslie*, 55 F. Supp. 134, 138 (D. Ill. 1944) (noting Illinois garnishment action may be properly used to test the liability of an alleged insurer on its policy); *Carpenter v. Superior Court*, 422 P.2d 129, 136 (Ariz. 1966) (holding insurer had the opportunity to test its liability in the garnishment action); *Sandoval v. Chenoweth*, 428 P.2d 98 (Ariz. 1967) (insurer was not deprived of due process where the insurer had the opportunity to set aside the default judgment, but failed to act promptly); *Baldrige*, 63 P.3d at 572 (insurer had right to due process and present its case in court, and that it could do so in an equitable garnishment action following a judgment against its insured).

²⁸⁰ 316 U.S. 491, 495-96 (1942).

²⁸¹ *Standard*, 55 F. Supp. at 138 (recognizing in Illinois that a garnishment action is an ancillary proceeding provided by statute); *City of Phoenix v. Collar, Williams & White Eng’g, Inc.*, 472 P.2d 479, 481 (Ariz. App. 1970) (“a garnishment proceeding is always ancillary to the main or principle action”); *Spears v. Preble*, 661 P.2d 1337, 1343 (Okla. 1983) (holding garnishment action against insurer is in aid of an ancillary to the main action against the insured).

²⁸² *Richmond v. Allstate Ins. Co.*, 624 F.Supp. 235, 236-37 (E.D. Pa. 1985) (finding garnishment action ancillary to state court liability and damages action when insurer raised issue of insured’s failure to pay premiums in the state court action).

²⁸³ *See Crist v. Hunan Palace, Inc.*, 89 P.3d 573 (Kan. 2004) (allowing garnishment action against insurer in spite of due process concerns where insurer could have defended state suit, but choose not to).

the subsequent garnishment action may be found to be ancillary to the state court damages and liability suit.²⁸⁴ If ancillary to the damages and liability suit, removal of the garnishment action would be precluded.²⁸⁵ Once the state court plaintiff has sequestered the garnishment action in state court by defeating removal, the garnishment proceeding may then serve as an anchor, utilized to pull the federal court declaratory judgment action into state court and the insurer loses the benefits of litigating the coverage issue in federal court.²⁸⁶

IV. STATE GARNISHMENT ACTIONS AND FEDERAL ABSTENTION

A. SURVEY OF CASE LAW WHERE GARNISHMENT AND ABSTENTION WERE ADDRESSED

There are only a handful of cases that address the propriety of abstaining in a federal declaratory judgment action when there is a garnishment proceeding pending in state court.²⁸⁷ *Brillhart v. Excess Insurance Company*,²⁸⁸ of course, is chief among them. In *Brillhart*, Excess Insurance Company filed a declaratory judgment action in federal court to determine its rights under a reinsurance agreement it entered into with Central Mutual Insurance Company of Chicago.²⁸⁹ Central had issued a public policy liability policy to Cooper-Jarrett, Inc.²⁹⁰ While the federal action was pending, a state court wrongful death action was brought against Cooper-Jarrett, and Central refused to defend.²⁹¹ Central and Cooper-Jarrett encountered financial difficulties and Central was liquidated and all

²⁸⁴ *Richmond*, 624 F. Supp. at 237-38.

²⁸⁵ *Id.* at 236-37 (refusing to remove garnishment action).

²⁸⁶ See *Huth v. Hartford Ins. Co. of the Midwest*, 298 F.3d 800, 802-3 (9th Cir. 2002) (refusing to exercise discretionary diversity jurisdiction when possibility of state court action existed).

²⁸⁷ See, e.g., *W. Heritage Ins. Co. v. Gallup*, No. 06-4165-CV-C-WAK, 2007 WL 62696 (W.D. Mo. Jan. 8, 2007); *Am. Family Mut. Ins. Co. v. Carter Enterprises, Inc.*, No. 04-0933-CV-W-JTM, 2005 WL 3310467 (W.D. Mo. Dec. 6, 2005); *Nw. Pac. Indem. Co. v. Safeway, Inc.*, 112 F. Supp. 2d 1114 (D. Kan. 2000); *Fed. Ins. Co. v. Sprigg Lane Inv. Corp.*, 915 F. Supp. 122 (E.D. Mo. 1996); *Lewis v. Blackmon*, 864 F. Supp. 1 (S.D. Miss. 1994).

²⁸⁸ 316 U.S. 491 (1942).

²⁸⁹ *Id.* at 493.

²⁹⁰ *Id.*

²⁹¹ *Id.*

claims against it barred; Cooper-Jarrett filed bankruptcy, pursuant to which any judgment entered against it was discharged.²⁹² Because Central and Cooper-Jarrett were both insolvent, the state court plaintiff initialed a garnishment proceeding against Excess Insurance Company through service on the Missouri superintendent of insurance.²⁹³ *Brillhart* moved for dismissal of the suit, which the district court granted.²⁹⁴

The matter was appealed to the Tenth Circuit, which remanded the matter to the federal court for adjudication on the merits.²⁹⁵ The ruling of the Tenth Circuit was then appealed to the Supreme Court.²⁹⁶ The Supreme Court, like the Tenth Circuit, remanded the matter to the district court.²⁹⁷ The Supreme Court noted that the motion to dismiss was predicated in its entirety on the assertion that there was a parallel state court suit pending, in which the issues between the parties could be fully resolved.²⁹⁸ The Court noted, “[t]he correctness of this claim was certainly relevant in determining whether the District Court should assume jurisdiction and proceed to determine the rights of the parties.”²⁹⁹ While the *Brillhart* court expressed some concern about the federal courts making a determination regarding the adequacy of a state garnishment proceeding to address the issues in the declaratory judgment action, the court ultimately held that the District Court erred in granting the motion to dismiss, and issued a remand.³⁰⁰

In contrast to *Brillhart*, in the majority of the other cases to consider abstaining in deference to a state court garnishment action, the federal court has abstained from exercising its jurisdiction.³⁰¹ In *Western Heritage Ins. Co. v. Gallup*, for example, the Missouri federal court considered whether abstention was proper under *Brillhart*.³⁰² The court gave a truncated

²⁹² *Id.*

²⁹³ *Id.* at 492-493.

²⁹⁴ *Brillhart v. Excess Ins. Co. of Am.*, 316 U.S. 491, 493 (1942).

²⁹⁵ *Id.* at 494.

²⁹⁶ *Id.*

²⁹⁷ *Id.* at 498.

²⁹⁸ *Id.* at 495.

²⁹⁹ *Id.*

³⁰⁰ *Brillhart v. Excess Ins. Co. of Am.*, 316 U.S. 491, 497-98 (1942).

³⁰¹ *See, e.g.*, *W. Heritage Ins. Co. v. Gallup*, No. 06-4165-CV-C-WAK, 2007 WL 62696, at *3 (W.D. Mo. Jan. 8, 2007); *Am. Family Mut. Ins. Co. v. Carter Enter., Inc.*, No. 04-0933-CV-W-JTM, 2005 WL 3310467, at *3 (W.D. Mo. Dec. 6, 2005); *Nw. Pac. Indem. Co. v. Safeway*, 112 F. Supp. 2d 1114, 1122 (D. Kan. 2000); *Fed. Ins. Co. v. Sprigg Lane Inv. Corp.*, 915 F. Supp. 122, 124 (E.D. Mo. 1996).

³⁰² No. 06-4165-CV-C-WAK, 2007 WL 62696, at *1 (W.D. Mo. Jan. 8, 2007).

consideration of four factors: (1) whether the garnishment involved the same issues between the same parties; (2) whether all issues could be resolved in the garnishment; (3) whether it would be inefficient to require duplicative litigation; and (4) whether the parties were amendable to process in the state proceeding.³⁰³ The *Gallup* court then concluded by noting that even though “the federal declaratory judgment action was filed prior to the state equitable garnishment proceeding ... the timing does not outweigh the other considerations favoring abstention.”³⁰⁴

A federal court in Kansas also elected to abstain from exercising its discretionary federal jurisdiction in *Northwestern Pacific Indem. Co. v. Safeway, Inc.*³⁰⁵ The Kansas District Court considered two of the four *Brillhart* factors addressed in *Gallup*, electing not to consider (1) whether the state court proceeding involved the same issues between the same parties, and (2) whether abstention would avoid duplicative proceedings.³⁰⁶ The Kansas District Court added to that analysis one additional *Brillhart* factor, whether the necessary parties have been joined in the state proceeding, and five supplemental factors articulated by the Tenth Circuit Court of Appeals.³⁰⁷ Northwestern urged the federal district court to decline from abstaining because, Northwestern argued, it had no means of

³⁰³ *Id.*, at *2.

In *Carter Enterprises*, the United States District Court for the Western District of Missouri applied a similar analysis, and again determined that abstention was appropriate. 2005 WL 3310467, at *1. In *Carter Enterprises*, however, the court only considered the first three of the four factors articulated in *Gallup*. *Id.* at *2. The *Carter Enterprises* court weighed these factors against American Family’s choice of forum, but still held in favor of abstention. *Id.* at *3.

³⁰⁴ *Gallup*, 2007 WL 62696, at *2.

³⁰⁵ 112 F. Supp. 2d 1114, 1122 (D. Kan. 2000).

³⁰⁶ *Id.* at 1118.

³⁰⁷ *Id.* (citing *Buzas Baseball, Inc. v. Bd. of Regents*, 189 F.3d 477 (10th Cir. 1999) and *St. Paul Fire and Marine Ins. Co. v. Runyon*, 53 F.3d 1167, 1169 (10th Cir. 1995) as setting forth the following five factors:

[1] whether a declaratory action would settle the controversy; [2] whether it would serve a useful purpose in clarifying the legal relations at issue; [3] whether the declaratory remedy is being used merely for the purpose of “procedural fencing” or “to provide an arena for a race to *res judicata*”; [4] whether use of a declaratory action would increase friction between our federal and state courts and improperly encroach upon state jurisdiction; and [5] whether there is an alternative remedy which is better or more effective.)

testing the validity of the judgment entered against it in the garnishment proceeding.³⁰⁸ The Kansas District Court discussed some state case law on the matter, and then suggested that, “affidavits with documentation could be offered to support the amounts of the claims ... [and] independent expert testimony evaluating the strengths and weaknesses of the parties’ positions could be presented.”³⁰⁹ In sum, the Kansas District Court held that the state garnishment action would provide an adequate opportunity for Northwestern to present its case, regardless of what that opportunity entailed.

In the only case to address both removal of a state court garnishment action and abstention from hearing a federal declaratory judgment action, the federal court entertaining the issues held removal was proper and abstention was not warranted.³¹⁰ In *Lewis v. Blackmon*, the plaintiff argued that the federal court should decline to exercise its jurisdiction over a declaratory judgment action based on *Pullman* and *Burford* abstention and a Fifth Circuit case, *United Services Life Insurance Company v. Delaney*.³¹¹ The federal court in Mississippi disagreed, holding that the concerns articulated in *Pullman*, *Burford*, and *Delaney* were not present in the declaratory judgment action, in which the insurer sought a declaration of the insurer’s duty to defend and indemnify its insured.³¹² After deciding that it would not abstain from exercising its discretionary jurisdiction, the federal court then turned to the issue of removal.³¹³ The court held the garnishment action was not ancillary to another state court action, and was properly removed under federal law.³¹⁴

B. NON-REMOVABLE GARNISHMENTS

The Supreme Court’s decisions in *Brillhart* and *Wilton* provide a broad tower of abstention over federal declaratory judgment actions where there

³⁰⁸ *Id.* at 1121.

³⁰⁹ *Id.* at 1119-20 (quoting *Associated Wholesale Grocers, Inc. v. Americold Corp.*, 934 P.2d 65, 87 (Kan. 1997). The *Safeway* court went on to note that, “[a]s the Supreme Court of Kansas has directly remanded this issue for the district court’s determination, the court has no doubts that the state court proceeding will provide an adequate forum for the determination of the propriety of the settlement amount.” *Id.*

³¹⁰ *Lewis v. Blackmon*, 864 F.Supp. 1, 2 (S.D. Miss. 1994).

³¹¹ *Id.* at 3 (citing *United Services Life Ins. Co. v. Delaney*, 328 F.2d 483 (5th Cir 1964)).

³¹² *Id.*

³¹³ *Id.* at 4.

³¹⁴ *Id.*

are pending parallel state actions. These decisions, however, left a glaring void in relation to the proper and valid application of the abstention doctrine when the parallel state action is no longer pending because it has been removed. In those cases where the insurance company denies a claim for coverage in a liability context, the insurance company must assess the timing of coverage litigation to minimize the risk of abstention.

It is not uncommon for insurance companies to decline to defend or indemnify its insured and then close the file, which results in the insured defending against the liability claim. Such a decision by the insurer can have dire consequences, not the least of which may be a liability judgment against the insured which the injured plaintiff will attempt to enforce against the insurer.³¹⁵ A final judgment creates a creditor/debtor relationship which is the foundational predicate for a garnishment action being initiated against the debtor policyholder. The presence of a garnishment action filed in state court may foreclose federal jurisdiction to the insurance company.

Where a non-removable garnishment action has been filed in state court, federal court jurisdiction can be challenged through the abstention doctrine because of the presence of a parallel state court garnishment proceeding. In this situation the *Brillhart* analysis asks whether another case involving the same parties would be able to also address the controversy in the declaratory judgment action.³¹⁶ The question of coverage is typically litigated in the garnishment action. The insurance company will object to the writ of garnishment claiming that it has no “indebtedness” to the insured because its policy does not provide coverage for the underlying claim. Thus, the essential subject matter of the garnishment litigation will focus upon the question of coverage which makes the scope of the garnishment proceeding co-extensive with the scope of the declaratory judgment action. There will also be a similarity of the

³¹⁵ Depending on the state in which the insurer is operating, a wrongful denial of a defense or indemnification can result in the insurer being held liable either up to policy limits, or for the full amount of the judgment. In New Mexico, for example, the courts have held that an insurer who wrongfully denies its insured a defense may be precluded from later asserting policy defenses, and may be held liable up to the full amount of the judgment in the liability action. *See, e.g., Valley Imp. Ass’n, Inc. v. U.S. Fid. & Guar. Corp.*, 129 F.3d 1108, 1125 (10th Cir. 1997) (holding, “[b]ecause we have affirmed the district court’s holding that USF & G breached its duty to defend, USF & G will not be heard to complain that the claims might not have been within the coverage”); *State Farm Fire & Cas. Co. v. Price*, 684 P.2d 524, 531 (N.M. App. 1984) (holding insurer was liable up to policy limits for its refusal to defend).

³¹⁶ *See Wilton v. Seven Falls Co.*, 515 U.S. 277, 282-83.

parties in both the garnishment and declaratory judgment actions. In order to bind the judgment creditor to a determination of no coverage, the insurance company oftentimes will name the judgment creditor as a party defendant in the declaratory judgment action. The insured is also named as a party defendant.

The Supreme Court has not specifically delineated a set of factors to be applied pursuant to *Brillhart*. However, the lower courts have done so. One of the essential factors to be considered is duplicative litigation.³¹⁷ Another factor focuses on whether the adjudication of the case by a federal court “would be disruptive of state efforts to establish a coherent policy with respect to a matter of substantial public concern.”³¹⁸

Whether the federal action would be duplicative of an action already proceeding before a state court, stems from the concern expressed by the Supreme Court that, “[g]ratuitous interference with the orderly and comprehensive disposition of a state court litigation should be avoided.”³¹⁹ Essentially, this *Brillhart* factor is focused on federal interference with ongoing state litigation.³²⁰ This factor is present when there is a pending parallel state garnishment proceeding.

A broad reading of the factor involving disruption of state efforts to establish a coherent policy can be applicable in the liability insurance context where many states have expressed a general public policy concern that victims of tortious conduct be fairly compensated.³²¹

³¹⁷ See *Gov’t Emp.’s Ins. Co. v. Dizol*, 133 F.3d 1220, 1225 (9th Cir. 1998); *Cont’l Cas. Co. v. Robsac Ind.*, 947 F.2d 1367, 1371, 1373 (9th Cir. 1991).

³¹⁸ *Colo. River Water Conservation Dist. v. United States*, 424 U.S. 800, 814 (1975). See also, *Lehman v. City of Louisville*, 967 F.2d 1474, 1478 (10th Cir. 1992); *Ripplinger v. Collins*, 868 F.2d 1043, 1049 n.5 (9th Cir. 1989).

³¹⁹ *Chamberlain v. Allstate Ins. Co.*, 931 F.2d 1361, 1367 (9th Cir. 1991).

³²⁰ *Id.*

³²¹ *Armstrong v. Land & Marine Applicators, Inc.*, 463 So.2d 1327, 1328-29 (5th Cir. 1984) (holding the proper approach for resolving choice of law problems regarding insurance policies written in other states is the interest analysis theory; it is good public policy meant to allow state courts to apply situations requiring choice of law where state interest is sufficient to require that result); *Richards’ Realty Co., L.L.C. v. Paramount Disaster Recovery, Inc.*, 476 F. Supp. 2d 618, 622-24 (E.D. La. 2007) (holding under Louisiana choice-of-law rules, Louisiana law, not law of California where the contract was entered, applied to validity of contingency fee contract between Louisiana insured and California adjuster for adjustment of insurance claims in Louisiana, despite adjuster having much business in California, because Louisiana’s interest in regulating insurance industry in state and strong public policy against private adjusters receiving contingency fees); *Transp. Ins. Co. v. Protective Ins. Co.*, 696 F. Supp. 870, 871-73 (S.D.N.Y. 1988) (concluding that Truckmen’s Endorsement in occupational comprehensive liability and comprehensive physical damage policies, denying coverage to insured vehicle use to carry property in any

Another *Brillhart* factor which must be taken into consideration is whether the declaratory judgment action is being filed as a means of forum shopping.³²² Whether the declaratory action was filed as a means of forum shopping “[u]sually is understood to favor discouraging an insurer from forum shopping. For example, filing a federal court declaratory action to see if it might fare better in federal court at the same time the insurer is

business or used in the business of any person to whom the vehicle was rented, was against New York public policy and therefore unenforceable regarding an accident in New York, even though the endorsement was valid in Ohio, where the insurance contract was entered into, especially where the policy provided for interpretation to give the broader coverage required by the financial responsibility or compulsory insurance laws of other states); *U.S. Fire Ins. Co. v. Beltmann N. Am. Co., Inc.*, 703 F. Supp. 681, 682-83 (N.D. Ill. E. Div. 1988) (holding that Illinois law was to determine the legality of purpose of a Minnesota corporation’s commercial umbrella policy issued in Minnesota; the claim against the corporation arose in Illinois, and if Illinois public policy forbade insurance against liability for insured’s claims, Illinois courts would not permit the parties to evade this policy by contracting for insurance in a state that allows such coverage.); *Am. States Ins. Co. v. Allstate Ins. Co.*, 922 A.2d 1043, 1052-53 (Conn. 2007) (holding Connecticut driver’s personal umbrella liability insurer could make a sufficiently compelling showing necessary to overcome the presumption favoring Florida law validating automobile policy’s household exclusion of liability coverage for injury to named insured, only if insurer demonstrated that applying Florida law would violate a fundamental public policy of Connecticut); *State Farm Mut. Auto. Ins. Co. v. Roach*, 945 So.2d 1160, 1163-65 (Fla. 2006) (recognizing that in the context of insurance contracts, the public policy exception of *lex loci contractus* requires a Florida citizen in need of protection, a paramount Florida public policy, and that the insured is on reasonable notice that he is a Florida citizen.); *Hartford Accident & Indem. Co. v. Am. Red Ball Transit Co., Inc.*, 938 P.2d 1281, 1285-86 (Kan. 1997) (noting that the law of the state where it was made normally determines the validity of an insurance contract and its construction, but that there is an exception when the contract violates public policy of the state whose tribunal is to enforce the contract.); *Daniels v. Nat. Home Life Assur. Co.*, 747 P.2d 897, 898-99 (Nev. 1987) (concluding life insurance policy bought by Nevada resident from Pennsylvania insurer, that did not provide for notice prior to termination for failure to pay when due, was against public policy of Nevada and therefore unenforceable, despite insurer’s argument that policy was a group policy that should be governed by Missouri law because the master policy was delivered in Missouri); *Demir v. Farmers Tex. County Mut. Ins. Co.*, 140 P.3d 1111, 1115-16 (N.M. App. 2006) (holding Texas law requiring physical contact to recover uninsured motorist benefits for injuries caused by unknown driver did not apply to Texas insured’s claim to recover uninsured motorist benefits from New Mexico accident under policy issued in Texas; Texas law would violate New Mexico’s public policy as expressed in its uninsured motorist statutes).

³²² The term “forum shopping” was first used in a judicial opinion in 1951. *See Covey Gas & Oil Co. v. Checketts*, 187 F.2d 561, 563 (9th Cir. 1951). Earlier, the phrase “shopping for a forum” was used by the court in *Miles v. Ill. Central R.R.*, 315 U.S. 698, 706 (1942) (Jackson, J. concurring). The concept was targeted in *Erie R.R. v. Tompkins*, 304 U.S. 64 (1938).

engaged in a state court action.”³²³ Federal courts generally decline jurisdiction in “reactive” declaratory judgment actions.³²⁴ In the insurance law context, declaratory judgment actions are routinely used by insurance companies and insureds to anticipate each others claims and, therefore, may be viewed as reactive.³²⁵ Thus, a declaratory judgment action by an insurance company against its insured during the pendency of a “non-removable”³²⁶ state court garnishment action presenting the same issues of state law can be seen as a “reactive” litigation.³²⁷ In situations where the insurance company waits until the garnishment action is initiated, the filing of the declaratory judgment action in federal court at that point runs the risk of being considered a “reactive” litigation.

In those jurisdictions where a garnishment action is considered to be ancillary or supplemental, a declaratory judgment action should be initiated at the earliest point in time while the state court liability lawsuit is occurring. If the federal declaratory judgment action can be advanced substantially prior to the entry of judgment against the policyholder, it will be difficult, as a practical matter, for a judgment creditor to establish an abstention challenge to the federal declaratory judgment action through the offensive use of a garnishment proceeding to create a parallel state court proceeding.³²⁸

³²³ Am. Cas. Co. of Reading, Penn. v. Krieger, 181 F.3d, 1113, 1119 (9th Cir. 1999). The Supreme Court has denounced state and federal forum shopping on grounds of comity and parity. See, e.g., Allen v. McCurry, 449 U.S. 90, 95-96 (1980).

³²⁴ Gov't Emp.'s Ins. Co. v. Dizol, 133 F.3d 1220, 1225 (9th Cir. 1998).

³²⁵ See Fed. Res. Bank of Atlanta v. Thomas, 220 F.3d 1235, 1246 n.11 (11th Cir. 2000) (declaratory judgment actions are “routinely used by potential litigants”).

³²⁶ Federal courts are courts of limited jurisdiction, Coury v. Prot, 85 F.3d 244, 248 (5th Cir. 1996), and therefore any case which is removed must be one which, at the time of removal, could have been brought in federal court initially. See, e.g., Cervantez v. Bexar County Civil Serv. Comm'n, 99 F.3d. 730, 733 (5th Cir. 1996).

³²⁷ Cont'l Cas. Co. v. Robsac, Ind., 947 F.2d 1367, 1372 (9th Cir. 1991) (noting that allowing declaratory judgment action to proceed while there is a non-removable state action would circumvent diversity jurisdiction).

³²⁸ As a technical matter, however, abstention may be raised by the parties or the court at any time during the federal court or federal appellate court proceedings. See, e.g., Columbia Basin Apartment Ass'n v. City of Pasco, 268 F.3d 791, 799 (9th Cir. 2001) (recognizing the Younger doctrine may be raised *sua sponte* at any time in the appellate process); Munich Am. Reinsurance Co. v. Crawford, 141 F.3d 585, 588 (5th Cir. 1998) (holding *Burford* abstention can be raised at any time); Mountain Funding Inc. v. Frontier Ins. Co., 329 F. Supp. 2d 994, 997 (N.D. Ill. 2004) (stating abstention principles can be raised and revisited at any time during a proceeding); Cal. Prolife Council Pol. Action Comm. v. Scully, 989 F. Supp. 1282, 1288 (E.D. Cal. 1998) (holding abstention by federal

C. ELIMINATION OF THE PARALLEL STATE COURT GARNISHMENT PROCEEDING THROUGH REMOVAL

Generally there is a judicial recognition that the use of the abstention doctrine to remand cases that have been removed on the basis of diversity should be done cautiously.³²⁹ Where federal diversity jurisdiction can be established, removal of a state garnishment action eliminates the parallel state court proceeding which is the predicate for the exercise of federal abstention. While *Wilton* set the standard for applying the abstention doctrine where there was a pending parallel state action, it did not establish the exact boundaries of discretion when there was no pending state court action achieved through removal.³³⁰ The modern trend is to view the existence of a pending parallel state court proceeding as only one factor in the overall abstention analysis.³³¹ Thus far, the Fourth Circuit,³³² the Ninth Circuit,³³³ and the Fifth Circuit³³⁴ have found that the lack of a pending parallel state court proceeding is not dispositive in the abstention analysis under the Federal Declaratory Judgment Act.

A significant case of concern for the insurance company is *Huth v. Hartford Ins. Co. of the Midwest*.³³⁵ In the district court, Hartford Insurance brought an action pursuant to the Federal Declaratory Judgment Act.³³⁶ Approximately one week after Hartford filed the suit under the Federal Declaratory Judgment Act, Huth filed an identical action in Arizona state court pursuant to Arizona's Declaratory Judgment Act.³³⁷ Because diversity jurisdiction existed, Hartford removed the state

court from considering constitutionality of state statute under the Pullman doctrine can be raised by the parties or the court at any time).

³²⁹ *Minot v. Eckardt-Minot*, 13 F.3d 590, 593 (2d Cir. 1994) ("The possibility of prejudice to out-of-state litigants, which provides whatever diminishing justification for federal diversity jurisdiction remains, suggests that courts should be wary of using judicially-crafted abstention doctrines to deny out-of-state litigants a federal forum that they prefer").

³³⁰ *Wilton*, 515 U.S. at 290.

³³¹ *Sherwin-Williams Co. v. Holmes County*, 343 F.3d 383, 393-94 (5th Cir. 2003).

³³² *See, e.g., Aetna Cas. & Surety Co. v. Ind-Com Electric Co.*, 139 F.3d 419, 423 (4th Cir. 1998).

³³³ *See, e.g., Huth v. Hartford Ins. Co. of the Midwest*, 298 F.3d 800, 802-803 (9th Cir. 2002).

³³⁴ *See, e.g., Sherwin-Williams Co.*, 343 F.3d at 394.

³³⁵ 298 F.3d 800.

³³⁶ *Id.* at 802.

³³⁷ *Id.* Unlike the Federal Declaratory Judgment Act, Arizona's Declaratory Judgment Act is not discretionary. *See* ARIZ. REV. STAT. ANN. § 12-1832 (2003).

declaratory judgment action to the Arizona District Court and the state and federal actions were then consolidated.³³⁸ Following removal, Huth filed a motion to remand the state portion of the consolidated action and to simultaneously stay the federal portion of the consolidated action.³³⁹ The District Court granted both the motion to remand and the motion to stay.³⁴⁰ The District Court found that despite the fact that the Arizona declaratory judgment action had been properly removed to federal court, that action still was a “pending” state action and could thus be remanded pursuant to the court’s discretion under the Federal Declaratory Judgment Act.³⁴¹ The District Court in *Huth* explained its decision to apply the abstention doctrine in a footnote:

[T]here is no state court action as it has been removed to federal court. The court does not find this argument persuasive. Clearly [the original state action] began in state court. Once this court decides to remand the action the case will proceed in state court rather than federal court. Hartford cannot avoid the court’s jurisdictional discretion under the FDJA by removing a state court action and then arguing no state court action exists.³⁴²

The authority by which the District Court in *Huth* remanded the state court action and thereby revested by federal decision a parallel state court proceeding, may be supported by recent amendments to 28 U.S.C. § 1447(c).³⁴³

³³⁸ *Huth*, 298 F.3d at 802.

³³⁹ *Huth v. Hartford Ins. Co. of the Midwest*, 298 F.3d 800, 802 (9th Cir. 2002).

³⁴⁰ *Id.*

³⁴¹ *Hartford Ins. Co. of the Midwest v. Huth*, No. CIV 00-2067-PHX-MSM, No. CIV 00-2345-PHX-MHM, Slip. Op. at 5 n.4 (D.Ariz. April 5, 2001).

³⁴² *Id.*

³⁴³ Commentators have noted that the 1988 amendments to 28 U.S.C. § 1447(c) have allowed courts to recognize other basis for remand other than jurisdictional and procedural defects. *See, e.g.*, David D. Siegel, *Commentary on 1988 Revision of Section 1447*, 28 U.S.C.A. § 1447 (1994 & Supp. 2006), H.R. REP. 100-889 at 72 (1988), a reprinted in 1988 U.S.C.C.A.N. 5982, 6033. The 1996 amendment to the statute has solidified this viewpoint. The 1996 amendment changed the basis of removal from “any defect in removal procedure” to “any defect other than lack of subject matter jurisdiction.” 28 U.S.C. 1447(c) (supp. II 1996). By using the phrase “any defect other than lack of subject matter jurisdiction,” it has been argued that Congress implicitly recognized situations that are neither procedural nor concerned with subject matter jurisdiction. David D. Siegel, *Commentary on 1996 Revision of Section 1447*, 28 U.S.C.A. § 1447 (Supp. 2006). Following these amendments, courts recognized the possibility of non-statutory justifications for remand. *See, e.g., Stevo v. CSX*

V. CONCLUSION

State court garnishment actions can be a formidable impediment to coverage litigation initiated by insurance companies in federal court. Where the garnishment action is non-removable, the insurance company should initiate its declaratory judgment action early while the state court tort litigation is being litigated. At that point, the two actions are significantly differentiated so that they are not identical or substantially similar regarding their scope of issues. The early filing of a declaratory judgment action will allow the federal court proceedings to advance sufficiently to make the exercise of abstention by the federal court unpalatable when the garnishment action is ultimately initiated after the liability lawsuit is resolved through judgment against the policyholder.

In those situations where the state garnishment action is removable, the abstention doctrine still presents a formidable impediment to sustaining federal jurisdiction. There is substantial elasticity in the *Brillhart* factors to permit a federal court to abstain by staying the federal declaratory judgment action and remanding the state declaratory judgment action under a broadened view of abstention exemplified in *Huth*. In this situation, the early filing of a declaratory judgment action, while the state court liability case is being litigated, will also allow the insurance company to substantially advance the federal declaratory judgment action before the ultimate judgment creditor can initiate a state garnishment action, which can only be brought after a final judgment is secured in the state liability lawsuit.

Transp., Inc., 940 F.Supp. 1222, 1224-25 (N.D. Ill. 1996) (collecting cases). A significant number of courts held that remand based on the abstention doctrine was proper. *Id.* at 1225 (collecting cases); see also, *IMFC Prof. Servs. of Florida., Inc. v. Latin American Home Health, Inc.*, 676 F.2d 152, 159-60 (5th Cir. 1982); *Todd v. Richmond*, 844 F. Supp. 1422, 1425 (D. Kan. 1994).

GOVERNMENT SUPPORT FOR TERRORISM INSURANCE

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ABSTRACT

This article examines the recent market for terrorism insurance, detailing the history and goals of the United States Terrorism Risk Insurance Act (TRIA) in all its iterations. Reinsurance, coverage, reimbursement, and liability are discussed in the context of the Act, as well as benefits and consequences of government-support terrorism insurance. The market reactions to the September 11th, 2001 terrorism attacks are presented to discuss imperfect capital markets. Additionally, the future of Chemical, Nuclear, Biological and Radiological (CNBR) terrorism and its impact on insurance programs and markets is also discussed.

Federal government support for the terrorism insurance industry has a very brief history. The terrorist attack(s) on September 11, 2001, radically altered the way the United States insurance industry perceived terrorist-related risks. Prior to the September 11th attack, terrorist-related losses were sufficiently small and infrequent that insurers did not take them into account when underwriting risks.¹ The industry did not even conceive of an attack that could generate such significant losses.² This dramatic shift in perception has caused many to suggest that terrorism risks are “uninsurable” from an underwriting perspective.³ Some claim that

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¹ See MUNICH RE, 11TH SEPTEMBER 2001, §§ 3.3-3.4 (2001); *Economic Impact of the Lack of Terrorism Risk Insurance: Hearing Before the Subcomm. on Oversight and Investigation of the H. Comm on Financial Services*, 107th Cong. (2002) (statement of Mark J. Warshawsky, Deputy Assistant Secretary for Economic Policy) available at http://www.treas.gov/offices/economic-policy/press/testimony_terrorism_risk_insurance.pdf [hereafter *Warshawsky*].

² See MUNICH RE, *supra* note 1, § 3.4.

³ See MUNICH RE, *supra* note 1, at 1. For a specific analysis of insurability, See INS. INFO. INST., TERRORISM, INSURANCE AND THE UNITED STATES GOVERNMENT 3-4 (2004).

uncertainty about the probability of a future attack and amount of damages caused by such an attack makes it impossible to calculate an appropriate premium for such coverage.⁴

The notion that terrorism risk was “uninsurable” was part of the rationale advanced for government intervention. When the initial efforts at legislation failed, the industry began to withdraw from the market for terrorism insurance by adding exclusions for terrorism-related losses to their policies.⁵ Reinsurers were the first to adopt such exclusions, in part because they bore about two-thirds of the losses from the September 11th attack.⁶ Because they are subject to more limited governmental regulation,⁷ reinsurers were able to exclude terrorism risk without governmental approval. A majority of reinsurance contracts were up for renewal in January 2002,⁸ and most of the renewed contracts excluded coverage for terrorist-related losses.⁹

⁴ See *Terrorism Insurance: Rising Uninsured Exposure to Attacks Heightens Potential Economic Vulnerabilities: Hearing Before the Subcomm. on Oversight and Investigations of the H. Comm. on Financial Services*, 107th Cong.3 (2002) (statement of Richard J. Hillman, Director of Financial Markets and Community Investment) available at www.gao.gov/news.items/d02472t.pdf [hereinafter *Hillman*]; see also *Terrorism Uninsurable*, INS. DAY, Feb. 27, 2002, at 1.

⁵ See *What Makes Terrorism Different?*, 23 VIEWPOINT No. 3, Winter 2002 (available at <http://www.aais.org>).

⁶ See Hillman, *supra* note 5, at 8.

⁷ See Hillman, *supra* note 5, at 3-4.

⁸ The majority of reinsurance policies expired in January, and by some reports could account for as much as 70% of reinsurance. See Hillman, *supra* note 5, at 4 n.2.

⁹ “Industry sources confirm that little reinsurance is being written today that includes coverage for terrorism.” Hillman, *supra* note 5, at 4; see also Warshawsky, *supra* note 1, at 2 (“[T]he reinsurance industry has almost entirely stopped assuming terrorism risk.”). This trend was confirmed in surveys. The New York Insurance Department received responses from companies that represented 89% of commercial insurance writings in NY state, and 83% of those companies reported that their reinsurers were excluding or limiting coverage for terrorism. *Testimony of New York State Insurance Department: Hearing Before the Subcomm. on Oversight and Investigations of the H. Comm. on Financial Services*, 107th Cong. 20-21 (2002) (statement of Gregory V. Serio, Superintendent of Insurance, New York State Insurance Department) available at www.ins.state.ny.us/speeches/pdf/testimony.pdf. Similarly, the AAIS found that “[m]ore than 80% of the 37 personal lines companies [surveyed] indicated that ‘their current or upcoming reinsurance contracts exclude or in some way limit coverage for loss caused by terrorism.’” AM. ASS’N OF INS. SERV., AAIS WEIGHS ACTION IN WAKE OF NAIC DECISION ON PERSONAL LINES TERRORISM EXCLUSIONS (2002) available at <http://www.aais.org>.

The reinsurers' withdrawal from the terrorism market left the primary insurers at risk of insolvency in the event of a major terrorism loss.¹⁰ According to the National Association of Insurance Commissioners ("NAIC"), a \$25 million loss for a single primary property/casualty insurer in 2001 would have threatened the solvency of 886 companies, or 44% of the companies writing commercial property/casualty insurance.¹¹ Consequently, the regulators endorsed a terrorism exclusion for commercial property/casualty insurers.¹² As of February 2008, "45 states and the District of Columbia and Puerto Rico" had approved a standard terrorism exclusion drafted by the Insurance Services Organization,¹³ which provides many standard form policies and endorsements used by the industry.

It is unclear whether the difficulty in obtaining terrorism insurance alone would have been enough to motivate Congress to adopt the Terrorism Risk Insurance Act ("TRIA"), but when Congress decided that reduced availability of terrorism insurance was causing a "drag" on the U.S. economy,¹⁴ TRIA was adopted. It was originally a "temporary" measure set to expire in 2005,¹⁵ but Congress first extended it for two years,¹⁶ and then extended it again in 2007 for another 7 years.¹⁷

WHAT ARE TRIA'S ESSENTIAL FEATURES?

¹⁰ See Press Release, Insurance Information Institute, Terrorism Coverage is a Taxpayer – Not Insurance Company – Responsibility, Industry Forum Told (Jan. 23, 2002) available at www.iii.org/media/updates/press.599963; *California, New York take Big Risks on Terrorism Policies*, NAT'L UNDERWRITER, Jan. 27, 2002, at 24.

¹¹ Hillman, *supra* note 5, at 17.

¹² News Release, National Association of Insurance Commissioners, NAIC Members Come to Agreement Regarding Exclusions for Acts of Terrorism (Dec. 21, 2001).

¹³ Hillman, *supra* note 5, at 5.

¹⁴ STAFF OF J. ECON. COMM., 107TH CONG., ECONOMIC PERSPECTIVES ON TERRORISM INSURANCE 8 (2002); Session Dates of Congress, http://clerk.house.gov/art_history/house_history/Session_Dates/100tocur.html (last visited Sept. 18, 2008). The White House suggested that the absence of terrorism insurance caused 300,000 jobs to be lost in construction alone. The source of this number was not given and detailed analysis suggests that actual job loss was an order of magnitude smaller. Thomas Russell, Dept of Econ., Santa Clara Univ., *The Costs and Benefits of the Terrorism Risk Insurance Act*, Nat'l Bureau of Econ. Research Presentation (2002).

¹⁵ Terrorism Risk Insurance Act of 2002, Pub. L. No. 107-297, § 108(a), 118 Stat. 2322, 2336.

¹⁶ Terrorism Risk Insurance Extension Act of 2005, Pub. L. No. 109-44, §2(a), 119 Stat. 2660, 2660.

¹⁷ Terrorism Risk Insurance Program Reauthorization Act of 2007, Pub. L. No. 110-60, § 3(b), 121 Stat. 1839, 1839-40.

TRIA has been described as creating a Federal “backstop” for terrorism insurance. The “backstop” is a statutory mechanism that provides Federal financial support for payment of terrorism claims in the event of a fairly large terrorism incident. This financial support is similar to reinsurance in that it provides reimbursement to insurers¹⁸ after they pay claims to a specified level (the insurer deductible). It is also similar to reinsurance in that insurers retain a proportion of the risk (a “co-pay). But the “backstop” is different from reinsurance because insurers don’t pay any premiums to be eligible, and the government does not establish any reserves or “underwrite” particular risks or books of business.¹⁹ Instead, the costs of the program are borne by the tax payer with some or all of those costs subject to being recouped after the payments through a premium tax on property and casualty insurance.

A. SCOPE OF COVERAGE

The backstop was made available for specific lines of property and casualty insurance in the event of an attack by foreign terrorists. TRIA covered commercial property and casualty insurance, including excess insurance, workers compensation insurance and surety insurance. It did not include Federal crop insurance, private mortgage insurance, financial guaranty insurance, insurance for medical malpractice, health or life insurance, flood insurance, or reinsurance.²⁰ TRIA originally only covered acts of terrorism in the United States by foreign terrorists. The Act defined terrorism as a violent act or an act dangerous to life, property or infrastructure that resulted in damage in the United States.²¹ To be covered, the acts must be committed “by an individual or individuals acting on behalf of any foreign person or foreign interest, as part of an effort to

¹⁸ See Terrorism Risk Insurance Act of 2002, Pub. L. No. 107-297, §§103-04, 118 Stat. 2322, 2327-29. It should be noted that the Secretary of Treasury has authority to pay policyholders directly rather than reimbursing insurers, but that is likely to be an exceptional circumstance.

¹⁹ See Terrorism Risk Insurance Act of 2002, Pub. L. No. 107-297, §103(a)(3), 118 Stat. 2322, 2327 (showing that all insurers are eligible for reimbursement, regardless of premium payment or specific risks). In this regard the TRIA program in the US differs from the equivalent program in the UK. The British program, Pool Re, essentially replicates a market based reinsurance program up to a threshold beyond which the UK government covers all loss. See Pool Reinsurance Company Limited (2008), available at <http://www.poolre.co.uk/Introduction.html>.

²⁰ Terrorism Risk Insurance Act of 2002, Pub. L. No. 107-297, §§ 101(b)(1), 102(12), 118 Stat. 2322, 2323, 2326.

²¹ § 102(1)(A). Including an air carrier or vessel or a U.S. mission. §102(1)(A)(iii).

coerce the civilian population of the United States or to influence the policy or affect the conduct of the U.S. Government by coercion.”²²

B. MANDATORY OFFERING

Insurers for those lines covered by the Act are required to participate. They must offer terrorism coverage on the same conditions as coverage for non-terrorist losses.²³ This means that the covered policies cannot have exclusions, limitations or conditions specifically for terrorism (as defined by TRIA). However, insurers were allowed to maintain certain exclusions applicable to all losses that might apply to some terrorism activity. For example, because most policies exclude or limit coverage for nuclear incidents, that exclusion would still be applicable to a terrorism event. In addition, insurers were allowed to set the price for terrorism coverage (within the parameters of state regulation for pricing).

C. GOVERNMENTAL REIMBURSEMENT FOR CERTIFIED ACTS OF TERRORISM

If a policyholder chooses to buy terrorism coverage, the Act provides that the government will reimburse for terrorism losses once aggregate insured losses for a certified terrorism event exceed a specified threshold. The original threshold was \$5,000,000.²⁴ The Secretary of Treasury decides, in consultation with the Secretary of State and the Attorney General, whether to certify an event as an “act of terrorism.”²⁵ This determination is final and not subject to judicial review.²⁶ After the triggering event, the government will pay a portion of terrorism losses above the deductible. The original proportion paid by the government was 90% of terrorism losses.²⁷ During the first year of TRIA, the insurer deductible was 7% of an insurer’s direct earned premium from the previous year for property and casualty insurance eligible for the program covering losses in the United States. The insurer deductible was increased to 10% in the second year of TRIA and then to 15% in the third year.²⁸

D. GOVERNMENTAL RECOUPMENT

²² § 102(1)(A)(iii)(I).

²³ § 103(c)(1).

²⁴ § 102(1)(B).

²⁵ Terrorism Risk Insurance Act of 2002, Pub. L. No. 107-297, § 102(1)(A), 118 Stat. 2322, 2323.

²⁶ § 102(1)(C).

²⁷ § 103(e)(1)(A).

²⁸ § 102(7)(C)-(D).

Federal government payments are subject to being recouped from the industry through a premium tax on eligible property and casualty insurance. The Act required a mandatory recoupment for amounts above the insurers' share and deductible up to a maximum of \$10,000,000,000 the first year of the program, which was increased to \$12,500,000,000 in the second year and to \$15,000,000,000 in the third year.²⁹ If aggregate insured losses exceed mandatory recoupment amount, the Secretary of Treasury had discretion to recoup more than the mandatory amount, up to a maximum 3% premium tax on property and casualty insurance.³⁰ While 3% of premiums will not recoup a large loss in a single year, the duration of the tax is not specified in the Act, so the process of recoupment could continue for a number of years after the loss should the Secretary of Treasury require it. In exercising discretion for recoupment, the Secretary is to take various factors into account and may set different taxes for different lines of insurance or smaller policyholders.³¹

E. CAP ON LIABILITY

The program has a \$100,000,000,000 cap. The original cap was a "soft cap" because it could easily be lifted. The Act in 2002 provided that payments made by the Secretary of Treasury under the program were limited to no more than \$100,000,000,000. If that amount is likely to be exceeded, the Secretary is to notify Congress, which "shall determine the procedures for and the source of any payments for such excess insured losses."³² Thus, if there were a \$150 billion loss, Congress could decide to fund the additional \$50 billion. It is somewhat unclear how supplemental Congressional action might affect insurers. On the one hand, the original Act provided that "no insurer that has met its insurable deductible shall be liable for the payment of any portion of that amount that exceeds \$100,000,000,000."³³ On the other hand, since that provision is only in reference to the \$100 billion cap, if Congress chooses to fund beyond the cap amount, perhaps it will decide that Insurers should bear some of those costs.

F. AMENDMENTS TO TRIA

²⁹ § 103(e)(6).

³⁰ Terrorism Risk Insurance Act of 2002, Pub. L. No. 107-297, § 103(e)(7)-(8), 118 Stat. 2322, 2329-30.

³¹ § 103(e)(8)(D).

³² § 103(e)(3).

³³ § 103(e)(2)(A)(ii).

The 2005 extension made relatively minor changes in the lines of insurance covered by the act and some of the numbers. Directors and officers liability insurance was added to the Act's coverage while commercial automobile, burglary and theft insurance, surety insurance, professional liability insurance and farm owners multiple peril insurance were removed.³⁴ The trigger for coverage was changed from \$5,000,000 to \$100,000,000.³⁵ The government's obligation for reimbursement was lowered from 90% to 85% (after insurer deductibles),³⁶ and insurer deductibles were raised to 17.5% of direct earned premium for the first year of the extension, and then to 20% for the second year.³⁷ The extension also raised the mandatory recoupment levels from \$15,000,000,000 to \$25,000,000,000 for the first year of the extension and to \$27,500,000,000 thereafter.³⁸

The 2007 extension also made relatively minor changes, but also made the notable change of extending the scope of the act to include domestic terrorism. This was done by striking the reference to "foreign" terrorism in the definition.³⁹ Insurer deductibles remained the same (20% of direct earned premium), as did the portion of losses to be paid by insurers (15%).⁴⁰ The cap remained at \$100 billion, but language suggesting that Congress might raise the cap was removed⁴¹ so that the limitation on liability for insurers is more definite. The recoupment numbers were changed somewhat to address the Congressional Budget Office analysis suggesting that the program was too costly to comply with Congressional spending rules.⁴² Under the 2007 extension, the mandatory recoupment is 133% of the difference between the industry retention (which was left at \$27.5 billion) and the amount that insurers have to pay due to their

³⁴ Terrorism Risk Insurance Extension Act of 2005 § 3, Pub. L. No. 109-144, 119 Stat 2660, 2660-61.

³⁵ § 6(2)(B)(i).

³⁶ § 4(1)(B).

³⁷ § 3(c)(3)(E)-(F).

³⁸ § 5(3)(D)(i), (E)(i).

³⁹ Terrorism Risk Insurance Program Reauthorization Act of 2007, Pub. L. No. 110-160, §2, 121 Stat. 1839 (providing that the definition of an act of terrorism was amended by "striking 'acting on behalf of any foreign person or foreign interest'").

⁴⁰ See Terrorism Risk Insurance Extension Act of 2005, Pub. L. No. 109-144, §4, 119 Stat. 2660, 2661.

⁴¹ § 4(a)(1)(A).

⁴² See CONG. BUDGET OFFICE, U.S. CONG., COST ESTIMATE, TERRORISM RISK INSURANCE PROGRAM REAUTHORIZATION ACT OF 2007 1-2 (2007) [hereinafter COST ESTIMATE].

deductibles and copayments.⁴³ For example, suppose that there was a \$25 billion loss, and that industry retentions and copays amounted to a total of \$7 billion. Mandatory recoupment would be 133% of the difference between these two figures, or about \$24 billion ($25 \text{ b} - 7 \text{ b} = 18 \text{ b} \times 1.33 = 23.94$). The 3% surcharge is still part of the program, but it is the maximum that can be allowed under discretionary recoupment. These changes will increase the amount of recovery that Treasury will be able to obtain from the industry after an event, which will reduce the cost of the program. The other noteworthy change in the 2007 extension is the requirement for Treasury to adopt allocation and recoupment regulations within a specified timeframe.⁴⁴

G. SUMMARY: CURRENT STRUCTURE

The following bullet points summarize the terms of the Act:

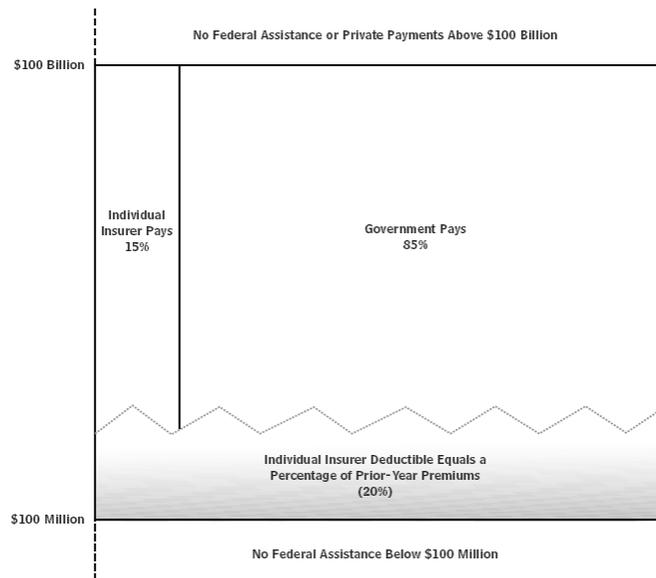
- Scope. The Act covers commercial property and casualty insurance, including excess insurance, workers compensation and directors and officers insurance; insurers selling those lines of insurance are required to participate;
 - Mandatory offering. Terrorism coverage must be offered on the same on the same conditions (but not at the same price) as non-terrorism coverage;
 - Certified act of terrorism. A terrorist event causing more than \$100,000,000 in insured losses certified by the Secretary of Treasury will trigger the Act's provisions;
 - Insurer deductibles and co-payments. Insurers must first pay 20% of their previous year's direct earned premium for the losses, after which they will be reimbursed by the government for 85% of additional covered losses;
 - Cap. The maximum to be paid under the Act is \$100 billion; and
 - Recoupment. The government is required to recoup 133% of the first \$27.5 billion paid out under the act (less the amount that insurers pay that is not subject to reimbursement) by imposing a premium surcharge on all eligible insurance, and may impose an additional surcharge of up to 3% in the Secretary's discretion.

⁴³ Terrorism Risk Insurance Program Reauthorization Act of 2007, Pub. L. No. 110-60 § 4(e)(1)(A), 121 Stat. 1839, 1841.

⁴⁴ See §§ 4(c), 4(e)(1)(B)(I).

A graphical depiction of the program is provided in the Figure below, prepared by the Congressional Budget Office:

Figure 1.
Initial Allocation of Claims Under TRIA, 2007



Source: Congressional Budget Office.

WHY SUPPORT TERRORISM INSURANCE?

The recent renewal of TRIA raises a number of important issues with regard to the structure of regulation of the terrorism insurance industry. First among these is the question of why the industry needs any support at all. With government support now guaranteed through 2014, all pretense of a need for “temporary” or “short term” assistance has been dropped. Instead it is now argued that private market provision of terrorism insurance is permanently compromised, uninsurability being a consequence of two features:

- 1) The size of potential loss.
- 2) The lack of precise underlying probabilities of terrorist attack.

Given that TRIA and its extensions set up a potential transfer from the tax payer to otherwise profitable enterprises, both of these arguments for

intervention require detailed scrutiny. With respect to the size of the loss, it is true that some potential terrorism losses, particularly those associated with Chemical, Nuclear, Biological, and Radiological (so called CNBR) attacks are of an order of magnitude greater than any losses experienced by the insurance industry to date. As an illustration, Table 1 shows the estimates of loss for various scenarios as developed by the American Academy of Actuaries.⁴⁵ Other loss estimates, for example by Risk Management Solutions, are of the same order of magnitude.⁴⁶

Table 1: Estimated Terrorism Losses

Scenario	Line of Business	New York City	Washington, DC	San Francisco	Des Moines
Large CNBR	Total	778.1	196.8	171.2	42.3
	Auto	1.0	0.6	0.8	0.4
	Commercial Property	158.3	31.5	35.5	4.1
	Residential Property	38.7	12.7	22.6	2.6
	Workers' Compensation	483.7	126.7	87.5	31.4
	General Liability	14.4	2.9	3.2	0.4
	Group Life	82.0	22.5	21.5	3.4
Medium CNBR	Total	446.5	106.2	92.2	27.3
	Auto	0.2	0.1	0.2	0.1
	Commercial Property	77.8	15.7	17.1	2.0
	Residential Property	10.3	3.1	6.9	0.4
	Workers' Compensation	313.2	71.6	50.8	21.8
	General Liability	7.3	1.5	1.6	0.2
	Group Life	37.7	14.2	15.6	2.9
Truck Bomb	Total	11.8	5.5	8.8	3.0
	Auto	0.0	0.0	0.0	0.0
	Commercial Property	6.8	2.1	3.9	1.2
	Residential Property	0.0	0.0	0.0	0.0
	Workers' Compensation	3.5	2.8	3.9	1.5
	General Liability	1.2	0.4	0.7	0.2
	Group Life	0.3	0.2	0.3	0.1

Source: American Academy of Actuaries: 2006

As a point of reference, the total surplus (reserves) of property/casualty insurers in the US in 2007 was \$687 billion.⁴⁷ This surplus is required to

⁴⁵ Open Letter from Michael G. McCarter, Chair, Terrorism Risk Insurance Subgroup of the American Academy of Actuaries, to the President's Working Group on Financial Markets: Terrorism Risk Insurance Analysis (April 21, 2006), *available at* http://www.actuary.org/pdf/casualty/tris_042106.pdf [hereinafter 2006 Open Letter].

⁴⁶ See RISK MGMT SOLUTIONS, INC., A RISK-BASED RATIONALE FOR EXTENDING THE TERRORISM RISK INSURANCE ACT (2005), *available at* <http://www.rms.com/Publications/A%20Risk%20Based%20Approach%20for%20Extending%20TRIA.pdf>.

⁴⁷ CONSUMER FED'N OF AM. 15.1(C)&(D), INSURERS MAINTAIN RECORD PROFITS IN 2007 BY OVERPRICING POLICIES AND UNDERPAYING CLAIMS (2008), *available at* http://www.consumerfed.org/pdfs/2008_INSURANCE_RELEASE_FINAL.pdf.

pay all property casualty losses, not just terrorism loss. Clearly a large CNBR attack in New York City could wipe out the whole property casualty insurance industry in one blow.

The cost of damages from CNBR attacks, however, is not a relevant benchmark to justify TRIA, because, as already noted, under the current Act, mandatory offering is limited to requiring only that insurers offer terrorism coverage on the same terms and conditions as non-terrorism insurance.⁴⁸ Non-terrorism insurance already excludes nuclear risks, pollution and contamination. As a consequence, even though the Treasury would support CNBR loss in exactly the same way as it supports conventional terrorism loss, CNBR coverage is typically excluded from standard terrorism insurance contracts. The one exception to this is workers compensation, where regulation permits no exclusions.⁴⁹ This and other issues related to CNBR coverage will be addressed later in the article, but within the context of current insurance practice and legislative parameters the only question is whether or not a conventional terrorist attack could cause such large damages that it would present any real capacity problem for the private sector. From that point of view, even such a dreadful event as a truck bomb in Manhattan (\$12b estimated loss) represents a mere 2% of current surplus.⁵⁰ Events of this magnitude clearly do not threaten the viability of the private sector and of course such events occur infrequently.

How infrequently? The second argument for continued government intervention goes to the difficulty in answering this question. Unlike, say auto or life insurance, there are no precise actuarial tables of terrorism attacks from which profit guaranteeing premiums can be calculated.

But this is not to say that anything can happen. The Congressional Budget Office, for example, is charged with estimating the costs to the Government of new legislation, and for the most recent TRIA extension they used expert opinion to estimate the probability of loss. As they state:

Although estimating losses associated with terrorist events is difficult because of the lack of meaningful historical data, the insurance industry has experience setting premiums for catastrophic events—namely, natural disasters. Setting premiums for hurricanes and earthquakes, for example, involves determining areas that could sustain damage, the value of the

⁴⁸ See *supra* note 19 and accompanying text.

⁴⁹ 2006 Open Letter, *supra* note 45, at 3.

⁵⁰ Again to calibrate the size of the loss, note that AIG lost \$1b in the 9/11 attacks and in January 2008 wrote down \$11.1 billion of guarantees sold to fixed-income investors.

losses that could result from various types of events with different levels of severity, and the frequency of such events.

Similarly, estimating premiums for losses resulting from terrorist attacks involves judgments regarding potential targets and the frequency of such attacks. Because there is a very limited history of terrorist attacks in the United States, many of the parameters needed by the insurance industry to set premiums are based on expert opinion regarding terrorist activities and capabilities rather than on historical data.⁵¹

Given the argument that losses are too large for the private sector to bear on its own, it is somewhat surprising that the CBO estimates that the new Act, which the industry argued was necessary for its survival, would only increase direct Government spending by \$3.1 billion over the entire 2008-2012 period and by \$6.6 billion over the 2008-2017 period. Clearly the removal of a subsidy this small does not threaten the viability of the private terrorism insurance industry.⁵²

It is true that, however, that in general insurers dislike imprecise estimates of risk. When it is difficult to attach a precise number to the probability of attack, risk becomes “ambiguous” in the sense identified by Ellsberg.⁵³ It is well known that insurers are “ambiguity averse,”⁵⁴ preferring to insure risks with known probabilities which are subject to actuarial calculation. As Kunreuther et al noted,⁵⁵ managers of insurance companies facing ambiguous probabilities demand a large premium over expected loss to write these lines.

Notwithstanding this ambiguity aversion, in the absence of price regulation, there is no reason why the ambiguity cannot be handled by setting larger premiums. As the CBO notes, other lines with uncertain risk parameters, notably earthquake insurance, are provided by the private sector.⁵⁶ So again it is puzzling why insurers continue to assert that terrorism is uninsurable.

⁵¹ COST ESTIMATE, *supra* note 42, at 5.

⁵² *Id.* at 4. The bill contains a provision that limits payments to no more than \$100 million, which helps to preserve private sector viability. We discuss this provision later.

⁵³ See Daniel Ellsberg, *Risk, Ambiguity, and the Savage Axioms*, 75 Q. J. ECON. 643 (1961).

⁵⁴ See Howard Kunreuther, J. Meszaros, R. Hogarth & M. Spranca, *Ambiguity and Underwriter Decision Processes*, 26 J. ECON. BEHAV. & ORG. 337 (1995); R. Hogarth & Howard Kunreuther, *Risk, Ambiguity and Insurance*, 2 J. RISK & INS. 5(1989).

⁵⁵ See Howard Kunreuther, J. Meszaros, R. Hogarth & M. Spranca, *Ambiguity and Underwriter Decision Processes*, 26 J. ECON. BEHAV. & ORG. 337 (1995).

⁵⁶ CONG. BUDGET OFFICE, *supra* note 42, at 5.

The market reaction to the September 11th attacks, while generally one of withdrawal and higher prices, is consistent with the theoretical explanation given above. Although many insurers excluded terrorism from standard coverages, the Treasury study found that significant terrorism coverage was still available in the market during 2002, prior to the enactment and effective date of TRIA.⁵⁷ Treasury found that “roughly 73 percent of commercial property and casualty insurers wrote some terrorism coverage in TRIA-eligible commercial property and casualty lines (excluding workers’ compensation) in 2002.”⁵⁸ This coverage was provided in approximately 60% of commercial property and casualty policies that year.⁵⁹

While this coverage was significant, it was far from universal. The Treasury study also found that while some 40% of insurers offered terrorism coverage in all of their policies (and many times without separate premium charges),⁶⁰ in 2002 about 27% of insurers offered terrorism insurance coverage in none of their policies, and about another 5% offered terrorism in 50% or less of their policies.⁶¹

Consistent with the ambiguity aversion, prices for terrorism insurance were quite high after September 11th, especially compared to the price prior to September 11th (zero, as it was not a separately considered risk), but those prices came down as the market was able to develop models to address the ambiguity and with the adoption of TRIA. Immediately after September 11th, insurers were worried that another attack could be imminent; as concerns subsided, prices dropped by 50-75% within the first nine months of 2002.⁶² But even in 2003, terrorism insurance could add 10% to the average property insurance premium for small to medium-sized properties, up to 20% for large properties, and considerably more for landmark properties in major urban areas.⁶³ By the third quarter of 2004, the typical price for terrorism coverage was about 4% of total premiums for

⁵⁷ See OFFICE OF ECON. POLICY, U.S. DEP’T OF THE TREASURY, ASSESSMENT: THE TERRORISM RISK INSURANCE ACT OF 2002 3, 27 (2005).

⁵⁸ *Id.* at 57 (2005).

⁵⁹ *Id.* at 58 (2005).

⁶⁰ U.S. Department of Treasury, *Assessment: the Terrorism Risk Insurance Act of 2002*, at 60 (2005).

⁶¹ See Figure 4.3, U.S. Department of Treasury, *Assessment: the Terrorism Risk Insurance Act of 2002*, at 59-60 (2005).

⁶² Congressional Budget Office, *Federal Terrorism Reinsurance: An Update*, at 6 n.18 (2005).

⁶³ *Id.* at 6.

property coverage.⁶⁴ By 2006, the median rate for terrorism insurance was down to \$47 per \$1 million compared to \$56 per million in 2003.⁶⁵

As prices declined, more policyholders purchased terrorism coverage.⁶⁶ According to a study conducted by Wharton Risk Management and Decision Processes Center at the University of Pennsylvania, by 2005 “about 50% of commercial enterprises had purchased TRIA-line terrorism insurance.”⁶⁷ The take-up rate climbed to 64% in the first half of 2007.⁶⁸ Without TRIA support, prices would likely rise and take-up rates decline.⁶⁹

While lower prices are certainly welcomed by consumers, lower prices and higher take up rates alone do not justify TRIA. If consumers are unwilling to pay the market price for terrorism insurance, one may conclude that they should bear the risk of terrorism. However, there are some social benefits from terrorism insurance. In particular, use of terrorism insurance makes available the insurance industry’s underwriting and claims apparatus. The claims process after September 11th, which at the time was the “largest single insured event in history,” went relatively smoothly.⁷⁰ Of the nearly 20,000 insurance claims filed two months after the attack, the New York Insurance Commissioner’s Office only received 63 complaints.⁷¹ The Insurance Commissioner concluded that consumers were generally “satisfied” with the claims handling, and that the industry approached its claims obligations “responsibly.”⁷² This is a dramatic

⁶⁴ Chalk, Peter; Hoffman, Bruce; Reville, Robert; & Kasupski, Anna-Britt; *Trends in Terrorism: Threats to the United States and the Future of the Terrorism Risk Insurance Act* (RAND Corp. 2005).

⁶⁵ Congressional Budget Office, *Federal Reinsurance for Terrorism Risks: Issues in Reauthorization*, at 16 (2007) (available at <http://www.cbo.gov/ftpdocs/87xx/doc8761/TRIASenate.pdf>).

⁶⁶ Chalk, Peter; Hoffman, Bruce; Reville, Robert; & Kasupski, Anna-Britt; *Trends in Terrorism: Threats to the United States and the Future of the Terrorism Risk Insurance Act* (RAND Corp. 2005).

⁶⁷ Wharton Risk Management and Decision Process Center, *TRIA and Beyond*, at 2 (Wharton School of Business 2005).

⁶⁸ Congressional Budget Office, *supra* note 62, at 15.

⁶⁹ Dixon, Lloyd; Lempert, Robert J.; LaTorrette, Tom; Reville, Robert T.; *Terrorism Insurance: Evaluating Alternatives in an Uncertain World* at 30 (RAND Corp. 2007) (noting that “studies suggest that the take-up rate would fall by 25 to 75 percent if TRIA were to expire, resulting in take-up somewhere between 14 and 49 percent”).

⁷⁰ Jeffrey Thomas, *Insurance Implications of September 11 and Possible Responses*, 34 *URB. LAW.* 727, 730-31 (2002).

⁷¹ Jeffrey E. Thomas, *Insurance Implications of September 11 and Possible Responses*, 34 *Urb. Lawyer* 727, 732 (2002) (citing testimony of Gregory V. Serio, New York Commissioner of Insurance).

⁷² *Id.*

contrast to FEMA's handling of Federal Assistance claims in the aftermath of Hurricane Katrina. The Government Accountability Office identified significant problems in the processes used by FEMA, and estimated that more than \$1 billion in payments were improper and/or fraudulent.⁷³ Moreover, because it seems likely that the government will step in to provide disaster relief to victims of a terrorist attack, terrorism insurance provides for private payment of at least part of the claims, which reduces the cost to the government even when the insurance is subsidized.

UNINSURABILITY AND IMPERFECT CAPITAL MARKETS

If the conventional arguments do not explain uninsurability, why did firms withdraw from this market following 9/11? In previous works it is argued that the failure of the terrorism and other catastrophe insurance markets is a consequence of imperfections in the market for capital.⁷⁴ The difficulty of raising external capital is documented in several works.⁷⁵ Gron and Lucas, for example, document that insurers raise premiums following a loss of surplus but make surprisingly little use of the external capital market.⁷⁶ This strategy will not work for catastrophic losses. In general, for infrequent, high loss events, it is not possible to guarantee payment of losses out of pre accumulated premiums. Suppose that a one in a hundred year event occurs soon after an insurance line has been established. Because sufficient time will not have elapsed in which to accumulate adequate reserves from premiums, an insurer will then be forced to raise capital in external capital markets. This can be a very difficult task.

Consider the analogy with the banking sector. A bank may be a perfectly solvent business going forward, but if there is a run (a type of catastrophe) or indeed any situation in which the bank is forced to liquidate

⁷³ U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-07-300, HURRICANE KATRINA AND RITA DISASTER RELIEF; CONTINUED FINDINGS OF FRAUD, WASTE AND ABUSE 1-4 (2007).

⁷⁴ See Dwight Jaffee & Thomas Russell, *Markets Under Stress: The Case of Extreme Event Insurance*, in *ECONOMICS FOR AN IMPERFECT WORLD: ESSAYS IN HONOR OF JOSEPH E. STIGLITZ* 35, 41-43 (Richard Arnott et al. eds., 2003); Dwight M. Jaffee and Thomas Russell, *Catastrophe Insurance, Capital Markets, and Uninsurable Risks*, 64 *RISK & INS.* 205, 227-228 (1997).

⁷⁵ See Anne Gron & Deborah Lucas, *External Financing and Insurance Cycles*, in *THE ECONOMICS OF PROPERTY-CASUALTY INSURANCE* 5 (David F. Bradford, ed., 1998); Anne Gron, *Capacity Constraints and Cycles in Property-Casualty Insurance Markets*, 25 *RAND J. ECON.* 110 (1994); Ralph A. Winter, *The Liability Insurance Market*, 5 *J. ECON. PERSP.* 115 (1991).

⁷⁶ See Gron & Lucas, *supra* note 75.

assets, the bank may find that the market's appetite for cash is so strong that even safe assets cannot be liquidated. This preference for cash may not be rational, but it is part of the environment of financial intermediation, and in the banking industry the institution of central banking exists to provide liquidity in just such circumstances. As one central banker has noted:

[P]olicy practitioners operating under a risk-management paradigm may, at times, be led to undertake actions intended to provide insurance against especially adverse outcomes When confronted with uncertainty, especially Knightian uncertainty, human beings invariably attempt to disengage from medium to long-term commitments in favor of safety and liquidity. . . . The immediate response on the part of the central bank to such financial implosions must be to inject large quantities of liquidity.⁷⁷

Providers of terrorism insurance are not as fortunate as bankers. Not only is there no central bank to provide liquidity following a large loss, insurance companies have no hard assets to use as security against a capital inflow. The insurer may well be solvent in the sense that the future flow of premiums (over perhaps a century or longer) would cover the loss and provide profits, but few counterparties, having just witnessed an event such as 9/11, will agree to provide capital against these future flows. Given that post loss capital is so difficult to obtain, a contract of terrorism insurance which relies on such external capital is not credible, and so insurers refrain from writing it. This analysis suggests a very different approach to terrorism insurance regulation, but before turning to this, it is useful to consider what, if any, private arrangements might reduce the reliance on external capital.

One obvious approach is to arrange in advance for capital injections following a loss. This is the "Lloyd's solution." Lloyds of London was originally organized as a syndicate of rich investors (names) who pledged their capital with unlimited liability "down to their last shirt button." Lloyd's itself held only operating capital, but in the event of a large loss, the capital of the names was subject to a "call," this internal capital removing the need to access external markets.

⁷⁷ Alan Greenspan, Chairman, Fed. Reserve, Risk and Uncertainty in Monetary Policy (Jan. 3, 2004), *available at* <http://www.federalreserve.gov/BoardDocs/Speeches/2004/20040103/default.htm>.

Indeed given the efficiency of English capital markets, there was no need even for the names to hold liquid capital. Many names were rich landowners who could meet a call by pledging their land as a security for a loan. In this way the capital of the names, land, which was pledgeable, was substituted for the future premium stream of the syndicate which was not. When this structure was in place, Lloyds fulfilled the function of a central bank for primary catastrophe insurers who could lay off their risks in the London market.

This solution, however, is no longer available. A series of financial reversals has made the names no longer willing to accept unlimited liability, and Lloyds, moving towards the organizational form of most of the world's major re-insurers, is in the process of becoming a limited liability joint stock company. With this organizational form, Lloyds too will face the problem of raising external capital ex post.

Given the difficulties which this entails, it is natural to look for alternative mechanisms to pre-capitalize the premium stream. Recently a number of creative ways of tapping into capital markets have been developed. Known collectively as Insurance Linked Securities, (ILS) the most notable instruments are catastrophe bonds ("cat bonds"), and "sidecars."⁷⁸ Cat bonds are loans whose principal is forfeited to the borrower in the event of a triggering loss. Sidecars are a type of insurance book- of- business based hedge fund.

Some market participants have high hopes that this market will grow large enough to pre fund even mega catastrophes. For example, extrapolating past growth, Jacques Aigrain, CEO of Swiss Re, predicted a size of between \$250 billion and \$710 billion by 2016.⁷⁹ Obviously if even the low end of this forecast were to be realized, the need for government intervention would evaporate.

⁷⁸ Morton N. Lane, *See Of Sidecars and Such*, LANE FINANCIAL TRADE NOTES (Lane Financial, Wilmette, IL), Jan. 31, 2007, available at http://www.lanefinancialllc.com/images/stories/Publications/2007-01-30_Of_Sidecars_and_Such.pdf (providing an excellent overview of the history and current state of the sidecar instrument).

⁷⁹ Jaques Aigrain, Chief Executive Officer, Swiss Re, UBS Swiss Alpine Summit (Jan. 19, 2007), available at <http://www.swissre.com> (follow "Investor Relations" hyperlink, then follow "Presentations" hyperlink, then follow "2007" hyperlink, scroll down to January 19th Presentation).

The compound annual growth rate from 1997 - 2006 is approximately 39.75%, which translates to a total outstanding amount of 25B.

CAGR	Amount Outstanding 2016
39.76%	710B
30.20%	360B
26.90%	260B

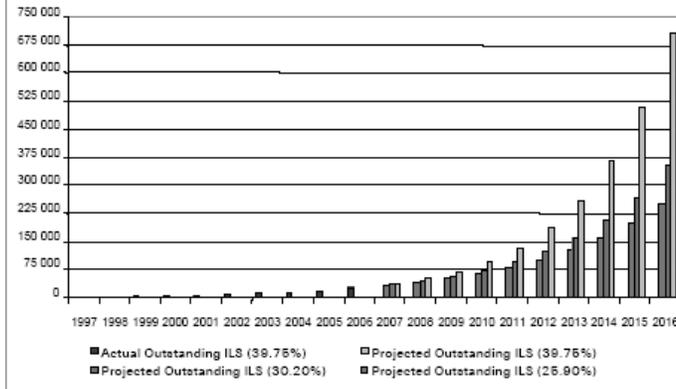


Figure 2: Growth of the ILS Market: Source Aigrain 2007.

However, extrapolation of past trends is a dangerous game, especially from a low base, and this predicted scenario seems to be particularly rosy. It is true that following the 2005 hurricane losses due to Katrina, Rita, and Wilma, (KRW) the ILS market proved remarkably resilient. Despite the fact that investors in one cat bond issue (Kamp Re) lost their entire principal, \$6.2 billion dollars was raised in the cat bond market in 2006, and \$6.3 billion was raised in sidecars. This growth has gone on into 2007.

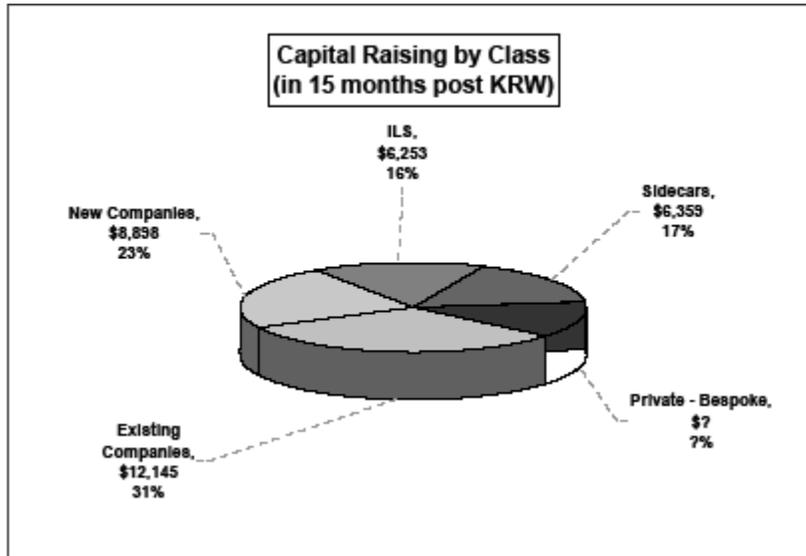


Figure 3: Post Katrina Financing: Source Lane Financial

It should be pointed out, however, that these sums fall far short of the KRW losses of \$56.5 billion. More worrying, the sub-prime problems have cast a shadow over the whole structured investment/special investment vehicle market, and it is unlikely that the ILS market will escape this pall.

POSSIBLE JUSTIFICATIONS FOR TRIA

In the absence, then, of a multi billion ILS Market, what is the appropriate role for government in regulating the conventional terrorism loss insurance industry? Based on the analysis here, several conclusions emerge.

1) TRIA may be justified as a way of limiting industry loss. A fixed cap on loss limits the size of the needed recapitalization following an event and thus reduces reliance on external capital markets. In light of the \$687 billion in total reserves, the current loss cap of \$100 billion, (\$70 billion after tax) seems more than adequate. There is evidence from other catastrophe lines (for example, earthquake insurance in California),⁸⁰ that private insurers will write insurance if they know that the maximum possible loss is limited to a manageable sum. As reserves increase, this upper limit could be increased. TRIA further limits industry losses through the reimbursement of 85% of losses after the insurer deductible has been met. Within the liability cap, this reinsurance seems unnecessary.

2) With a manageable total loss cap in place, there seems no reason why, within the overall \$100 billion limit, the government should provide the industry with any subsidy. As noted above, the expected value of this subsidy is in any case small, and with total loss capped, the industry seems quite capable of paying claims without any co-payments from the government. The more the industry is required to bear its own risk, the more incentive there will be to discover creative financing arrangements such as the ILS discussed above. It is little wonder that some insurers such as Swiss Re are reluctant to enter the terrorism insurance market when they must compete with an agency, the federal government, which makes reinsurance available at zero cost.

3) TRIA may be justified as a way of reducing the price for terrorism insurance. Although insurers have the capability to pay claims, because of uncertainty about the probability of the losses, ambiguity aversion drives up the price of terrorism insurance. While it is beyond the

⁸⁰ Dwight M. Jaffee and Thomas Russell, *Should Governments Provide Catastrophe Insurance?*, *ECONOMISTS' VOICE*, Apr. 2006 at 2.

scope of this paper to explore in detail, it may be that without TRIA the price of terrorism insurance will be higher than many policyholders are willing to pay.⁸¹ In the absence of insurance it seems likely that Federal and State governments would be obliged to make ex post payments following a terrorist attack, and the larger the share of these losses covered by insurance, the smaller the burden on the taxpayer.⁸² TRIA also helps to address ambiguity aversion through the recoupment process, which uses actual costs of a terrorism incident rather than trying to model and predict what those costs would be. Public policy reasons (such as ex ante planning and ex post claims adjusting expertise) may justify the program to improve take-up rates and to reduce prices.

All of this said, the parameters of government intervention in the conventional terrorism insurance industry have now been set till 2014, so reforms are not imminent. There does remain the question of what to do about CNBR risk, and since the extension of TRIA requires the Comptroller General to study “the availability and affordability of insurance coverage for losses caused by terrorist attacks involving nuclear, biological, chemical, or radiological materials” and issue a report by December 2008,⁸³ this question remains of some current interest.

WHAT SHOULD BE DONE ABOUT CNBR RISK?

In the original House version of what became the Terrorism Risk Insurance Program Reauthorization Act of 2007, the “mandatory offer” provision was extended to acts of CNBR terrorism. Although at least parts of the industry supported this provision, which was supplemented by lower deductibles and other provisions favorable to insurers (such as the so-called “reset” provision), the final version did not expand TRIA’s coverage to include CNBR risks. The administration and some Senators opposed the inclusion of CNBR risks as an inappropriate expansion of TRIA. In the

⁸¹ Take-up rates have gone from about 24% to 60% since TRIA was first enacted. These take-up rates are at least in part because of lower pricing under the program, and without TRIA it is reasonable to expect that prices would rise and take-up rates would fall. See PETER CHALK ET AL., TRENDS IN TERRORISM: THREATS TO THE UNITED STATES AND THE FUTURE OF THE TERRORISM RISK INSURANCE ACT 7-8 (2005).

⁸² This view informs the RAND study. See LLOYD DIXON ET AL., RAND CTR FOR TERRORISM RISK MGMT POLICY, THE FEDERAL ROLE IN TERRORISM INSURANCE: EVALUATING ALTERNATIVES IN AN UNCERTAIN WORLD 37-41 (2007) available at http://www.rand.org/pubs/monographs/2007/RAND_MG679.pdf.

⁸³ Terrorism Risk Insurance Program Reauthorization Act of 2007, Pub. L. No. 110-160, § 5(a), 121 Stat. 1839, 1841-42 (2007).

show-down between the House and Senate versions the Senate version won, in significant part because of a threatened veto, and so the CNBR provision was not included, leaving only the requirement for the Comptroller General study.

Although in many ways the issues raised by CNBR terrorism are the same as those raised by conventional terrorism (except with larger loss estimates), the risk of large losses combined with even less experience and data about such attacks makes it less likely that the private market will provide significant insurance coverage for NBCR risks. In its September 2006 report on insuring NBCR risks, for example, the GAO notes that “insuring NBCR risks is distinctly different from insuring other risks because of the potential for catastrophic losses, a lack of understanding or knowledge about the long-term consequences, and a lack of historical experience with NBCR attacks in the United States.”⁸⁴ The GAO concluded that, “[g]iven the challenges faced by insurers in providing coverage for, and pricing, NBCR risks, any purely market-driven expansion of coverage is highly unlikely in the foreseeable future.”⁸⁵

As noted above in Table 1, some scenarios of CNBR attacks are estimated to cause losses that approach \$700 billion. Under the current TRIA structure, however, this would present no marginal threat to the surplus positions of private insurers. Even with CNBR coverage included, private insurance losses would remain capped at \$100 billion (\$70 billion after tax).⁸⁶

For insurers, then, the real question is the extent to which the addition of CNBR risk would increase the probability of payouts below the \$100 billion cap. To answer this question, it is necessary to estimate the probability of a CNBR attack, and, because we have little clear data on how close terrorists are to developing weapons of mass destruction,⁸⁷ this is even more difficult than estimating the probability of a conventional terrorism attack.

⁸⁴ U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-06-1081, TERRORISM INSURANCE: MEASURING AND PREDICTING LOSSES FROM UNCONVENTIONAL WEAPONS IS DIFFICULT, BUT SOME INDUSTRY EXPOSURE EXISTS 4 (2006).

⁸⁵ *Id.* at 4.

⁸⁶ See McCarter, *supra* note 45, at 30 tbl. 1.

⁸⁷ *E.g.*, WILLIAM LANGEWIESCHE, THE ATOMIC BAZAAR: THE RISE OF THE NUCLEAR POOR (2007) (providing an interesting discussion of the challenges which terrorists face in obtaining highly enriched uranium, the heart of a nuclear bomb). For a qualitative assessment of CNBR risks based on current terrorism threats, see PETER CHALK ET AL., TRENDS IN TERRORISM: THREATS TO THE UNITED STATES AND THE FUTURE OF THE TERRORISM RISK INSURANCE ACT 11-38 (2005).

Experts are deeply divided on this issue. On the one hand, there are those who see a CNBR attack on the US in the near future as all but inevitable. For example, William Frist, the former United States Senate majority leader in 2005 stated, “The greatest existential threat we have in the world today is biological” and would come “at some time in the next 10 years.”⁸⁸

On the other hand, there is much data suggesting that terrorism risk is in fact very low. As Mueller has pointed out:

Even with the September 11 attacks included in the count, however, the number of Americans killed by international terrorism over the period [1975-2003] is not a great deal more than the number killed by lightning--or by accident-causing deer or by severe allergic reactions to peanuts over the same period. In almost all years the total number of people worldwide who die at the hands of international terrorists is not much more than the number who drown in bathtubs in the United States--some 300-400.⁸⁹

Attempts to reach scientific estimates of probability are bedeviled by the well known judgmental bias called by Tversky and Kahneman, the availability heuristic.⁹⁰ Events such as a suitcase nuclear bomb attack on a US city are vivid and easy to imagine, a fact reinforced by the frequent use of such events in popular fiction. Because such events are “available,” they are believed to occur more frequently than the data suggests. When the availability heuristic is combined with the fact that inducing fear of an invisible enemy is often a powerful political instrument, the divergence of views is easy to understand.

Insurers are caught in the middle of this debate, and thus find it very difficult to know what premium would be appropriate for CNBR coverage. So even though extending the “must offer” requirement within the \$100 billion cap would not threaten the viability of insurers, it would require an increase in premiums to cover the ambiguity in the estimates of likelihood.

⁸⁸ Kevin McElderry, *US Senate Leader Urges Research Push Against Bio-terrorism*, AGENCE FRANCE PRESSE, January 27, 2005. For a more scholarly assessment of CNBR risks from Al-Qaeda, see CHALK ET AL., *supra* note 81.

⁸⁹ JOHN MUELLER, *REACTING TO TERRORISM: PROBABILITIES, CONSEQUENCES, AND THE PERSISTENCE OF FEAR* (2007), <http://psweb.sbs.ohio-state.edu/faculty/jmueller/ISA2007T.pdf>.

⁹⁰ See Amos Tversky & Daniel Kahneman, *Availability: A Heuristic for Judging Frequency and Probability*, 5 COGNITIVE PSYCHOL. 207, 207 (1973).

To offset this premium increase, some form of special subsidy for CNBR terrorism may be needed. The government payment of 85% of losses (after insurer deductibles) would help reduce the price for such coverage. Industry representatives have argued that for CNBR coverage to be affordably priced, the industry deduction for CNBR terrorism loss should be lower than for conventional losses.⁹¹ This kind of special treatment of CNBR loss was a feature of the House version of 2007 extension of TRIA (which was not accepted by the Senate or the Administration).⁹²

CNBR AND WORKERS COMPENSATION

The workers compensation line faces two special challenges with respect to CNBR risks.

1) With the exception of Pennsylvania,⁹³ workers compensation statutes permit no exclusions for CNBR risks.

2) The benefits payable under workers compensation are preset by statute. For some injuries likely to be associated with CNBR attacks, for example skin grafting following burns, these individual benefits may exceed \$15 million.

Thus, private insurers who offer this line have substantial exposure. For example, some 5.7% of total 9/11 losses (approximately \$2 billion) was due to workers compensation claims, and the estimates of the workers compensation loss from a New York City CNBR incident given in Table 1 approach one half trillion dollars.

To be sure, not all of this risk is written by the for-profit private sector. In four states and two territories,⁹⁴ workers compensation insurance is

⁹¹ See *Hearing on Terrorism Risk Insurance Before the Subcomm. on Capital Markets, Insurance, and Government Sponsored Enterprises of the H. Comm. on Financial Servs.*, 110th Cong. (2007) (statement of Brian Dowd, CEO, Insurance-North America).

⁹² Terrorism Risk Insurance Revision and Extension Act of 2007, H.R. Res. 2761, 110th Cong. § 101 (2007).

⁹³ In Pennsylvania, workers compensation statutes explicitly exclude acts of war. See 77 PA STAT. ANN. § 431 (West 2002). Other jurisdictions are silent on this class of risk. Since acts of war may therefore be included in workers compensation contracts, TRIA and its extensions provide that the Federal program includes acts of war as well as acts of terrorism.

⁹⁴ North Dakota, Ohio, Puerto Rico, the U.S. Virgin Islands, Washington, Wyoming. See Carl Hammersburg, *Benefits of Adding Workers' Compensation Data to the Public Assistance Reporting Information System (PARIS)*, http://www.acf.hhs.gov/programs/paris/state_info/worker_white_paper.html.

provided by a state run monopoly, and in thirteen other states⁹⁵ a not-for-profit state enterprise competes with the private sector. In New York State, the state exposed to the half trillion dollar estimate of Table 1, the top five writers of workers' comp insurance in 2006, according to A.M. Best Co. were: the State Insurance Fund of New York, a not-for-profit state agency, with 40.4% market share; American International Group Inc., with 18.7%; Liberty Mutual Insurance Cos., with 9.1%; Hartford Insurance Group, with 4%; and Zurich Financial Services North America Group, with 3.6%. Clearly, the exposure of the private sector in this state (60%) is significant,⁹⁶ and for private insurers who write this line, the argument that, because of its size and non predictability, CNBR risk is uninsurable, apparently does not apply.

Obviously when given the all or nothing choice to offer CNBR insurance or quit the workers compensation line, many companies have found a way to stay in business. How did they do it? In the first place, many companies scrutinized their book of business to make certain that they had no accumulation of geographic risk. This statement by the CEO of New York Mutual describes the policy:

With respect to workers' compensation coverage, as long as employee counts were not too concentrated, our company considered offering coverage. We also implemented a computer system to geo track risk accumulations to the street level as well as the number of employees in a given building, and risk concentrations by zip code.⁹⁷

Concentration of risk is clearly a major issue. If an insurer were to write workers compensation insurance in the District of Columbia (where the death benefit is worth approximately \$1.8 million) for a company which lost 300 employees as a result of a terrorist attack, the total claim

⁹⁵ Arizona, California, Colorado, Idaho, Maryland, Minnesota, Montana, New York, Oklahoma, Oregon, Pennsylvania, Utah. *See id.*

⁹⁶ In California, the share of the risk taken by the state enterprise, State Compensation Insurance Fund, fell sharply between 2005 and 2006 (from over 42% to 31%) and the state is actively campaigning to attract further private capital. Apparently investors in this state are not put off by the fact that their capital is exposed to CNBR risk. *See* 2006 ANNUAL REPORT, STATE COMPENSATION INSURANCE FUND 5 (2006), available at <http://www.scif.com/pdf/2006AnnualReport.pdf>.

⁹⁷ *Hearing on the Need to Extend the Terrorism Risk Insurance Act Before the Subcomm. on Capital Markets, Insurance, and Government Sponsored Enterprises of the H. Comm. on Financial Servs.*, 110th Cong. 3 (2007) (statement of Warren Heck, Chairman and CEO, Greater New York Mutual Insurance Company, Insurance Company of Greater New York and Strathmore Insurance Company), available at http://www.house.gov/apps/list/hearing/financialsvcs_dem/htheck030507.pdf.

would equal \$500 million. It would clearly not be prudent for one company to cover all these employees.

Given the obvious benefit of regional diversification, it might be thought that there would be benefits to the development of an industry pool to share workers compensation risks.⁹⁸ A 2004 private market sponsored study by Tillinghast Reinsurance, however, concluded that such a pool would do little to add to capacity, and the industry opted instead to rely on the federal program. As the study states,

In the face of catastrophic events (the type that threaten the viability of the industry), the pool could not provide the industry any meaningful protection for the foreseeable future. This is true even under the most optimistic of assumptions including, notably, that the pool could achieve favorable tax treatment that enables it to accumulate capacity more quickly.⁹⁹

Secondly, though it is true that forecasting terrorist attack is more art than science, if a premium rate must be developed, assumptions can be made, and a rate brought forth. Following 9/11 this was done by the National Council on Compensation Insurance for insurers in the states for which they develop rates.¹⁰⁰ Details of how it was done are available at NCCI (2002).

In any case, we simply note that conventional and CNBR terrorism risk is currently provided by the private sector under the workers compensation line. The private sector has clearly concluded that the federal backstop provides adequate reinsurance in the event of a major loss. If, the Comptroller General report on CNBR insurance recommends that CNBR events be added to the must offer provision in TRIPRA, it seems likely that property /casualty insurers would react in much the same manner as providers of workers compensation insurance. Indeed, as with AIG, in many cases the same companies are involved.

⁹⁸ In the UK, all terrorism risks are shared via an organization called Pool Re with the UK Government providing a backstop. Details may be found on the Pool Re webpage <http://www.poolre.co.uk/>.

⁹⁹ TOWERS PERRIN, WORKERS COMPENSATION TERRORISM REINSURANCE POOL FEASIBILITY STUDY 3 (2004), available at https://www.towersperrin.com/tillinghast/publications/reports/WC_Terr_Pool/WC_Terr_Pool_Study.pdf

¹⁰⁰ The NCCI is the workers compensation rate making body rate for 35 states (AL, AK, AZ, AR, CO, CT, DC, FL, GA, HI, ID, IL, IA, KS, KY, LA, ME, MD, MS, MO, MT, NE, NV, NH, NM, OK, OR, RI, SC, SD, TN, UT, VA, and VT), see NCCI State Map, <https://www.ncci.com/nccimain/IndustryInformation/TerrorismWC/Resources/Pages/default.aspx>.

CONCLUSION

In this article we have deliberately discussed terrorism insurance regulation within the context of the recently passed Terrorism Risk Insurance Program Reauthorization Act of 2007. Since this Act provides the regulatory framework for the next seven years, this seems appropriate. Recognizing that the original Terrorism Risk Insurance act of 2002 was passed in some haste, the question may be raised as to how terrorism insurance would be optimally regulated if we started with a clean slate.

To the extent that this article correctly identifies the fundamental problem of terrorism insurance (indeed of all catastrophe insurance) as being the near impossibility of obtaining adequate capital in the aftermath of a large loss, there is clearly an argument for maintaining some limit on the industry's aggregate loss. The Comptroller General is charged with examining this question, but in the context of lowering the limit after a loss. Given the growth in size of reserves since the \$100 billion limit was set five years ago, there would seem to be an argument in the opposite direction for raising the limit, keeping it to some fixed fraction of industry reserves. Certainly experience with the California Earthquake Authority and with the Price Anderson Act governing the insurance of nuclear accidents suggests that if the industry knows its liability is limited to a manageable amount, it will be more willing to continue to offer this line.

Beyond that, it may be time to recognize a fact of which bankers have been aware since at least the time of the 19th century English writer on capital markets, Walter Bagehot.¹⁰¹ From time to time, capital markets fail to act rationally in their evaluation of streams of future payments. During these periods markets fail to provide liquidity, so it is necessary to have liquidity provided by a government agency. In the case of banking this role is played by the central bank.

By making it difficult to raise capital, a catastrophe such as a terrorist attack has much the same effect on an insurance company as does a run on a bank during a period of illiquidity. In both cases, external capital is needed, and in both cases external capital is not available. To a limited extent, TRIA provides this needed liquidity by providing government support to pay terrorism claims (followed by recoupment of some or all of the government payments). Perhaps the time has come to address this liquidity problem more systematically by extending to insurers the same

¹⁰¹ WALTER BAGEHOT, *LOMBARD STREET: A DESCRIPTION OF THE MONEY MARKET* (Charles Scribner's Sons 1897).

courtesy which the Federal Reserve System extends to banks, namely giving them temporary access to public capital until such times as the liquidity crisis passes.¹⁰²

In addition to addressing the capital problems associated with terrorism risk, TRIA provides a mechanism to address the ambiguity problem in two ways: First, by limiting the amount of risk faced by insurers to their deductible and co-payments (even within the \$100 billion cap); and second, by providing for an ex post assessment of the risk based on actual costs passed on to insureds through the recoupment mechanism. This reduces the price of terrorism insurance, and increases the take-up rates. Wider use of terrorism insurance has social benefits of providing access to the insurance industry claims apparatus and at least marginally reducing the government cost of compensating victims of a terrorist attack.

¹⁰² More details of such a scheme may be found in Dwight Jaffee & Thomas Russell, *NBCR TERRORISM: WHO SHOULD BEAR THE RISK*, IN *GLOBAL BUSINESS AND TERRORISM* (Harry Richardson, ed., forthcoming 2008).

THE SCOPE OF EXPERT TESTIMONY IN INSURANCE BAD FAITH CASES: CAN THE EXPERT TESTIFY ON THE MEANING OF THE INSURANCE POLICY?

*Charles Miller**

ABSTRACT

This article discusses the use of claims handling experts in bad faith insurance claims and the admissibility of their testimony in legal malpractice cases. While a duty of good faith has been established in insurance case law, insurance claims experts are used in court to provide information and analysis on training, policy, and interpretation by various insurance claims handlers and their subsequent decisions in covering or denying situations. Such experts minutely examine the training and preparation regimes of the claims handlers, but their testimony is sometimes limited based on concerns over invading the court's province and whether policies are ambiguous. This article argues that such concerns are invalid and unworkable, and that such expert testimony, analogous to testimony for cases in legal malpractice, is both acceptable and helpful to legal proceedings.

I. INTRODUCTION

The use of claims handling experts in insurance bad faith cases has dramatically increased in the past several years. Claims handling experts are used to provide testimony on whether the insurance company handled the claim properly, in bad faith, or in accordance with insurance industry practices and standards. Claims experts can also provide the trier of fact with an important understanding of how the insurance claims business works—i.e., what an insurance adjuster does and what they are supposed to do.

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Expert testimony in insurance bad faith cases can be extremely important to both sides. Indeed, expert testimony may be the key factor that sways the trier of fact. For example, in the trial of *Campbell v. State Farm* in Utah, the expert testimony of two claims experts was a significant factor in the \$145 million punitive damage award.¹

Although insurance claims experts are being increasingly used by both plaintiff and defense in insurance bad faith cases, the testimony of such experts has, however, been limited to whether the insurer's conduct complied with the practices and standards in the insurance industry for claims handling.² Many courts have precluded insurance claims experts from testifying on whether the insurer properly interpreted and applied an

¹ *Campbell v. State Farm Mut. Auto Ins. Co.*, 65 P.3d 1134 (Utah 2001), *rev'd in part*, 538 U.S. 408 (2003).

To rebut State Farm's "honest mistake" defense, the Campbells called experts Stephen Prater and Gary Fye. These men were intimately acquainted with the intricacies of the insurance industry and with State Farm's practices in particular. Their qualifications as experts were not challenged by State Farm. Their testimony focused upon explaining State Farm's PP & R policy and demonstrating its far-reaching effects. State Farm now argues that much of this testimony was without foundation and was prejudicial. In particular, State Farm challenges the experts' testimony concerning the company's excess liability handbook, its failure to maintain statistics on excess verdicts, the profits it derived from improper claims handling and the effects of its PP & R policy and related practices in the insurance industry in general. State Farm also argues that Mr. Prater impermissibly testified to legal conclusions.

Id. at 1159.

We have reviewed the entire transcript of both Prater's and Fye's trial testimony. With the exception of the argument concerning legal conclusions, we find it unnecessary to address with particularity State Farm's specific challenges. That the experts' testimony was helpful is evident. State Farm conceded the witness' qualifications. Although the rule does not require that the issue to which an expert testifies be arcane, the issues raised in this case were in fact quite difficult for the average person to understand. The experts' familiarity with the insurance industry in general, and State Farm in particular, must have greatly aided the jury's understanding of the issues. Moreover, our review of the record satisfies us that the experts' testimony, given its relevance and its helpfulness, did not raise any concerns under rule 403 sufficient to warrant exclusion. Thus, because the experts' testimony was helpful to the jury, the trial court did not abuse its discretion under rule 702.

Id. at 1160.

² Experts in insurance bad faith cases frequently testify on the standards and practices in the insurance industry for the handling of claims. *See, e.g.*, *Hanson v. Prudential Ins. Co. of America*, 783 F.2d 762, 765 (9th Cir. 1985); *Tricor Cal. Inc. v. State Comp. Ins. Fund*, 35 Cal. Rptr. 2d 550, 551-552 (Cal. Ct. App. 1994); *Rawlings v. Apodaca*, 726 P.2d 565, 569, 574 (Ariz. 1986) (insurance claims expert permitted to testify that insurer's conduct breached insurance industry custom and practice). However, an insurer may not excuse its treatment of the insured by proving that it conformed to industry standards. *Silberg v. Cal. Life Ins. Co.*, 521 P.2d 1103, 1109 (Cal. 1974).

insurance policy provision.³ The courts have usually reasoned that the interpretation of a contract provision is the domain of the court and not expert testimony.

The purpose of this article is to examine whether insurance claims experts should be permitted to testify on the meaning of insurance contract provisions in evaluating whether the insurer acted reasonably in applying a policy provision to a given claim. In the article I will argue that the courts have too narrowly limited the scope of insurance claims experts' testimony in insurance bad faith cases. Insurance claims experts should be able to testify on whether an insurance claims handler has properly interpreted and applied insurance policy provisions. Admissible expert testimony should not only include insurance industry claims handling standards pertaining to the interpretation and application of insurance policy provisions, but also testimony regarding the applicable case law. This is necessary because insurance claims handlers, in applying an insurance policy provision, have been trained to consider and apply both industry standards and case law when making a coverage decision. Accordingly, expert testimony concerning not only insurance industry practices but also the applicable case law is needed in insurance bad faith cases where there is a coverage issue in order to provide the trier of fact with all the relevant facts and testimony concerning the insurer's conduct.

The first section of the article will summarize the development of bad faith law and how it relates to the handling of claims. To find that the insurer has breached its duty of good faith and fair dealing, the trier of fact must, in most jurisdictions, find that the insurer's conduct was not only unreasonable but also in reckless disregard for the interests of the policyholder.⁴ In spite of this broad standard, insurance claims handling experts have often been prevented from testifying as to whether the claim handler investigated and resolved insurance coverage issues in accordance with insurance industry standards, including the applicable case law. This is in spite of the fact that the claims handler almost daily addresses and

³ See, e.g., *McHugh v. United Serv. Auto. Ass'n*, 164 F.3d 451, 454-55, 457 (9th Cir. 1999); *Flintkote Co. v. Gen. Accident Assurance Co.*, 410 F.Supp.2d 875, 876, 885 (N.D. Cal. 2006).

⁴ Although this article focuses on expert testimony on insurance contract interpretation with regard to the bad faith cause of action, the same testimony would be helpful, and should be considered, with regard to the breach of contract claim. Any reference herein to bad faith cause of action should also be read to include the breach of contract cause of action.

makes important decisions concerning the application of coverage, which themselves involve consideration of the applicable case law.

The second section of the article will examine what insurance claims personnel do in their day to day handling of claims. Here, it will be noted that insurance claims personnel receive a wide range of training and experience in the interpretation of insurance policy provisions, and are called upon, on a daily basis, to interpret and apply insurance policy provisions to an equally wide variety of insurance claims. Further, there is substantial literature in the insurance industry regarding the interpretation and application of insurance policy provisions. This literature is available to insurance claims personnel to assist them in the interpretation and application of insurance policy provisions. This training and education, along with the available literature, constitutes, at least in part, the insurance industry's standards for insurance claims handling with regard to the interpretation and application of insurance policy provisions. Such information is relevant in both insurance contract and bad faith actions in order for the trier of fact to determine, first, the meaning of the contract provision, and second, in the bad faith cause of action, whether the insurer has complied with those standards.

The third section of the article will address the current status of case law as it applies to the admissibility of expert testimony on the interpretation of insurance policy provisions in insurance bad faith cases. Here, it is noted that the courts have articulated two principle reasons for restricting expert testimony when it comes to insurance contract construction: First, the rules of evidence preclude such testimony absent a finding of ambiguity, and second, such testimony invades the province of the court. Both of these limitations fail to recognize the nature of insurance claims handling, including insurance industry publications and materials on insurance policy interpretation and that claims handling routinely involves consideration of the applicable case law. Further, these limitations have proved to be unworkable either because they are fraught with exceptions or they are artificial and fail to offer sufficient guidance on how to determine what expert testimony is admissible and what is not.

The fourth section will turn to a discussion of expert testimony in legal malpractice cases. A discussion of expert testimony in legal malpractice cases is appropriate because of the similarities between the legal and claims handling professions. A consideration of expert testimony in legal malpractice cases also offers a possible approach to the admissibility of expert testimony on the meaning of insurance contract provisions in insurance bad faith cases. In this regard it will be noted that expert testimony in legal malpractice cases can extend to legal issues, or in other

words, matters that may normally be considered to be in the province of the court. Here, it will be argued that insurance claims handling is a quasi-legal profession with regard to the interpretation and application of insurance contract provisions. Accordingly, insurance claims experts should be given the same latitude of testimony that is granted to experts in legal malpractice cases. Without such latitude the trier of fact will be precluded from hearing relevant evidence concerning the conduct of the insurance claims handler.

The article will conclude that expert testimony on the interpretation of insurance contracts should be permitted on both insurance industry practices and standards and applicable case law. By expanding insurance expert testimony to include the interpretation and application of insurance policy provisions the trier of fact will be permitted to hear relevant evidence concerning the insurer's conduct. Any concern that such testimony will amount to instructing the jury on the law can easily be obviated by appropriate procedural mechanisms.

II. INSURANCE BAD FAITH LAW AND THE ROLE OF THE INSURANCE CLAIMS EXPERT

Most courts have held that every insurance contract contains an implied covenant of good faith and fair dealing "that neither party will do anything which will injure the right of the other to receive the benefits of the agreement."⁵ In the seminal case of *Gruenberg v. Aetna Ins. Co.*, the California Supreme Court held that, "in every insurance contract there is an implied covenant of good faith and fair dealing. The duty to so act is imminent in the contract whether the company is attending to the claims of third persons against the insured or the claims of the insured itself."⁶

Having held that insurance contracts contain a duty of good faith the courts were then required to address how that duty was to be established. Several courts have adopted a two pronged test, under which the insured has the burden (1) "[t]o show...the absence of a reasonable basis for denying the benefits of the policy; and (2) the insurer's "knowledge or

⁵ See, e.g., *Commuale v. Traders & Gen. Ins. Co.*, 328 P.2d 198, 200 (Cal. 1958); see also, Dougals G. Houser, *Good Faith As a Matter of Law: The Insurance Company's Right to be Wrong*, 27 TORT & INS. L.J. 665, 666 (1991-1992).

⁶ 510 P.2d 1032,1038 (Cal. 1973).

reckless disregard of the lack of a reasonable basis for denying the claim.”⁷ It appears that two jurisdictions, Hawaii⁸ and Ohio⁹, have adopted only the first prong of this test.

The first part of the two prong test requires a determination of whether the insurer’s conduct is objectively reasonable, whereas the second prong addresses the mental state of the claims handler and asks whether he/she acted “deliberately and consciously rather than negligently.”¹⁰

Insurance claims experts are frequently called upon to provide testimony on both prongs of the bad faith test. The expert may provide testimony of whether the insurer’s conduct was reasonable (the first prong) in light of insurance industry claims handling standards and practices. Similarly the expert may be asked to testify on whether insurance company programs or policies created, in the expert’s opinion, improper incentives such that the claims handler was motivated to handle the claim to the insurer’s benefit and the detriment of the policyholder.¹¹

The insurance claims expert may also be asked to testify on whether the insurer reasonably interpreted and applied a particular policy provision. For example, where the insurer denies coverage on a first party water loss because of a policy exclusion for long term seepage,¹² the claims expert may be asked not only for his/her opinion on the adequacy of the insurer’s investigation but also on whether, based on the facts, the insurer was reasonable in its denial of coverage. Such expert testimony may not only

⁷ *Regal Homes, Inc. v. CNA Ins.*, 171 P.3d 610, 621 (Ariz. Ct. App. 2007); *Picket v. Lloyd’s*, 621 A.2d 445, 453 (N.J. 1993); *Anderson v. Cont’l. Ins. Co.*, 271 N.W.2d 368, 376 (Wis. 1978).

⁸ *Best Place, Inc. v. Penn. America Ins. Co.*, 920 P.2d 334, 347 (Haw. 1996).

⁹ *Zoppo v. Homestead Ins. Co.*, 644 N.E.2d 397, 399-400 (Ohio 1994).

¹⁰ *Vandeventer v. All American Life & Cas. Co.*, 101 S.W.3d 703, 721 (Tex. App. 2003) (citing *Colley v. Ind. Farmers Mut. Ins. Group*, 691 N.E.2d 1259, 1261 (Ind. Ct. App. 1998)).

¹¹ Courts have found that certain insurance company programs or policies create such improper claims handling motivations. For example, the Arizona Supreme Court in *Zilisch v. State Farm*, 995 P.2d 276, 280 (Ariz. 2000), called attention to these practices when it wrote: “There was sufficient evidence in this case from which a jury could find that State Farm acted unreasonably and knew it. There was evidence that State Farm set arbitrary goals for the reduction of claims paid. The salaries and bonuses paid to claims representatives were influenced by how much the representatives paid out on claims.”

¹² Homeowners’ insurance policies may commonly contain an exclusion for “loss caused by continuous or repeated seepage or leakage of water or steam from within a plumbing, heating or air conditioning system or from within a domestic appliance which occurs over a period of weeks, months or years.” See *Fidelity Casualty & Surety Bulletins, Personal Lines Volume, Dwellings HIB-3*, Nov. 1994.

involve consideration of the policy language, but also insurance industry publications which provide guidance generally on the interpretation of insurance policies as well as industry publications concerning the meaning of the operative policy provision itself. In addition, the reasonableness of the insurer's conduct in interpreting and applying the policy provision may also depend on whether the insurer properly considered the applicable case law.¹³ Some courts have precluded expert testimony on insurance industry policy interpretation, excluding testimony on the applicable case law on the grounds that such testimony invades the court's domain.¹⁴

The limitations on the scope of an insurance claims expert's testimony appear artificial when considered in context with how insurance claims handlers are trained and what they are asked to do on a daily basis; that is, make coverage decisions. The limitation also fails to recognize the extensive insurance industry literature on the interpretation of insurance policies, which are relied upon frequently by insurance claims handlers to adjust claims. In other words, the limitations on the scope of testimony of experts concerning insurance policy interpretation issues are not tied to the real world. In order to appreciate this disconnect between the rules concerning admissibility of expert testimony and the real work of insurance claims handlers it is necessary to examine that "real world."

III. INTERPRETATION AND APPLICATION OF INSURANCE POLICY PROVISIONS IN THE INSURANCE CLAIMS HANDLING PROCESS

Insurance claims handling not only involves the proper investigation, evaluation and settlement of claims, but also, and frequently on a daily basis, the interpretation and application of insurance policy provisions. In the real world of insurance claims handling, insurance claims handlers are trained in policy interpretation; provided resources on how to interpret and apply policy provisions, and then required to interpret and apply insurance policies to specific fact situations. Any evaluation of whether the insurer's conduct in applying and interpreting a policy provision must, therefore,

¹³ See, e.g., *Redies v. Attorneys Liab. Prot. Soc'y*, 150 P.3d 930, 938 (Mont. 2007); *Barnes v. Okla. Farm Bureau Mut. Ins. Co.*, 11 P.3d 162, 174 (Okla. 2001); *Transcontinental Ins. v. Wash. Pub. Utilities Districts' Util. Sys.*, 760 P.2d 337, 347 (Wash. 1988).

¹⁴ See, e.g., *McHugh v. United Serv. Auto. Ass'n*, 164 F.3d 451, 454-55, 457 (9th Cir. 1999). *McCrink v. Peoples Benefit Life Ins. Co.*, 2005 WL 730688, at *4 (E.D. Pa. March 29, 2005).

consider the resources and training available to insurance claims handlers and whether those resources and training were utilized and followed.¹⁵

Insurance claims handlers are trained on how to interpret and apply insurance policies. This training includes educating the claims person on the insurance industry rules for the interpretation of insurance policies. These include the following: (a) exclusions are to be interpreted narrowly,¹⁶ (b) insuring agreements are to be interpreted broadly,¹⁷ (c) the insurance company must resolve doubts concerning coverage in favor of the policyholder,¹⁸ (d) policy language should be given its plain, ordinary and popular meaning;¹⁹ (e) ambiguous policy provisions should be interpreted against the insurer and in favor of coverage,²⁰ (f), and that the insurance company has the burden of proving the application of an excluded peril.²¹

There are also several texts which have been used to train insurance industry claims handlers on not only proper claims handling but also on the interpretation and application of insurance policy provisions.²² A partial list of such insurance texts would include the following:²³

¹⁵ At least one commentator has contended that there is no such thing as insurance industry standards and that the expert's opinion in insurance cases should "be based upon the same three things that a court's opinion would be based upon: the policy language, judicial precedent and any relevant statutes." ALLAN D. WINDT, *INSURANCE CLAIMS & DISPUTES: REPRESENTATION OF INSURANCE COMPANIES & INSUREDS* § 9:26A (4th ed. 2001 & Supp. 2006) (hereinafter "WINDT") Such a view ignores the vast amount of material used in the insurance industry, other than case law, to assist in the interpretation and application of insurance policies.

¹⁶ KENNETH S. WOLLNER, *HOW TO DRAFT AND INTERPRET INSURANCE POLICIES* 19 (1999) ("Exclusions and other limitations are strictly construed against the party seeking to impose the limitation.").

¹⁷ ERIC A. WIENING & DONALD S. MALECKI, *AM. INST. OF CPCU, INSURANCE CONTRACT ANALYSIS* 76 ("[I]nsuring agreement provides a broad statement of coverage.").

¹⁸ DONNA J. POWOW, *AM. INST. OF CPCU, PROPERTY LOSS ADJUSTING* § 5.34 (2003).

¹⁹ PRENTISS REED & PAUL THOMAS, *ADJUSTMENT OF PROPERTY LOSSES* 48 (McGraw Hill 1977).

²⁰ *Id.* at 50.

²¹ Insurance claims handlers have testified that these standards are used in the insurance industry to interpret and apply insurance policies. See Deposition of Stephen Hinkle at 166, *Illing v. State Farm Fire and Cas. Co.*, No.: 1:06cv513-LG-RHW (So. Dist. Miss., Feb 9, 2007) (Stephen Hinkle, a State Farm claim consultant, testified at his deposition that it is a basic tenant of insurance claims handling that the insurer must prove the application of the exclusion).

²² In addition to texts, there are a number of insurance industry publications which may provide invaluable information. Possibly the most important such publication is the magazine, "Claims," published by the National Underwriter Company. This magazine, which is published monthly, contains articles on a wide variety of insurance claims

PRENTISS REED & PAUL THOMAS, *ADJUSTMENT OF PROPERTY LOSSES* (McGraw Hill 1977).

JANE S. LIGHTCAP, INT'L CLAIM ASSOC., *MANAGING CLAIM DEPARTMENT OPERATIONS* (1997).

JAMES J. MARKHAM ET AL., INS. INST. OF AM., *THE CLAIMS ENVIRONMENT* (1993).

DONNA J. POPOOW, AM. INST. OF CPCU, *PROPERTY LOSS ADJUSTING* (2003).

JAMES R. JONES, AM. INST. OF CPCU, *LIABILITY CLAIM PRACTICES* (2003).

DONALD J. HIRSCH, *CASUALTY CLAIM PRACTICE* (McGraw Hill 1996).

Some of these texts have been cited by several courts,²⁴ and may be admissible as evidence of insurance industry standards.²⁵ These texts frequently contain advice on how a claims handler should interpret an insurance policy. For example, Thomas and Reed in their book, *Adjustment of Property Losses*, which has been used in the training of insurance claims handlers,²⁶ sets forth 16 standard rules for the construction of insurance policies.²⁷

adjusting issues, including the investigation and adjustment of mold claims, catastrophic injury claims, and workers compensation claims, among others. The magazine provides additional information on insurance industry standards, including the state of the art on insurance industry claims handling practices. See Claims Magazine, available at <http://www.claimsmag.com/cms/claims/website>.

²³ Frequently, the insurer's counsel will argue that such publications should not be admissible because they are parole evidence, which should not be allowed to change the agreed terms to a contract. In the insurance contract context, however, many courts have allowed the introduction of extrinsic evidence as an aid in contract interpretation. See, e.g., *Montrose Chem. Corp. v. Admiral Ins. Co.*, 897 P.2d 1, 14 (Cal.1995).

²⁴ For example, REED & THOMAS, *supra* note 19, has been cited by several courts. See, e.g., *Willhite v. Marlow Adjustment Co.*, 623 S.W.2d 254, 261 (Mo. Ct. App. 1981); *Los Angeles Mut. Ins. Co. v. Cawog*, 106 Cal. Rptr. 307, 310 (Cal. Ct. App. 1973); *Creole Explorations, Inc. v. Underwriters at Lloyds, Inc.*, 161 So.2d 768, 775 (La. 1964).

²⁵ The Federal Rule of Evidence permits the admittance of such texts as substantive evidence. "[S]tatements contained in published treatises, periodicals, or pamphlets on a subject of history, medicine or other science or art, established as a reliable authority by the testimony or admission of the [expert] witness or by other expert testimony or by judicial notice." FED. R. EVID. 803(18).

²⁶ In the preface, the authors note that the text "provides guidance and information to enable the claim representative to perform his or her duties in an effective and professional manner," and "[t]his...is a text for both student and instructor; it is a reference for all property claim personnel." REED & THOMAS, *supra* note 19, at iii, iv.

²⁷ *Id.* at 47-50.

Insurers often require that their claims handlers be trained in how to interpret and apply insurance policies. For example, State Farm mandates that its claims personnel attend claim training courses in which they are taught “[h]ow to read a policy, [and] how to determine coverage.”²⁸

In addition to insurance industry texts, insurance claims handlers make use of a wide range of publications that provide guidance on the interpretation of insurance policies.²⁹ For example, the Fidelity, Casualty and Surety Bulletins (FC&S Bulletins”), published by the National Underwriter Co., has been used in the insurance industry for decades to provide guidance on the interpretation and application of insurance policies.³⁰ The FC&S Bulletins have also been widely cited in court opinions. As one court noted:

The FC & S bulletin, which is published by the National Underwriters Association, is used by insurance agents and brokers to interpret standard insurance policy provisions. (*Maryland Casualty Co. v. Reeder* (1990) 221 Cal.App.3d 961, 972, 270 Cal.Rptr. 719.) “[R]eliance on [an] FC & S bulletin is appropriate under Civil Code section 1645 which provides: ‘Technical words are to be interpreted as usually understood by persons in the profession or business to which they relate, unless clearly used in a different sense.’” (*Maryland Casualty Co. v. Reeder, supra*, at p. 973, fn. 2, 270 Cal.Rptr. 719; *American Star Ins. Co. v. Insurance Co. of the West* (1991) 232 Cal.App.3d 1320, 1331 & fn. 8, 284 Cal. Rptr. 45.) “[I]nsurance industry publications are particularly persuasive as interpretive aids where they support coverage on behalf of the insured. Ultimately, the test is whether coverage is ‘consistent with the insured’s objectively reasonable expectations.’ [Citation.]” (*Prudential-LMI Commercial Ins. Co. v. Reliance Ins. Co.* (1994) 22 Cal.App.4th 1508, 1512-1513, 27 Cal.Rptr.2d 841.)³¹

²⁸ Deposition of Mike Porterlance at 88, *Davis v. State Farm*, No.: 1:06cv638-LTS-JMR (quoting Mike Porterlance, a State Farm claims department employee).

²⁹ See *Maryland Cas. v. Reeder*, 270 Cal. Rptr. 719, 722-723, 725 (Cal. Ct. App. 1990). The court also found that the insurance industry’s own interpretation of the broad form endorsement and certain exclusions precluded application of the exclusions in plaintiff’s policy. *Id.* at 725-726.

³⁰ See FC&S Bulletins Homepage, <http://cms.nationalunderwriter.com/cms/fcsbulletins/public+website/> (last visited Oct 13, 2008).

³¹ *Golden Eagle Ins. Co. v. Ins. Co. of the West*, 121 Cal. Rptr. 2d 682 (Cal. Ct. App. 2002).

Similarly, the International Risk Management Institute publishes several volumes, which are used in the insurance industry, among other subjects, on the interpretation and application of personal and commercial lines policy forms and provisions.³²

In addition to being knowledgeable regarding insurance industry policy interpretation standards and rules, insurance claims handlers need to be, and are often familiar with the applicable law in the jurisdictions in which they work. This includes the law of tort and contracts, as it applies to insurance contracts. In the book, *The Claims Environment*, Markham points out that “claims representatives should have expert knowledge of insurance policy coverages, the law, and determination of damages.”³³ Insurance claims personnel are commonly trained in the applicable law of the jurisdictions in which they work. For example, Stephen Hinkle, a State Farm Claim Consultant, has testified that, “over the course of [my] tenure as a claim consultant I’ve become familiar with the law in all four states that I’m involved in.”³⁴ Without such training and knowledge, an insurance adjuster would not be able to handle properly many of the claims assigned to him or her.

Insurers also publish their own written guidance documents on the interpretation and application of the insurance policies that they sell. For example, State Farm publishes a number of Operation Guides, which provide guidance to claims personnel on the handling of first party property claims. These Operation Guides frequently provide information on how particular policy provisions are to be interpreted. For example, State Farm Operation Guide 75-100, entitled “Claim Interpretations-Losses Insured First Party,” is “[t]o provide the Company interpretation of selected Section I-Losses Insured.”³⁵ With regard to Hurricane Katrina, Stephen Hinkle of

³² The International Risk Management Institute (“IRMI”) publishes several volumes on various types of insurance policies, including commercial liability, commercial property, and personal property policies. These volumes are also used widely in the insurance industry to assist claims personnel in the interpretation and application of insurance policies.

³³ JAMES J. MARKHAM ET AL., *INS. INST. OF AM., THE CLAIMS ENVIRONMENT* 12 (1993). (Markham, the director of Curriculum, General Counsel, and Ethics Counsel of the Insurance Institute of America, was previously employed by State Farm.)

³⁴ Deposition of Stephen Hinkle at 121, *Illing v. State Farm Fire and Cas. Co.*, No. 1:06 CV 513-LG-RHW (S.D. Miss. Mar. 16, 2007). Mr. Hinkle, who was responsible for consulting on State Farm claims in several southern States, testified that he actually kept a “folder that says Georgia law, Alabama law, South Carolina law, and Mississippi law.” *Id.* at 123.

³⁵ State Farm Operation Guide 75-100, entitled “Claim Interpretations-Losses Insured First Party” (on file with author).

State Farm drafted the Wind-Water Protocol, which provided guidance to State Farm claims personnel on how to apply State Farm policies to Katrina related claims.³⁶ These training materials are consistent with State Farm's requirement that one of the responsibilities of a claims representative is to "determine if the cause of that loss is covered [under] the contract."³⁷

An insurance claims handlers' obligation to interpret and apply properly insurance policy provisions is required by the National Association of Insurance Commissioners Model Unfair Claims Practices Act ("Act") and Model Unfair Claims Practices Regulations ("Regulations").³⁸ Over 45 states have adopted the Act either in its original form or in a modified form.³⁹ Likewise, many state insurance commissioners have adopted the Regulations.⁴⁰

The Act and the Regulations are two of many important sources of information for insurance industry standards for the proper handling of claims.⁴¹ The requirements set forth in the Regulations address an

³⁶ Memorandum from Stephen Hinkle, State Farm, State Farm Wind-Water Protocol (Sept. 13, 2005).

³⁷ Deposition of Mike Porterlance at 51, *Davis v. State Farm*, No. 1:06cv638-LTS-JMR (S.D. Miss. Date?); *see also* Porterlance Dep. at 116 (adjusters are expected to make a coverage determination on the loss).

³⁸ NAIC UNFAIR CLAIMS SETTLEMENT PRACTICES ACT, vol. 6, § 900-1 (2008); NAIC UNFAIR PROPERTY/CASUALTY CLAIMS SETTLEMENT PRACTICES MODEL REGULATION, vol. 6, § 902-1 (2008). Regulations or statutes which govern insurance claims handling can be used as standards against which the insurer's conduct can be measured. *Wailua Assocs. v. Aetna Cas. & Sur. Co.*, 27 F. Supp. 2d 1211, 1221 (D. Haw. 1998) (the Hawaii Supreme Court, in adopting a common law remedy for bad faith, expressed its concern that the administrative remedies provided in H.R.S. § 431:13-103(a) were inadequate to "provide sufficient incentive to insurers to perform their obligations in good faith" . . . [a]lthough H.R.S. § 431:13-103 does not provide for a private cause of action, the insurance industry should not be encouraged to commit the types of unfair practices contained therein. Therefore, the Court finds that violations of the unfair settlement provision, § 431:13-103(a), may be used as evidence to indicate bad faith." (citation omitted)). *See also* *Spray, Gould & Bowers v. Associated Int'l Ins. Co.*, 84 Cal. Rptr. 2d 552,560 (Cal. Ct. App. 1999) (where the court observed that "[t]he [Insurance] Commissioner's Regulations establish the standard of conduct for insurers in California"); *Peiffer v. State Farm Mut. Auto. Ins. Co.*, 940 P.2d 967, 971 (Colo. Ct. App. 1996) (expert permitted to testify that insurer violated provisions of the Colorado Unfair Claims Settlement Practices Act).

³⁹ NAIC UNFAIR CLAIMS SETTLEMENT PRACTICES ACT, vol. 6, § 900-1 (2008).

⁴⁰ For example, in California the Act is codified at CAL. INS. CODE § 790.03(h) (2005), and the Regulations, which have been adopted by the California State Insurance Commissioner, can be found at CAL. CODE REGS. tit. 10 § 2695.1 (2008).

⁴¹ Markham has pointed out that, "insureds are frequently permitted to introduce evidence of violations of the Model Unfair Claims Settlement Practices Act and Model Unfair Claims Settlement Practices Regulations "because the model act is a nationally

insurer's obligations when it comes to interpreting and applying insurance coverage provisions. For example, the Regulations require:

Every insurer shall disclose to a first party claimant or beneficiary, all benefits, coverage, time limits or other provisions of any insurance policy issued by that insurer that may apply to the claim presented by the claimant.⁴²

It is difficult to imagine an insurer complying with this requirement without knowing how to interpret and apply the applicable policy provisions. Similarly, the Regulations set forth detailed requirements with regard to denial letters, which would also mandate knowledge on how to interpret and apply the insurance policy.

Where an insurer denies or rejects a first party claim, in whole or in part, it shall do so in writing and shall provide to the claimant a statement listing all bases for such rejection or denial and the factual and legal bases for each reason given for such rejection or denial which is then within the insurer's knowledge. Where an insurer's denial of a first party claim, in whole or in part, is based on a specific statute, applicable law or policy provision, condition or exclusion, the written denial shall include reference thereto and provide an explanation of the application of the statute, applicable law or provision, condition or exclusion to the claim.⁴³

Many insurers have inserted the Act and Regulations into their claims manuals.⁴⁴ State Farm, in its 1997 Catastrophe Claims Manual, sets forth the Act.⁴⁵ Similarly, Farmers' Regional Claims Manual States: "In all

recommended standard of care. It was developed [by the National Association of Insurance Commissioners] as a guide for insurance regulators in every state to establish reasonable claim practices. Since the NAIC [National Association of Insurance Commissioners] is made up of insurance "experts," juries should consider their opinion of what constitutes unfair claim practices when evaluating the behavior of an insurer in a bad faith case. Thus, although the model [Unfair Claims Settlement Practices] act may not allow insureds or claimants who have been treated unfairly by an insurer to file a private action, it has been used indirectly for the benefit of many plaintiffs." MARKHAM, *supra* note 33, at 397.

⁴² CAL. CODE REGS. tit. 10 § 2695.4(a) (2008).

⁴³ CAL. CODE REGS. tit. 10 § 2695.7(b)(1) (2008).

⁴⁴ Insurers may be required to have manuals or written claims handling standards. For example, The Act required insurers to "adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies." CAL. INS. CODE § 790.03(h)(3) (2005).

⁴⁵ State Farm Catastrophe Claims Manual, P. 1.1 (on file with author).

cases, the applicable state's Unfair Claims Settlement Practices Act/Regulations take precedence over anything in this manual.⁴⁶ The principles defined are so basic to good claims practice that we adhere to them throughout our operating territory as a matter of company policy. The Unfair Claims Practices Regulations of some states are more restrictive than the Model Regulations. If that is the case, those regulations will take precedence over anything in this manual."⁴⁷

IV. THE SCOPE OF THE INSURANCE CLAIMS EXPERT'S TESTIMONY⁴⁸

Ignoring the real world of insurance claims handling, many courts have held that an insurance claims expert cannot testify on the insurer's interpretation of an insurance policy because such testimony either invades the court's province as the sole interpreter of contract provisions,⁴⁹ or is barred by rules of evidence concerning contract interpretation.⁵⁰ These two barriers to expert testimony on the meaning of insurance policies have

⁴⁶ Farmers' Regional Claims Manual (on file with author).

⁴⁷ Farmers' Regional Claims Manual, p. IV-1 (on file with author). Similarly, Farmers' Claims Representative Field Manual sets forth the same standard as in the Regional Claims Manual, and, in addition, requires that "[e]ach claims representative be thoroughly familiar with the model act and their states' specific regulations." Similar requirements are set forth in Farmers' Branch Claims Office Procedure Manual. Randy Sommers, a Farmers' claims supervisor, who was deposed in the matter of Farmers Ins. Co. of Ariz. v. Stanley Wirick, Ariz., Case No. 2004-0201, pp. 19-20 & 34, testified that the unfair claims practices act sets forth Farmers' minimum standards for claims handling.

⁴⁸ For further discussion of expert testimony in insurance bad faith cases see Joel S. Feldman et al., *Expert Witnesses in Insurance Class Actions and Individual Cases – Defense Perspective*, 2000 A.L.I.-A.B.A. COURSE OF STUDY 249 (2000).

⁴⁹ See *Devin v. United Servs. Auto. Ass'n*, 8 Cal. Rptr. 2d 263, 268 (Cal. Ct. App. 1992); *Elder v. Pac. Tel. and Tel. Co.*, 136 Cal. Rptr. 203, 210 (Cal. Ct. App. 1977) (expert opinion testimony inadmissible where the issue is one of law for the court); *G & G Servs., Inc. v. Agora Syndicate, Inc.*, 993 P.2d 751,762 (N.M. Ct. App. 1999) (refusing to let insurer's expert witness, an attorney, testify generally concerning insurance law in suit for breach of duty to defend); *Lone Star Steakhouse & Saloon, Inc. v. Liberty Mut. Ins. Group*, 343 F. Supp. 2d 989, 1015 (D. Kan. 2004) (excluding testimony of claims expert on whether allegations in complaint fell within policy definition of "occurrence," that insurer had no basis to apply exclusion for "expected and intended" injury, that insurer was inconsistent in its claims handling, and that insurer is barred by estoppel from denying coverage).

⁵⁰ Nonetheless, even under this limited approach to expert testimony in insurance bad faith cases, the expert may refer to facts in legal terms. *Peiffer v. State Farm Mut. Auto. Ins. Co.*, 940 P.2d 967, 971 (Colo. Ct. App. 1996).

proved either unworkable or are so fraught with exceptions as to be virtually meaningless.

A. LIMITATIONS ON EXPERT TESTIMONY IN INSURANCE CASES
BASED ON CONCERN THAT TESTIMONY WILL INVADe THE
COURT'S PROVINCE HAVE PROVED UNWORKABLE AND FAIL
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ADJUSTING.

The admissibility of expert testimony under the Federal Rules of Evidence, as well as the rules of evidence for many states, is governed by whether the testimony will “assist the trier of fact.”⁵¹ The Federal Rules permit experts to testify on ultimate issues.⁵² While many courts have held that an expert cannot testify on legal matters, including the interpretation of insurance policies,⁵³ courts will permit experts to testify on mixed questions of law and fact.⁵⁴ Some commentators have noted that the distinction between purely legal testimony and testimony on mixed

⁵¹ FED. R. EVID. 702 (“If scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education, may testify thereto in the form of an opinion or otherwise.”); *see Soutiere v. Soutiere*, 657 A.2d 206, 208 (Vt. 1995).

⁵² “Testimony in the form of an opinion or inference otherwise admissible is not objectionable because it embraces an ultimate issue to be decided by the trier of fact.” FED. R. EVID. 704. At least one commentator has noted that, “[e]arly cases rejected expert testimony couched in terms of the ultimate issue—whether there is bad faith. These cases suggested that the testimony was inadmissible because it invades the province of the jury. Because of the latitude afforded trial courts by the Federal Rules of Evidence and similar state rules, however, this objection may be difficult to sustain today.” Timothy J. Muldowney & Robert A. Zupkus, *Bad Faith Claims: The Role of the Expert*, 64 DEF. COUNS. J. 226, 231 (1997) [hereinafter Muldowney & Zupkus] (citations omitted).

⁵³ *See, e.g., Mukhtar v. Cal. State Univ., Hayward*, 299 F.3d 1053, 1065 n.10 (9th Cir. 2002) (“an expert witness cannot give an opinion as to her legal conclusion, i.e., an opinion on an ultimate issue of law.”) (emphasis omitted).

⁵⁴ *See, e.g., Nimely v. City of N.Y.*, 414 F.3d 381, 397 (2nd Cir. 2005); *U.S. v. Segna*, 555 F.2d 226, 229 (9th Cir. 1977) (allowing expert testimony on defendant’s sanity); *Dixon v. Jacobs*, 427 F.2d 589, 595, n.17, 600-01 (D.C. Cir. 1970) (allowing testimony on the dangerousness of a mental patient); *U.S. v. Sisson*, 294 F. Supp. 520, 522-23 (D. Mass. 1968) (noting general permissibility of expert testimony on the mixed question of patent infringement).

questions of law and fact has not been workable.⁵⁵ A lawyer can frame the question as a matter of fact in order to get admitted expert testimony which otherwise would be excluded as testimony on the law.⁵⁶

Despite the inherent problems with distinguishing between fact and legal testimony, many courts have held that expert testimony regarding the meaning of an insurance policy is admissible under the guise that such testimony is limited to insurance industry practices and not the law.⁵⁷ As one District Court noted:

The Court alone determines the legal effect and construction of the USF&G policy. But the Court was not seeking expert testimony to determine the ultimate legal issue of coverage under the policy. Instead, the Court was seeking the testimony solely to determine what general understanding, if any, the insurance industry has as to the meaning of certain provisions in USF&G's policy. While resolution of this factual question affects the legal issues involved, the factual issue of industry custom is distinct from the legal issue of construction.⁵⁸

At the very least, this approach comports, to some degree, with what actually occurs in the insurance industry. That is, the industry has adopted its own interpretation of what policy provisions mean, if not provided its claims handlers with protocols on how to interpret and apply insurance policies.⁵⁹ Despite the statement that factual issues are distinct from legal issues, it is apparent that the distinction cannot always be easily determined.

⁵⁵ Note, *Expert Legal Testimony*, 97 HARV. L. REV. 797, 798 (1983-1984); Wilburn Brewer, *Expert Witness Testimony in Legal Malpractice Cases*, 45 S.C. L. REV. 727, 761 (1993-1994) [hereinafter Brewer].

⁵⁶ Brewer, *supra* note 56, at 767; *see also*, North River Ins. Co. v. Employers Reinsurance Corp., 197 F. Supp. 2d 972, 982-84 (S.D. Ohio 2002); Prof'l Consultants Ins. Co. v. Employers Reinsurance Co., 2006 WL 751244, at *21-22 (D.Vt. Mar. 8, 2006) (noting that expert opinions regarding policy meaning are admissible where opinion based on documents and depositions in the case, the course of conduct of the parties, and the experts knowledge of industry custom and practice).

⁵⁷ *See, e.g.*, U.S. Fid. & Guar. Co. v. Williams, 676 F. Supp. 123, 126 (E.D. La. 1987).

⁵⁸ *Id.* at 126 (footnote omitted).

⁵⁹ Expert testimony on the meaning of a policy provision may be particularly appropriate where the court determines that the provision is of a "specialized nature," *Playtex FP, Inc. v. Columbia Cas. Co.*, 622 A.2d 1074, 1076-77 (Del. Super. Ct. 1992).

An ample demonstration of the difficulty, if not the artificiality, of determining whether an expert opinion is based on law or fact is found in the District Court's decision in *Professional Consultants Ins. Co. v. Employers Reinsurance Co.*⁶⁰ The case presented the court with an issue of whether a reinsurance agreement limit was "an annual, or per policy, limit or a single limit for the life of the agreement."⁶¹ The insured, Professional Consultants, in its opposition to the insurer's motions for summary judgment, submitted an affidavit from Waterman, an expert on reinsurance matters, in which Waterman provided three opinions, which were challenged by the insurer as inadmissible legal conclusions. Waterman's opinions were:

1. "It is my opinion that the plain language of the 1993 Agreement stipulates emphatically that the reinsurance coverage pertains to each policy issued by PCIC that became effective after the effective date and prior to the termination date of the 1993 Agreement." (Paper 121 ¶13.)

2. "[I]t is my opinion that the 1993 Agreement affords, and in accord with reinsurance industry custom and practice should be understood to provide reinsurance indemnity for all policies issued to each insured during the period the 1993 Treaty Agreement was in effect." (Paper 121 ¶ 13.)

3. "It is also my opinion that ERC's [Employers' Reinsurance Company] argument that the dates of claim assigned to the LACERA and Raytheon claims are improper because they should have been assigned to later policy periods, which it raised for the first time in October 2003---over 5 ½ years after PCIC had first notified ERC of the claims and assigned the dates of claims---is contrary to the reinsurance custom, practice, and standards and does not conform with ERC's obligation of utmost good faith to PCIC." (Paper 121 ¶ 16.)⁶²

These would appear to be impermissible legal opinions, because they offer legal conclusions, such as whether the insurer acted in "utmost good

⁶⁰ See *Prof'l Consultants Ins. Co., No. 1:03-CV-216*, 2006 WL 751244 (D.Vt. Mar. 8, 2006).

⁶¹ *Id.* at 2.

⁶² *Id.* at 21.

faith,” and provided an interpretation of the policy. Nonetheless, the court found the opinions admissible.

Mr. Waterman’s statements appear not to be based on case law or legal standards but rather on his knowledge of the facts of the case, his experience, and his understanding of industry custom. (Paper 121 ¶ 9) The first bulleted statement [number 1 above] . . . might be read as a legal determination that the contract is unambiguous. *See Luneau*, 750 A.2d at 1033-34 (question of whether a contract term is ambiguous is a matter of law for the court to decide). Mr. Waterman made the statement, however, in the middle of a paragraph in which he opined that if ERC intended more limited coverage, ERC would have been required by industry custom to make such restrictions explicit to PCIC. (Paper 121 ¶ 13). Insofar as the statement is intended as a factual statement concerning prevailing reinsurance practices, the statement is an admissible factual description. To the extent that it may be read as an opinion on the ultimate legal issue, it is not admissible. *See N. River Ins.*, 197 F. Supp. 2d at 982-84.⁶³

In the second and third bulleted statements [numbers two and three above] above, Mr. Waterman explicitly discusses “industry custom” as it applies to the parties here. To the extent that the statements are intended as facts concerning prevailing reinsurance customs, they are admissible as expert opinion testimony. To the extent that they may be read as opinions on the ultimate legal issues before the Court, they are not admissible. In accordance with the findings above, ERC’s motion to strike on this ground is DENIED in part and GRANTED in part.⁶⁴

The Court’s opinion is troublesome because the Court offers no guidance on how the parties are to determine what portions of the expert opinion are based on legal conclusions and what are based on industry

⁶³ In support of its position, the court cited the opinion in *North River Ins. Co. v. Employers Reinsurance Corp.*, 197 F. Supp. 2d 972 (S.D. Ohio 2002), noting that the “*North River* court excluded the testimony where the parties based their opinions on case law and legal standards, but allowed the testimony where the experts based their opinions on facts of the case, experience in the industry, and their own research of reinsurance practices.” *Prof. Consultants Ins. Co. v. Employers Reinsurance Co.*, No. 1:03-CV-216, 2006 WL 751244, at *22 (D. Vt. Mar. 8, 2006).

⁶⁴ *Id.* at 22.

standards. What if the law and industry standards are the same? The Court does not address this issue either. It would appear that to be admissible all that an expert has to do is label otherwise inadmissible legal opinions “insurance industry standards.” Thus, form conquers substance.⁶⁵ Finally, nowhere do we see any evidence of industry standards. Indeed, the court concedes that “Waterman does not appear to base his testimony on any reference materials or treatises.”⁶⁶

The weaknesses in the court’s approach may be addressed by simply admitting that the issues addressed by the expert are both legal conclusions and opinions of insurance industry practice. Where the law and industry practice are consistent the opinion should not be disregarded.⁶⁷ The court could, therefore, make a determination of whether the opinions are consistent with the law, and where they are admit them even though they might also be legal opinions. By taking this approach the court avoids the near impossible task of dividing up the opinions into legal and non-legal opinions and provides clearer guidance to the parties on what is admissible and what is not.⁶⁸

Despite the apparent artificiality between legal conclusions and insurance industry standards, some courts have persisted in their view that the testimony of insurance claims handling experts should be limited to industry standards, even when the expert is testifying on the meaning of a policy provision. Therefore, the court in *Aetna Insurance Co. of Hartford, Conn. v. Loxahatchee Marina, Inc.*⁶⁹ held:

⁶⁵ “The prohibition of expert legal testimony often seems to be an elevation of form over substance.” *Expert Legal Testimony*, *supra* note 56, at 800.

⁶⁶ Prof. Consultants Ins. Co., No. 1:03-CV-216, 2006 WL 751244, at *21 (D. Vt. Mar. 8, 2006).

⁶⁷ *North River*, 197 F. Supp. 2d at 982 (noting that where insurance industry standards and the law are the same the expert’s opinion should not be disregarded).

⁶⁸ The Court should also require the expert to provide support for his or her opinions on industry practice, with citations to either texts or other materials. *See North Star Mut. Ins. Co. v. Zurich Ins. Co.*, 269 F. Supp. 2d 1140, 1148 (D. Minn. 2003) (noting that it is important that expert’s opinion be “tethered to...independent authority”). Absent such supporting evidence the opinions are merely general statements of practice, which may not be admissible. *See Chateau Chamberay Homeowners Assoc. v. Assoc. Int’l. Ins. Co.*, 108 Cal. Rptr. 2d 776 (Cal. Ct. App. 2001) (holding two page conclusionary expert report on insurance company’s claims handling practices inadmissible). In other words, the expert’s opinion should not be based solely on the law. *See North River*, 197 F. Supp. 2d at 981 (noting that an expert opinion is inadmissible where it is based on “settled principles of indemnity law.”).

⁶⁹ 236 So. 2d 12 (Fla. Dist. Ct. App. 1970).

On the final question, the expert in the insurance business testified as to the customs and usages in the insurance business, types of policies, premium rates, exclusions and other matters and also answered hypothetical questions. Aetna did not question the qualification of the witness but contends his testimony invaded the province of the trial judge to interpret the insurance contract. This contention is not tenable. Obscure connotations of an insurance policy can be greatly illuminated by knowledge of custom and usage in the industry as well as the expert's knowledge of terms which take on a different hue in the specialized field than in the field of general knowledge."⁷⁰

Permitting an insurance expert to testify on the meaning of the policy based on insurance standards may comfortably avoid the legal testimony issue, but what then is the court to do when the issue is whether the insurer's coverage decision was reasonable in light of all considerations normally considered in making a coverage decision, such as case law?⁷¹ Equally troubling is whether the coverage dispute is reasonably debatable.⁷² Courts may dismiss the insured's bad faith claim if it can be shown that the insurer's position is reasonably debatable. Whether the position is reasonably debatable may depend not only on insurance industry standards, but also on applicable case law.⁷³ Finally, what are the courts to do where

⁷⁰ *Id.* at 14. *See also* Travelers Indem. Co. v. Scor Reins. Co., 62 F.3d 74, 78 (2d Cir. 1995) (permitting testimony about reinsurance industry practice where testimony was relevant to interpret ambiguous policy provision), and *North River Ins. Co.*, 197 F. Supp. 2d at 983 (permitting an expert to construe a certification of reinsurance to the extent it "constitutes a statement of fact concerning industry custom and practice").

⁷¹ Some courts, in apparent recognition of the need to allow expert testimony of the law, have allowed "[an expert] witness to give an opinion on the ultimate issue of whether the duty of good faith and fair dealing was breached. The witness is allowed to describe industry standards and their historical basis, including a description of reported cases, statute or insurance commissioner regulations that shaped claim handling practices. Such testimony is less truncated and usually more beneficial and easily understood by jurors. It captures for the jury the complete claim universe, how standards were established, what they are and the significance of compliance or non-compliance with them." Timothy J. Muldowney & Robert A. Zupkus, *Bad Faith Claims: The Role of the Expert*, 64 DEF. COUNS. J. 226, 232 (1997).

⁷² "The mistaken [or erroneous] withholding of policy benefits, if reasonable or if based on a legitimate dispute as to the insurer's liability under California law, does not expose the insurer to bad faith liability." *Tomaselli v. Transamerica Ins. Co.*, 31 Cal. Rptr. 2d 433, 440 (Cal. Ct. App. 1994).

⁷³ *See* Delgado v. Interinsurance Exch. Of Auto. Club of So. Cal., 59 Cal. Rptr. 3d 799, 811-13 (Cal. Ct. App. 2007) (holding that the determination of whether an insurer had

the insurer has invoked the defense of reliance on counsel? The insurer may have a defense to a bad faith claim where it can show that it obtained a coverage opinion from its counsel and reasonably relied on that opinion.⁷⁴ But how is the insurer's reasonable reliance to be determined without consideration for not only insurance industry standards, but also applicable case law.⁷⁵ In other words, the courts' formulation that expert testimony must be limited to insurance industry standards is not only artificial, but it also does not address very real issues that face the courts every day in insurance bad faith cases.

Excluding expert testimony on the law is also contrary to the widely held rule that insurance claims handling experts can testify on whether the insurer complied with or violated applicable statutory standards for claims handling.⁷⁶ If an expert can testify on statutory standards then what can be the justification for precluding the expert from testifying on applicable case law, where consideration of that case law is pivotal to determining whether the insurer acted reasonably? The same should be the case where the expert testifies with regard to the interpretation and application of insurance policies.

reasonable basis to deny a duty to defend may turn on a question of law applicable to the facts).

⁷⁴ *State Farm Mut. Auto. Ins. Co. v. Superior Court ex rel. Johnson Kinsey, Inc.*, 279 Cal. Rptr. 116, 117-18 (Cal. Ct. App. 1991) (holding good faith reliance on advice of counsel is factor in determining whether insurer acted in bad faith).

⁷⁵ *George F. Hillenbrand, Inc. v. Ins. Co. of N. Am.*, 128 Cal. Rptr. 2d 586, 608 (Cal. Ct. App. 2002) (holding reliance on counsel is not a defense if insurer did not have probable cause to file a declaratory relief action).

⁷⁶ *Hangarter v. Paul Revere Life Ins. Co.*, 236 F. Supp. 2d 1069, 1089 (N.D. Cal. 2002) ("It would be reasonable for experts in bad faith insurance practices to look to the relevant statutory and regulatory requirements in examining the reasonableness of an insurer's actions."); *Kraeger v. Nationwide Mut. Ins. Co.*, No. Civ. A. 95-7550, 1997 WL 109582, at *1 (E.D. Pa. 1997) ("[Expert] [t]estimony about how insurance claims are managed and evaluated and the statutory and regulatory standards to which insurance companies must adhere could be helpful to the jury in evaluating whether the claim in the instant case was handled in bad faith."); *Peiffer v. State Farm Mut. Auto. Ins. Co.*, 940 P.2d 967, 971 (Colo. Ct. App. 1996) ("[W]hile we agree with State Farm that an expert witness should not dictate the law that the jury should apply, an expert witness is permitted, in the trial court's discretion, to refer to the facts of the case in legal terms."); *Crum & Forster, Inc. v. Monsanto Co.*, 887 S.W.2d 103, 134 (Tex. App. 1994) ("An expert . . . may offer his or her opinion as to a mixed question of law and fact . . ."); *accord Century Indem. Co. v. Aero-Motive Co.*, 254 F. Supp. 2d 670, 677 (W.D. Mich. 2003); and see Deposition of Stephen Hinkle, *supra* note 34.

B. PRECLUSION OF EXPERT TESTIMONY ON INSURANCE POLICY INTERPRETATION BECAUSE POLICY IS NOT AMBIGUOUS IS NO LONGER AN EFFECTIVE LIMITATION ON EXPERT TESTIMONY.

Courts are also reluctant to allow expert testimony on the meaning of contract provisions unless the court first finds that the operative contract provision is ambiguous.⁷⁷ This rule, however, is fraught with numerable exceptions. Courts have, held that it is proper to consider facts extrinsic to the contract in determining whether the contract is ambiguous.⁷⁸ Similarly, evidence of industry custom and practice is admissible even where there is no ambiguity where it is shown that the parties to the contract were presumed to have known of the practice.⁷⁹ Courts will also consider expert testimony on the purpose of insurance and the history of a particular policy even though there is no issue of ambiguity.⁸⁰ Drafting history may also be

⁷⁷ See *Twin City Fire Ins. Co. v. Fireman's Fund Ins. Co.*, 386 F. Supp. 2d, 1272, 1277 (S.D. Fla. 2005) (“[I]ntroduction of extrinsic evidence regarding the drafting history or intent behind an insurance policy is “inappropriate and unnecessary” when the policy language is unambiguous.”) (citation omitted), *but see* *Prof'l Consultants Ins. Co. v. Employers Reins Co.*, No. 1:03-CV-216, 2006 WL 751244, at *20-22 (D. Vt. Mar. 8, 2006); *Tapatio Springs Builders, Inc. v. Md. Cas. Ins. Co.*, 82 F. Supp. 2d 633, 649 (W.D. Tex. 1999) (admitting testimony by insurance claims expert that an insurance policy was ambiguous); *MacKinnon v. Truck Ins. Exch.*, 73 P.3d 1205, 1217 (Cal. 2003) (holding history and purpose of pollution exclusion “may properly be used by courts as an aid to discern the meaning of disputed policy language”); *and* *Montrose Chem. Corp. of Cal. v. Admiral Ins. Co.* 42 Cal. Rptr. 2d 645, 670-71 (Cal. Ct. App. 1995) (holding drafting history and similar insurance industry materials “may be of considerable assistance in determining coverage issues.”).

⁷⁸ See, e.g., *Tapatio*, 82 F. Supp. 2d at 641 (“[T]he contract may be read in the light of the surrounding circumstances to determine whether an ambiguity exists.”); *Pac. Gas & Elec. Co. v. G.W. Thomas Drayage & Rigging Co.*, 442 P.2d 641, 644 (Cal. 1968) (holding extrinsic evidence is relevant when it is offered to prove the meaning to which the contract language is reasonably susceptible); *Feurzeig v. Ins. Co. of the West*, 69 Cal. Rptr. 2d 629, 632-34 (Cal. Ct. App. 1997) (holding expert testimony is admissible to show that a provision of a policy is or is not ambiguous); *Imbrandtsen v. N. Branch Corp.*, 556 A.2d 81, 84 (Vt. 1988) (noting a number of courts have held “circumstances surrounding the making of the agreement, [including] the “object, nature, and subject matter of the writing,” can be considered when the court is inquiring into whether the contract is ambiguous); *and see Prof'l Consultants Ins. Co.* 2006 WL 751244, at *3 (permitting a look at circumstances surrounding the making of the agreement when inquiring into contract ambiguity).

⁷⁹ *Lambourne v. Manchester Country Props.*, 374 A.2d 122, 123-24 (Vt. 1977).

⁸⁰ *Playtex FP, Inc., v. Columbia Cas. Co.*, 622 A.2d 1074, 1077-78 (Del. Super. Ct. 1992).

considered, even in the absence of any ambiguity in the policy.⁸¹ Indeed, some courts have held that expert testimony is admissible regarding insurance industry understanding or usage to assist the court in interpreting the relevant policy provisions without any determination that the policy is ambiguous.⁸² Sometimes courts may also preclude expert testimony on the grounds that it presents impermissible evidence of a party's subjective intent,⁸³ but even then expert testimony has been admitted on what an insurer intended when it wrote the policy.⁸⁴ Given these many exceptions it would appear that the rules regarding the admissibility of extrinsic evidence are of little practical use in providing guidance on how and when expert testimony on the meaning of an insurance policy should be admitted.

⁸¹ *Fireguard Sprinkler Sys., Inc. v. Scottsdale Ins. Co.*, 864 F.2d 648, 651-52 (9th Cir. 1988) (relying on explanatory information contained in an ISO circular and excerpt from a Fire Casualty & Surety Bulletin about the intended scope of a standard completed operations exclusion); *Nestle Foods Corp. v. Aetna Cas. & Sur. Co.*, 135 F.R.D. 101, 105 (D.N.J. 1990) (holding interpretation of policy language and establishment of whether policies are ambiguous, policyholder "must be allowed to explore the creation of the language and whether the intent of the drafter(s) is inconsistent with its application."); *Md. Cas. Co. v. Reeder*, 270 Cal. Rptr. 719, 723 (Cal. Ct. App. 1990) ("[T]he concomitant availability of interpretative literature is of considerable assistance in determining precisely what risks the Maryland policies cover."); *Eaton Corp. v. Aetna Cas. & Sur. Co. No. 189068*, slip op. (Ohio Ct. App. Sept. 9, 1992), *reprinted in* 8 MEALEYS LIT. REP. (INS.) 44, at F-1 (allowing drafting history because it might reveal admissible evidence concerning "ambiguity, meanings(s) of language, breath of coverage, intent, risks assumed and impeachment"); 1 LAW AND PRACTICE OF INSURANCE COVERAGE LITIGATION §1:15 (David L. Leitner et al. eds., 2005) ("drafting history evidence may used to (a) establish ambiguity, by demonstrating that the provision is susceptible to more than one reasonable interpretation; (b) provide extrinsic evidence to interpret the provisions; and/or (c) preclude the insurer from disputing the meaning advanced when approval for the clause was sought from the relevant regulatory authorities, irrespective of the policyholder's reliance on, or even awareness of, that meaning (so-called 'regulatory estoppel')."). *But see* *U.S. Fid. & Guar. Co., v. Treadwell Corp.*, 58 F. Supp. 2d 77, 100-101 (S.D.N.Y. 1999) (excluding drafting history because insurer did not participate in drafting of policy and because drafting history did not unambiguously support insured's position).

⁸² *Gerawan Farming Partners, Inc., v. Westchester Surplus Lines Ins. Co.*, No. CIV F 05-1186 AWI DLB, 2008 WL 80711, at *19-20 (E.D. Cal. Jan. 4, 2008).

⁸³ *Winet v. Price*, 6 Cal. Rptr. 2d 554, 558 (Cal. Ct. App. 1992) (holding uncommunicated subjective intent prior to the execution of the contract is not admissible to interpret the meaning of the contract).

⁸⁴ *U.S. Elevator Corp. v. Associated Int'l Ins. Co.*, 263 Cal. Rptr. 760, 764-65 (Cal. Ct. App. 1989) (holding testimony of insurer's underwriter may be offered to establish that a policy provision is or is not applicable to the issue before the court).

Courts may need to look elsewhere for guidance if they are to recognize the true nature of insurance claims handling and adopt an approach to expert testimony that reflects that handling.

V. EXPERT TESTIMONY IN LEGAL MALPRACTICE CASES: A MODEL FOR EXPERT TESTIMONY IN INSURANCE BAD FAITH CASES.⁸⁵

Expert testimony in legal malpractice cases offers a model for how courts may approach similar expert testimony in insurance bad faith cases. Like the legal profession, the insurance industry considers claims handling a profession.⁸⁶ Insurance claims handlers, like lawyers, are required to have extensive knowledge concerning legal matters.⁸⁷ As with the legal profession,⁸⁸ insurance claims handlers are subject to professional ethical standards.⁸⁹ Given the nature of an insurance claims handler's work, it is

⁸⁵ For further discussion of expert testimony in legal malpractice cases see Ambrosio, Michael P., and McLaughlin, Denis F., "The Use of Expert Witnesses in Establishing Liability in Legal Malpractice Cases," 61 TEMP. L. REV. 1351.

⁸⁶ MARKHAM, *supra* note 33, at 373 ("As professionals, claim representatives should use their position, knowledge and expertise for the benefit of their customers. Claim representatives must have a professional attitude towards providing customer service...There are ethical obligations that arise out of the professional duties of claims representatives.").

⁸⁷ *Id.* at 389 ("Claim representatives should be expert in matters of insurance coverage, legal liability, damages and methods of repair."). Granted the scope of a claims handler's legal knowledge will be more limited than a lawyer's. For example, claims handlers will need to be informed on the law concerning tort liability and damages as well as applicable contract law but not, as with a lawyer, the law of estates or tax law.

⁸⁸ See *Rogers v. Robson, Masters, Ryan, Brumund and Belom*, 392 N.E.2d 1365, 1371 (Ill. App. Ct. 1979), *aff'd*, 407 N.E.2d 47 (Ill. 1980) (Violations of rules of professional responsibility or ethical standards may be admitted as evidence or legal malpractice. The court observed: "It is true that the present action is one for malpractice and not a disciplinary proceeding, but it would be anomalous indeed to hold that professional standards of ethics are not relevant considerations in a tort action, but are in a disciplinary proceeding. Both malpractice actions and disciplinary proceedings involve conduct failing to adhere to certain minimum standards and we reject any suggestion that ethical standards are not relevant considerations."). See also Brewer, *supra* note 56, at 767; see also KATHERINE J. MCKEE, ANNOTATION, *Admissibility and Effect of Evidence of Professional Ethics Rules in Legal Malpractice Action*, 50 A.L.R.5th 301 (1997).

⁸⁹ MARKHAM, *supra* note 33, at 381-386. For example, the Society of Special Investigation Units, the National Association of Public Adjusters, and the National Association of Independent Adjusters all publish ethical standards for their members. One of the most well-known of these organizations is the American Institute of Chartered Property Casualty Underwriters ("CPCU"), which publishes a Code of Professional Ethics.

not surprising that courts have long recognized that insurance claims handlers often act in the capacity of a lawyer.⁹⁰ Insurance claims adjusters have been found to be acting as a lawyer when they complete settlement and release forms, or advise the claimant regarding the claim process.⁹¹ In such circumstances the insurance claims adjuster may be subject to the standard of care of a practicing lawyer.⁹² Further, at least one court has held that an insurer's standard of care is "analogous to the standard of care

Canon 3 of the CPCU Code contains the following ethical standards: "R3.1 In the conduct of business or professional activities, a CPCU shall not engage in any act or omission of a dishonest, deceitful, or fraudulent nature. R3.2 A CPCU shall not allow the pursuit of financial gain or other personal benefit to interfere with the exercise of sound professional judgment and skills." CODE OF THE PROFESSIONAL ETHICS OF THE AMERICAN INSTITUTE FOR CPCU, Canon 3 (2007).

⁹⁰ See, e.g., *Liberty Mut. Ins. Co. v. Jones*, 130 S.W.2d 945, 949 (Mo. 1939).

⁹¹ *Jones v. Allstate Ins. Co.*, 45 P.3d 1068, 1070 (Wash. 2002); *Blinston v. Hartford Accident and Indem. Co.*, 441 F.2d 1365, 1367 (8th Cir. 1971) (holding that the standard of care for a practicing lawyer may not apply to an insurance claims handler where the claims handler is providing his/her employer with an appraisal of the company's legal position, even though the claims handler is not a member of the bar); *Liberty Mut. Ins. Co.*, 130 S.W.2d at 961 (However, an insurance claims handler may not be engaging in the practice of law when he (1) "investigates...the facts and circumstances relating to a casualty or claim arising under a policy of casualty insurance issued by his employer, and reports to his employer the facts ascertained in such investigation"; (2) "determines for his employer the pecuniary limit which his employer will be willing to offer or pay in settlement of any claim arising under a policy of casualty insurance issued by such employer"; (3) state in his or her report to his or her employer "the opinion...given by the company's counsel on any question of liability upon any given claim"; and (4) during "the negotiation and settlement of a claim arising under a policy of casualty insurance issued by his employer, truthfully states to the claimant or claimant's representative what the company's attorney has advised."); see also Sande L. Buhai, *Act Like a Lawyer, Be Judged Like a Lawyer: The Standard of Care for the Unlicensed Practice of Law*, 2007 UTAH L. REV. 87, 88 (2007) ("A majority of courts have held that one who provides legal services, regardless of whether licensed or authorized, should be held to the standard of care applicable to attorneys providing those same services.")

⁹² *Allstate Ins. Co.*, 45 P.3d at 1075 ("[W]e hold that insurance claims adjusters, when preparing and completing documents which affect the legal rights of third party claimants and when advising third parties to sign such documents, must comply with the standard of care of a practicing attorney."). See also JAMES MCLOUGHLIN, ANNOTATION, *Activities of Insurance Adjusters as Unauthorized Practice of Law*, 29 A.L.R.4th 1158 (1984) ("[T]he courts have held that adjusters for insurers who gave legal advice, made legal recommendations, appeared in court, or engaged in other activities requiring a lawyer's training or status were engaged in the unauthorized practice of law."); see also Jeffrey A. Parness, *Civil Claim Settlement Talks Involving Third Parties and Insurance Company Adjusters: When Should Lawyer Conduct Apply?*, 77 ST. JOHN'S L. REV. 603, 604-606 (2003).

owed by other professionals to their clients and [which] is elucidated by expert testimony.”⁹³

As with insurance claims handlers, expert testimony is commonly used in legal malpractice cases to establish the standard of care. Courts will require expert testimony in legal malpractice cases unless the breach of the standard is so obvious that jurors can rely upon their common knowledge to determine if there has been malpractice.⁹⁴ Expert testimony in legal malpractice cases may be limited to only factual issues, in the same way such testimony is limited in insurance bad faith cases. One commentator has noted that, “[e]xpert legal testimony is frequently permitted (and sometimes required) on the issue of the standard of care in legal malpractice actions. Even in jurisdictions which generally exclude expert testimony about the law, the testimony of legal experts about the ordinary knowledge and skill of members of the legal profession is admitted on grounds that it concerns a question of fact, not an issue of law.”⁹⁵ In some cases, however, it is practically impossible to separate a lawyer’s standard of care from the law.⁹⁶ Courts will, in certain circumstances, permit the expert to testify on legal matters.⁹⁷ In other words, to provide an opinion on the standard of care requires a discussion of the applicable law.

⁹³ See *Sullivan v. Utica Mut. Ins. Co.*, 788 N.E.2d 522, 536 (Mass. 2003) (citing to cases in which expert testimony required in legal malpractice cases); see also *Lentino v. Fringe Employee Plans, Inc.*, 611 F.2d 474, 480 (3d Cir. 1979).

⁹⁴ See, e.g., *Ankey v. Franch*, 652 A.2d 1138, 1153 (Md. Ct. Spec. App. 1995) (expert testimony was necessary to establish whether attorney’s decision, in advising client not to appeal was reasonable); *Suritz v. Kelner*, 155 So. 2d 831, 834 (Fla. Dist. Ct. App. 1963) (holding that expert testimony not required where jury alone could determine whether attorney committed malpractice).

⁹⁵ See TRIAL OBJECTIONS HANDBOOK § 8:28 (2d ed. 2001), and the cases cited therein.

⁹⁶ *Smith v. Childs*, 437 S.E.2d 500, 506 (N.C. Ct. App. 1993) (citing *HAJMM Co. v. House of Raeford Farms, Inc.*, 403 S.E.2d 483, 488 (N.C. 1991)) (“When the expert witness is an expert legal witness, the voidance of testimony regarding legal conclusions can be problematical since attorneys deal with legal terms of art on a daily basis.”). *Expert Legal Testimony*, *supra* note 56, at 799 (It is evident that “courts have had great trouble parsing the legal and factual elements in attorney malpractice cases.”).

⁹⁷ In *Mazer v. Sec. Ins. Group*, 368 F. Supp. 418, 422 n.4 (E.D. Pa. 1973) *aff’d*, 507 F.2d 1338 (3d Cir. 1975), the court said that the general rule “that a witness will not be permitted to give an opinion as to the ultimate fact in issue...is not followed where the matters involved are beyond the knowledge of ordinary laymen” and it made “no difference that this was being tried by a judge without a jury” since, “[o]bviously, not all judges are experts in all tactical matters which may pertain to all lawsuits.” See also MICHAEL A. DISABATINO, ANNOTATION, *Admissibility and Necessity of Expert Evidence as to Standards of Practice and Negligence in Malpractice Action Against Attorney*, 14 A.L.R.4th 171

Similarly, expert testimony regarding the reasonableness of an insurance claims handler's conduct will often involve not only purely factual issues, but also mixed questions of law and fact, as well as purely legal matters. The latter situation may arise where the issue is whether the insurance claims handler properly interpreted and applied an insurance policy provision to the facts of a particular case.⁹⁸ In such cases a coverage decision could not be reached without consideration of the insurance industry standards and publications regarding the policy provision at issue, as well as applicable case law. Therefore, the claims handler may be asked not only whether he/she considered insurance industry standards and publications but also whether they considered the applicable case law, or whether they sought the advice of counsel on the coverage issue, and if so, whether they independently reviewed and evaluated that advice.⁹⁹ Such an independent review may involve determining whether all the applicable case law has been considered and properly evaluated. In other words, as with the legal professional, the claims professional's conduct in a given case must consider the applicable case law.

Where the claims professional's conduct is inseparable from the law it would be appropriate to allow expert testimony on whether the claims handler reasonably evaluated the coverage issue, not just in light of applicable insurance industry standards, but also considering the applicable case law. Any concern that the expert's opinions may be contrary to the law can be addressed by the court hearing the expert's testimony before it is heard by the jury.¹⁰⁰ Further, the court can require that the expert's

(1982); *Nieves-Villanueva v. Soto-Rivera*, 133 F.3d 92, 100-101 (1st Cir. 1997) (expert testimony on the law in legal malpractice cases may be admissible in some cases); *Sharp v. Coopers & Lybrand*, 457 F. Supp. 879 (E.D. Pa. 1978), *aff'd in part*, 649 F.2d 175 (3d Cir. 1981), *cert. denied*, 455 U.S. 938 (1982) (law professor permitted to testify about tax consequences of an oil drilling venture and about the meaning of the relevant code provision).

⁹⁸ See *WINDT*, *supra* note 15, § 9:26A ("Case Law can, in many circumstances, constitute evidence that the insurer's policy interpretation or understanding of its rights/obligations was reasonable.").

⁹⁹ See *Klinger v. State Farm Mut. Auto. Ins. Co.*, 895 F. Supp. 709, 712 (M.D. Pa. 1995) (testimony regarding the insurer's reliance of counsel is admissible). Of course, a review of the case law discussing the operative policy provision would be circumscribed by other standards applicable to insurance claims handling, such as the insurer's duty to resolve any coverage doubts in favor of the policyholder. See *POPOW*, *supra* note 18, at § 5.34.

¹⁰⁰ *Expert Legal Testimony*, *supra* note 56, at 813 (Court can prescreen proffered expert testimony to determine if testimony on the law is warranted, and if such testimony will conflict with the court's instructions); see *BREWER*, *supra* note 56, at 761 ("[C]ommentators have suggested that the trial judge should first hear the testimony outside

opinions not be based solely on the law, but also be grounded in insurance industry practices and standards.

VI. CONCLUSION

The traditional rules limiting the admissibility of expert testimony on insurance policy interpretation have proved to be either unworkable or are fraught with so many exceptions so as to make them of doubtful use. No longer do courts rigorously adhere to their prior refusal to hear expert testimony on policy interpretation unless the court first finds that the operative policy terms are ambiguous. Rather, courts have shown an increasing willingness to consider a wide range of evidence on the meaning of policy terms, including insurance industry publications and drafting history materials, even where there is no determination that the policy is ambiguous. Similarly, many courts have virtually abandoned the age-old requirement that expert testimony should not be admitted on the law because it invades the province of the court. Courts have achieved this result by agreeing to hear expert testimony on policy interpretation as long as it couched in terms of insurance industry practices and standards, even though that same testimony may, for all practical purposes, be nothing more than the otherwise prohibited testimony on the law.¹⁰¹

The historic limitations on expert testimony concerning insurance policy interpretation also fail to recognize the reality of insurance claims handling. Insurance claims handlers are commonly trained in the interpretation of insurance policy provisions. Those same claim handlers have access to a wide range of insurance industry publications and materials that provide further guidance on insurance policy interpretation. The claims handlers' training includes training on the applicable insurance law. Indeed, claims handlers are expected to know the case law that may be applicable to the interpretation of policies.

In revisiting the traditional limitations on expert testimony in insurance bad faith cases the courts may gain guidance from decisions in legal

the presence of the jury to determine whether the expert's legal premises are compatible with the anticipated jury instructions and then admit only that part of the testimony that the court finds to be in harmony with its view of the law.").

¹⁰¹ This is not to suggest that there are no insurance industry standards on the interpretation of policy terms generally and with regard to specific policy terms. That is obviously not the case. (See discussion, *supra*, pp. 6-13) Such evidence of insurance industry standards concerning policy interpretation has an equal place in the evaluation of an insurer's conduct as does the case law.

malpractice cases. Courts have recognized that expert testimony on the standard of care in legal malpractice cases must, in certain cases, include reference to the law. Indeed, without consideration of the applicable law it may not be possible to determine the standard of care for a lawyer in a particular specialty or case.

It is appropriate to apply the standards for expert testimony in legal malpractice cases to expert testimony on the interpretation of insurance policies. There are many similarities between the legal and claims handling professions. One important similarity is that, within their respective realms, the members of each profession are called upon to consider applicable case law when they make important decisions. Accordingly, in determining whether an insurer has properly applied its insurance policy to a given set of facts the trier of fact should take into account whether the insurer properly considered that relevant case law in its coverage decision. In addition, at the least, the courts should also permit testimony on insurance industry standards concerning the interpretation of policy provisions. Such testimony will assist the court and the trier of fact in not only better understanding, and therefore interpreting, the operative policy provision, but also in determining whether the insurer acted in bad faith when it applied the policy provision to the facts of the claim.

Concerns that expert testimony on insurance industry standards and case law concerning the interpretation of policy provisions will invade the province of the court can be addressed by the court hearing, outside the jury, and the proffered expert testimony in order to determine whether the testimony will be in accord with the court's instructions to the jury.

Permitting expert testimony on the interpretation of insurance policy provisions in both breach of contract and bad faith actions will permit the trier of fact to hear a broader range of relevant evidence and, thereby, be better informed on the meaning and application of the operative policy provision. Such expert testimony will provide for a more informed judiciary when it comes to the interpretation and application of insurance policy provisions.

INSURANCE AND CREDIT DEFAULT SWAPS: SHOULD LIKE THINGS BE TREATED ALIKE?*

*Arthur Kimball-Stanley***

ABSTRACT

This article focuses on the potential moral hazards created by the use of credit default swaps (“CDS”) and argues that perhaps such swaps should be regulated as analogous to regular insurance regimes. The author discusses academic mischaracterization of the issue, including arguments that CDS is not the same as insurance, and refutes this mischaracterization by comparing original rationales for regulating insurance with moral hazards created by the use of this credit risk management practice. Several specific examples are provided to illustrate this argument, including that of investment banks, scholarship on insurance contracts, control, regulatory value, and the issues of risk that underlie both regimes. Finally, the author asserts that, given the similarities and risks involved in CDS as compared to traditional insurance, regulation possibilities should be investigated.

“...[L]egal rule and economic principle are but the concavity and convexity of the single lens of general policy. To ignore this fact is to chance the invidious probability that legal rules will calcify and become divorced from basic social values.”¹

* Editor’s Note: This student note was written in February and March 2008, during the relatively early period of what has become a financial crisis of historical proportions. Since that time, the credit default swap market has received significant attention from regulators, including insurance regulators. This note does not discuss the newfound interest of insurance regulators in the credit default swap market because when it was written such interest seemed a remote possibility. Given the extent to which the credit default swap market has changed, much of the argument made by the author can be considered anachronistic. The note remains as originally conceived to show how much the regulatory culture and consequently the regulatory landscape has changed in that short space of time.

** J.D. Candidate, Boston College Law School, 2010. I would like to thank Professors Thomas E. Baker, John Day, Thomas Morawetz, and Sanchin Pandya from the University of Connecticut School of Law for their guidance.

¹ Bertram Harnett & John V. Thornton, *Insurable Interest in Property: A Socio-Economic Reevaluation of A Legal Concept*, 48 COLUM. L. REV. 1162, 1162 (1948) (citations omitted).

INTRODUCTION

Recent scholarship and journalism on the use of credit default swaps (“CDS”) provide evidence that these financial products create moral hazard similar to that created during the early history of insurance contracts. The insurable interest and indemnity doctrines, as well as other principles of insurance, created to mitigate moral hazard, provide guidance in dealing with the moral hazard CDS trading may create.

Compare the following hypotheticals:

An 18th century speculator buys insurance on a British cargo ship in which he has no interest. The speculator then sends a message to his cousin in Paris, asking the cousin to inform the French fleet of the ship’s schedule. A French frigate uses the information to sink the British vessel. The speculator collects on his insurance contract. To mitigate this danger, the insured interest doctrine was created to keep the speculator from profiting on his insurance contract.

A 21st century hedge fund manager buys millions of dollars in CDSs that will pay off only if company (x) declares bankruptcy. The hedge fund manager then organizes the short-term purchase of creditor voting rights as the embattled company (x) attempts to borrow money to avert Chapter 11. The hedge fund votes against allowing further borrowing and company (x) is forced to declare bankruptcy. The CDS bet pays off and the hedge fund manager finds herself with a substantial return.

In terms of the moral hazard to be averted, the second hypothetical is no different from the first as both create new risk through contract. Both hypotheticals effectively illustrate the moral hazard created by risk distribution contracts and why mitigation through the insurable interest and indemnity doctrines is necessary. The growth of risk management products in the financial industry over the last few decades, in particular the emergence of a multi-trillion dollar CDS market, merits a reexamination of the purposes and the history of the insurable interest and indemnity doctrines.

Since the market’s inception little more than a decade ago, CDS traders and their attorneys have worked hard to distinguish their new financial product from insurance to avoid stringent regulatory insurance regimes

operated throughout the United States and in the United Kingdom.² Applying the insurable interest doctrine to CDSs requires reevaluating the chief arguments for treating these contracts differently from traditional insurance.

The focus of this reevaluation is not whether CDSs are insurance, as that misstates the problem, but whether CDS trading results in moral hazard typical of insurance contracts. This paper argues that attempts to distinguish CDSs from insurance on the basis of regulation rather than on the resultant risks are mischaracterizations of the issue. Instead, this paper argues that CDSs create moral hazard similar to insurance such that policy-makers should consider whether CDS should be regulated like insurance.³

Part one of this paper defines CDSs and discusses the arguments that attempt to show CDSs are not insurance as well as the stakes involved in making those arguments a success. Part two identifies evidence of morally hazardous uses of CDSs and compares that evidence to the original rationale for instituting early insurance regulations such as the insurable interest and indemnity doctrines. Part Three analyzes the arguments used to differentiate CDSs and insurance in light of this evidence. The conclusion addresses the need for further research regarding the moral hazard created by CDSs, and argues that insurance regulators should examine the costs and benefits of their decision not to regulate CDSs.

I. THE PRODUCT

CDS contracts are used to manage credit risk. They are among the most popular credit derivative products traded today, having grown into a multitrillion-dollar business in less than a decade.⁴ In June of 2007 over

² See HELENE RAINELLI & ISABELLE HUALT, OLD RISK, NEW MARKET: CONSTRUCTING THE OVER-THE-COUNTER FINANCIAL MARKET FOR CREDIT DERIVATIVES, 16, (Multilevel Governance Workshop Papers 2007), available at <http://www2.warwick.ac.uk/fac/soc/csgr/activitiesnews/conferences/gmorgan/papers/>; Paul C. Harding, A PRACTICAL GUIDE TO THE 2003 ISDA CREDIT DERIVATIVES DEFINITIONS 19 (Euromoney Institutional Investor Plc 2004); Robert F. Schwartz, *Risk Distribution In the Capital Markets: Credit Default Swaps, Insurance and a Theory of Demarcation*, 13 FORDHAM J. CORP. & FIN. L. 167, 190 (2007).

³ This paper does not explore the policy implications inherent in the determination that CDS and insurance are innately alike.

⁴ Stephen J. Lubben, *Credit Derivatives and the Future of Chapter 11*, 81 AM. BANKR. L.J. 405, 409-10 (2007); Rick Hyman & Amit Trehan, *Credit Default Swaps: What You Need to Know Now*, THE SECURED LENDER, 26 (2007); See *Deutsche Bank AG v.*

\$42 trillion in outstanding CDS contracts were recorded by the Bank for International Settlements.⁵ Originally designed to meet the needs of bondholders who did not want to resort to traditional forms of credit enhancement, these contracts have grown into a freely traded, liquid market all their own.⁶ This market, commonly referred to as the over the counter (“OTC”) derivatives market, is free from regulation or disclosure rules.⁷ The International Swaps and Derivatives Association (“ISDA”) does, however, attempt to standardize CDS contracts and help buyers and sellers manage transactions.⁸

A. CDS DEFINED

A CDS contract allows a buyer to purchase credit protection with respect to one or more referenced entities from a seller. The two parties agree that the seller will pay a certain amount to the buyer upon the occurrence of a “credit event” with respect to the referenced entity or entities—usually some kind of debt obligation such as a bond—in exchange for the purchase price of the contract.⁹ The agreement allows the

Ambac Credit Prods., LLC, No. 04 CIV. 5594(DLC), 2006 WL 1867497, at *2 (S.D.N.Y. July 6, 2006) for a brief discussion of the history and use of credit default swaps.

⁵ Bank for International Settlements, Credit Defaults Swaps Market Notational amounts outstanding at end December 2007, *available at* <http://www.bis.org/statistics/otceder/dt21.pdf>.

⁶ Hyman, *supra* note 4 at 20, 22. The authors refer to letters of credit, guarantees and financial guarantee insurance as more traditional forms of credit enhancement; *See also* Frank Partnoy & David A. Skeel, Jr., *The Promise and Perils of Credit Derivatives*, 75 U. CIN. L. REV. 1019, 1020-1023 (2007).

⁷ PHILIP M. JOHNSON & THOMAS L. HAZEN, DERIVATIVES REGULATION § 1.02[2][E] (Aspen Publishers 2004); The Commodity Futures Modernization Act of 2000 (CFMA) in most cases completely bars and in some cases severely limits regulation of the Over-The Counter Derivatives Market. Neither the Securities and Exchange Commission nor the Commodities Futures Trading Commission have jurisdiction to regulate OTC CDS trading. In recent months, regulators have examined the possibility of changing this regime. Such methods have been resisted by the ISDA. At the time of this writing, there seems to be a stringent effort to create a clearinghouse for CDS trading. The hope is that a clearinghouse service would eliminate many of the structural problems created by the Over-The-Counter CDS market. This paper does not examine those structural market risks. *See* Commodity Futures Modernization Act of 2000 §1(a)(5), 7 U.S.C.A. §1 (2000).

⁸ *See generally* About ISDA, <http://www.isda.org/>.

⁹ Deutsche Bank AG v. AMBAC Credit Prods., LLC, No. 04 CIV. 5594(DLC), 2006 WL 1867497, at *2 (S.D.N.Y. July 6, 2006); Robert D. Aicher et al., *Credit Enhancement: Letters of Credit, Guaranties, Insurance and Swaps (The Clash of Cultures)*, 59 BUS. LAW. 897, 954-55 (2004).

buyer to hedge the risk associated with owning a reference entity that might suffer a credit event such as bankruptcy or default.¹⁰

University of San Diego School of Law Professor Frank Partnoy offers the following example regarding the typical use of CDS contracts: A bank lends \$10 million to company (y). The bank then enters into a \$10 million dollar CDS with a third party to protect itself in case company (y) defaults on the loan. If company (y) defaults, the bank executes its CDS, and recoups the loss. If company (y) does not default payment for the CDS reduces the profit accordingly. The seller of the CDS purchased by the bank determines the price of the contract by evaluating the likelihood of the company's defaulting on the loan.¹¹

A CDS contract can be settled physically or with cash. In a physical settlement the CDS buyer delivers to the seller one of the obligations of the reference entity upon which the CDS contract is based in exchange for the payout amount.¹² CDS contracts may specify a certain obligation of a reference entity or may accept delivery of any obligation issued by the reference entity.¹³ Alternatively, in a cash settlement the buyer exchanges the value of a specific defaulted obligation for a predetermined payout amount.¹⁴

The chief difference between CDSs and insurance is that the buyer of a CDS contract need not own or have any relationship with the reference entity's obligation.¹⁵ Unlike insurance, CDSs can be and are often used for speculation and arbitrage.¹⁶ These trades are intended to make the CDS market liquid.¹⁷

CDS contracts provide a number of benefits to capital markets. As discussed above, the primary benefit is that they allow investors to hedge or reduce their risk. In 2005, Federal Reserve Chairman Alan Greenspan reminded the Federal Reserve Bank of Chicago's Conference on Bank Structure that CDS contracts were one of the reasons banks had been able to shrug off the losses of the 2000 downturn relatively easily.¹⁸ The ability

¹⁰ *Id.*

¹¹ Partnoy & Skeel, *supra* note 6, at 1021-22.

¹² Harding, *supra* note 2, at 134.

¹³ David Z. Nirenberg & Richard J. Hoffman, *Are Credit Default Swaps Insurance?*, 3 DERIVATIVES REP. 7, 14 (2001).

¹⁴ Harding, *supra* note 2, at 134.

¹⁵ Aicher et. al., *supra* note 9, at 955.

¹⁶ Partnoy & Skeel, *supra* note 6, at 1022; Schwartz, *supra* note 2, at 190.

¹⁷ Partnoy & Skeel, *supra* note 6, at 1022.

¹⁸ Alan Greenspan, Chairman, Fed. Reserve Bd., Risk Transfer and Financial Stability, Remarks to the Federal Reserve Bank of Chicago's Forty-first Annual Conference

to hedge risk using CDSs also injects liquidity into the markets by making investors more comfortable in taking on risk. Finally, the pricing of CDS contracts and the result of the spread created by the buying and selling of CDSs, creates new information helpful in evaluating securities.¹⁹

These advantages, however, come at a price. The last several years are illustrative of how CDS contracts, in Partnoy's words, might create incentives to destroy value by allowing profit to be born from loss.

B. THE ARGUMENT THAT CDS ARE NOT INSURANCE

Black's Law Dictionary defines insurance as "[a] contract by which one party undertakes to indemnify another party...against the risk of loss, damage or liability arising from the occurrence of some specified contingency."²⁰ This basic definition by itself, is not dispositive of what should be considered insurance. It is important to note that there is no consensus regarding the definition of insurance. Some scholars argue that a short definition of insurance is inherently misleading.²¹ However, simplicity has its merits. For example, the argument in favor of treating CDS like insurance is simple: that for the purpose of insurance regulation, contracts that create similar moral hazard as traditional insurance should be treated as insurance.

The literature arguing that CDSs should not be considered insurance is limited but influential. It has allowed the market for CDSs to remain regulation-free. In an opinion commissioned by the ISDA, Robin Potts QC, an English barrister, argued what has become the basis for not treating CDSs as insurance.²² The so-called "Potts opinion" concluded that credit derivatives should not be characterized as insurance contracts because they are structured to pay out on the occurrence of a default or other credit event, irrespective of whether the buyer suffers a loss.²³ Breaking down this point further, Potts wrote that CDSs "plainly differ from contracts of insurance" because "the payment obligation is not conditional on the

on Bank Structure (May 5, 2005), <http://www.federalreserve.gov/Boarddocs/Speeches/2005/20050505/default.htm>.

¹⁹ Partnoy & Skeel, *supra* note 6, at 1026-27.

²⁰ BLACK'S LAW DICTIONARY 814 (8th ed. 2004).

²¹ See 1 ERIC MILLS HOLMES & MARK S. RHODES, HOLMES'S APPLEMAN ON INSURANCE § 1.4 (2d ed. 1996).

²² Opinion by Robin Potts QC, Erskine Chambers, prepared for the Int'l Swaps & Derivatives Ass'n (24 June 1997) (on file with author)

²³ *Id.* at 2-3.

payee's sustaining a loss or having a risk of loss."²⁴ The contract is thus not one which seeks to protect an insurable interest on the part of the payee. "His rights do not depend on the existence of any insurable interest."²⁵

According to Potts, these are substantial differences that justify the dissimilar treatment of CDSs and insurance. Potts's reasoning was premised on the British common law which defines an insurance policy as "a contract to indemnify the insured in respect of some interest which he has against the perils which he contemplates it will be liable to."²⁶ Despite acknowledging "the economic effect of certain credit derivatives can be similar to the economic effect of a contract of insurance," Potts concluded that CDS contracts are not insurance because the contracts lacked an insurable interest requirement and indemnity requirement.²⁷

ISDA attorneys, scholars and regulators in both the United Kingdom and the United States have used Potts' argument, or similar reasoning ever since. In 2000, an opinion from the New York Department of Insurance, responding to an inquiry as to whether CDSs constituted insurance, stated "[i]ndemnification of loss is an essential indicia of an insurance contract which courts have relied upon in the analysis of whether a particular agreement is an insurance contract under New York law. Absent such a contractual provision the instrument is not an insurance contract."²⁸

Scholarship has also developed in support of the disparate treatment of CDSs and insurance. In "Are Credit Default Swaps Insurance?," authors David Z. Nirenberg and Richard J. Hoffman concluded that though there were similarities between CDSs and insurance, the objectives of the financial products were sufficiently distinct to justify differential treatment.²⁹ They applied three insurance tests set forth in Holmes' *Appleman on Insurance Law and Practice*.³⁰ Holmes' tests are: (1) whether the contract constitutes the transfer of risk ("Substantial Control Test"); (2) whether that transfer is the dominant feature of the contract ("Principle Object Test"); and (3) whether it is in the public interest to regulate the contract as insurance ("Regulatory Value Test").³¹

²⁴ *Id.* at 7.

²⁵ *Id.*

²⁶ *Id.* at 4-5, (citing *Wilson v. Jones*, (1867) 2 Exch. Div. 150).

²⁷ *Id.* at 7, 10.

²⁸ Re: Credit Default Option Facility, (NY Dept. of Ins. Gen. Counsel June 16, 2000).

²⁹ Nirenberg & Hoffman, *supra* note 14, at 16.

³⁰ HOLMES & RHODES, *supra* note 21, at § 1.4.

³¹ Nirenberg & Hoffman, *supra* note 14, at 11-12.

Based on this analysis, the authors posited: “[t]o facilitate a determination that a particular credit default swap is not insurance, the transaction should be structured so that payment to the protection buyer is not contingent on the protection buyer suffering a loss.”³² In other words, the authors recommended that CDS trades be structured so that they do not perform the same function as insurance.

Most recently, a Fordham Journal of Corporate and Financial Law article argued in favor of the dissimilar treatment of CDSs and insurance.³³ The article argued that “CDS[s] are capital market products” and not insurance.³⁴ In support of this theory, the author Robert F. Schwartz,³⁵ outlined six propositions, at least one of which applies to any CDS trade.³⁵ The propositions are:

1) [w]here a party enters into a contract for contingent recovery possessing no economic interest in protecting the covered property from loss or damage, the contract is not insurance;...2) [w]hen the contract for recovery fails to reference property that the purchasing party has economic incentive to protect from loss or damage, the contract is not insurance;...3) [w]hen recovery under a contract can be had without substantiating any actual loss or damage the contract is not insurance;...4) [w]here a party can recover under a contract an amount that exceeds expenses caused by loss or damage, the contract is not insurance;...5) [w]here a contract for recovery allows physical settlement, the contract is not insurance;...6) [w]here a contract for recovery provides for cross-payment netting under a master agreement, the contract is not insurance.³⁶

Failure of one proposition is dispositive of the analysis; meaning the CDS contract involved is insurance.³⁷

The premise of these arguments is that the insurable interest and indemnity doctrines are defining characteristics of insurance contracts. This premise is incorrect. These doctrines are policy responses to the moral hazard that insurance contracts create. Though they have become defining

³² *Id.* at 16.

³³ *See* Schwartz, *supra* note 2, at 174.

³⁴ *Id.*

³⁵ *Id.* at 200-01.

³⁶ *Id.*

³⁷ *Id.*

characteristics of insurance in some contexts, distinguishing CDSs from insurance using these requirements is disingenuous and circuitous. Such reasoning fails to consider the origins of the doctrines and does not utilize the appropriate legal framework for evaluating the benefits and costs of the CDS market.

To date, there has been little work discussing the problems with the arguments used to distinguish CDSs from insurance. University of North Carolina Law Professor Thomas Lee Hazen identified the similarity between early insurance contracts and certain derivatives in a paper published in 2005. He wrote:

The insurable interest doctrine attempts to provide a basis for drawing the line with respect to insurance contracts that the law will tolerate. It is an imperfect measure at best. A significant problem is whether the insurance limitation is really meaningful without a comparable control of derivatives contracts? The derivatives markets may now offer a way around the insurable interest requirement, unless courts treat the contract in question as insurance rather than as a derivative investment. If the insurable interest requirement remains justifiable for insurance contracts, then there may be good reason to close the gap with respect to parallel derivatives transactions created by the [Commodities Futures Modernization Act of 2000]. It would appear appropriate to either rethink the insurable interest doctrine or attempt to import something comparable into derivatives regulation.³⁸

Hazen's argument succinctly highlights the illogical distinction between CDSs and insurance, and the potential adverse consequences it may have. This article elaborates on the consequences of the double standard currently applied to CDSs and traditional insurance, and emphasizes the flaws of arguments against treating CDSs as insurance.³⁹

³⁸ Thomas Lee Hazen, *Disparate Regulatory Schemes for Parallel Activities: Securities Regulation, Derivatives Regulation, Gambling, and Insurance*, 24 ANN. REV. BANKING & FIN. L. 375, 426 (2005).

³⁹ *Id.*

C. THE IMPORTANCE OF A DISTINCTION

The National Association of Insurance Commissioners⁴⁰ (“NAIC”) published a Draft White Paper in 2003 arguing that weather derivatives should be treated similarly to insurance contracts.⁴¹ The study noted that businesses that accept risk transfers for a fee are generally known as insurers and the fee paid by the entity seeking to transfer risk is comparable to an insurance premium.⁴² The same reasoning arguably applies to CDSs, where coverage in the event of a default is traded in exchange for an upfront payment.

The NAIC noted: “These weather derivatives and other ‘non-insurance’ products are primarily temperature protection coverages (heating and cooling degree days) that appear to be disguised as ‘non-insurance’ products to avoid being classified and regulated as insurance products. In fact, there is evidence that the promoters of these products go to great lengths to be sure that the energy companies involved do not use terms that naturally describe what is taking place—namely the transfer of risk from a business to another professional risk taker.”⁴³

The ISDA quickly responded to the draft white paper in a letter to the NAIC.⁴⁴ The letter argued that because weather derivatives do not require a party to have an insurable interest they are not insurance.⁴⁵ The ISDA did not analyze whether weather derivatives or other derivative products, such as CDSs, create sufficient moral hazard to necessitate requiring the application of the insurable interest or indemnity doctrines. The ISDA’s letter also stated that the “Draft White Paper’s logic could extend to a broad array of derivatives and would create substantial and disruptive regulatory uncertainty.”⁴⁶ Such concerns are frequently expressed by the ISDA.

⁴⁰ National Association of Insurance Commissioners, About the NAIC (2008), http://www.naic.org/index_about.htm. The National Association of Insurance Commissioners is the organization of insurance regulators for all 50 of the United States, Washington D.C., and five United States territories.

⁴¹ PROP. AND CAS. INS. COMM., WEATHER FINANCIAL INSTRUMENTS (TEMPERATURE): INSURANCE OR CAPITAL MARKET PRODUCTS? (Nat’l Ass’n of Ins. Comm’rs Draft White Paper, Sept. 2, 2003).

⁴² *Id.* The NAIC included all contracts used to hedge or protect against weather related risk in defining weather derivatives.

⁴³ *Id.*

⁴⁴ Letter from Robert G. Pickel, Executive Dir. and CEO, ISDA, to Ernst N. Csiszar, President, NAIC and Robert Esson, Senior Manager, Global Ins. Mkts., NAIC (Feb. 23, 2004) (on file with author).

⁴⁵ *Id.*

⁴⁶ *Id.* at 2.

In 2006, the ISDA sent a similar letter to the United Kingdom's Law Commission addressing the commission reevaluation of British insurance law. The letter concluded by stating:

There is a range of possible outcomes to such a review. If the outcome is seen as differing materially from the current market consensus view, it could create very considerable uncertainty and damage the [credit derivatives] market itself. Conversely, if the outcome is not seen as differing materially from the current market consensus, its value will be low.

In the circumstances, we do not consider that it would be desirable to proceed with a review in this area. However, should the Commission decide to proceed regardless, then it will be critical to ensure that there is extensive consultation at every stage of the review in order to minimize the risks to the smooth operation of the market.⁴⁷

CDS traders, as well as the derivative industry in general, have worked hard to keep government regulation from interfering with their market. The ISDA has been highly successful in standardizing derivative contracts and managing potential disputes that arise between parties to a trade.⁴⁸ Given that its members include some of the most powerful financial institutions in the world—J.P. Morgan Chase, Goldman Sachs, Citigroup⁴⁹—it is unsurprising that the industry's efforts have been sufficient to keep government regulators at bay.⁵⁰

Classifying CDSs as insurance has numerous and substantive consequences. CDS vendors would be required to obtain an insurance license. Further, those responsible for paying out upon the occurrence of a credit event would be subject to state insurance regulatory oversight regarding market operations and reserve requirements.⁵¹ These requirements would complicate the current free market system in which

⁴⁷ Letter from Richard Metcalfe, Senior Policy Dir., ISDA, to Peter Tyldesley, Law Comm'n, U.K. 2 (Apr. 18, 2006) (on file with author).

⁴⁸ See Sean M. Flanagan, *The Rise of a Trade Association: Group Interactions Within the International Swaps and Derivatives Association*, 6 HARV. NEGOT. L. REV. 211, 229-34 (2001).

⁴⁹ *ISDA Primary Members* (Jul. 18, 2008), <http://www.isda.org/membership/isdamemberslist.pdf>.

⁵⁰ See Flanagan, *supra* note 46, at 246.

⁵¹ Nirenberg & Hoffman, *supra* note 14, at 8; PROP. AND CAS. INS. COMM., *supra* note 41.

CDSs are traded.⁵² Interestingly, had regulation been implemented from the beginning, much of the current uncertainty regarding the American financial system could have been avoided.⁵³ This is because regulation would limit the amount of risk banks take on and state regulators would review CDS accounts to make sure sellers could meet their obligations.⁵⁴

Some argue that much of the ISDA's work consists of convincing the world that derivatives' approach to risk is wholly different from anything that has come before and that in truth, there are few if any differences from decades and centuries old financial products, such as insurance, securities and commodities futures.⁵⁵ Such questions, however, are beyond the scope of this paper.

Interestingly, insurance companies have also argued against the classification of CDSs as insurance. In 2004, the Association of Financial Guarantee Insurers successfully lobbied New York State to create a statutory definition of CDSs.⁵⁶ An amendment to the New York state Insurance Laws that went into effect October 19, 2004 declared: "the making of [a] credit default swap does not constitute the doing of an insurance business."⁵⁷ The statute is hardly a convincing analysis of the legal issues involved in such a statement; but it is effective nonetheless.

⁵² Insurance companies generally keep more cash on their balance sheets than banks. For a study of the differences see Richard Herring & Til Schuermann, *Capital Regulation for Position Risk in Banks, Securities Firms, and Insurance Companies*, in CAPITAL ADEQUACY BEYOND BASEL: BANKING, SECURITIES, AND INSURANCE 15 (Hal S. Scott ed., Oxford University Press 2005). Overall, the problem is that capital adequacy requirements for insurance companies and banks are calculated differently. One financial commentator put it succinctly when he said: "a dollar of risk in banking is not the same thing as a dollar of risk in insurance." Martin Mayer, *THE FED: THE INSIDE STORY OF HOW THE WORLD'S MOST POWERFUL FINANCIAL INSTITUTION DRIVES THE MARKET* 302-303 (The Free Press 2001).

⁵³ See Jenny Anderson & Vikas Bajaj, *A Wall Street Domino Theory*, N.Y. TIMES, Mar. 15, 2008, at A1.; Gretchen Morgenson, *Arcane Market is Next to Face Big Credit Test*, N.Y. TIMES, Feb. 17, 2008, at A1.

⁵⁴ See Hazen, *supra* note 38, at 416.

⁵⁵ See HELENE RAINELLI & ISABELLE HUALT, *OLD RISK, NEW MARKET: CONSTRUCTING THE OVER-THE-COUNTER FINANCIAL MARKET FOR CREDIT DERIVATIVES*, 16, (Multilevel Governance Workshop Papers 2007).

⁵⁶ Letter from Bob Mackin, Executive Dir., Ass'n of Fin Guarantee Insurers, to George E. Pataki, Governor of the State of N.Y., (Jul. 15, 2004) (on file with author).

⁵⁷ N.Y. Ins. Law § 6901 (j-1) (2005 & Supp. 1 2008).

II. THE PROBLEM

The following examples are illustrative of the moral hazard created by CDSs. This resulting moral hazard has the potential to create negative economic interests and destroy value.

A. TOWER AUTOMOTIVE AND STRANGE BEHAVIOR

Truck frame supplier Tower Automotive's declaration of bankruptcy in 2005 may have been caused by speculators interested in profiting on CDS positions.⁵⁸ Unable to pass the rising costs of metals and other supplies onto car-makers, Tower fought the squeeze by turning to the credit markets for cash.⁵⁹ Hedge funds bought Tower's debt in May, 2004.⁶⁰ By November, Tower needed more money. The hedge funds refused to provide approval for the necessary new loans. Without the additional loans Tower was forced to file under Chapter 11 two months later.⁶¹ Some bankers believe hedge funds purposely triggered the filing in order to collect on CDS positions.⁶² The monetary gain for doing so exceeded any potential profits from the loans to Tower and therefore outweighed any incentive to maintain those loans.⁶³ "Many hedge funds play in a gray world," said Henry Miller, a restructuring advisor quoted in *The Journal* article, "[t]hey sometimes do things to make their positions worth more, which can cause difficulty for others."⁶⁴

Tower supports the proposition that a lender with a credit derivative position may have an incentive to force a default, regardless of costs or the impact on the value of underlying assets.⁶⁵ Partnoy argues, that the lack of required disclosure in the derivatives market makes assessing the adverse impact of transactions difficult.⁶⁶

Moreover, Professors Henry T.C. Hu and Bernard Black, both of the University of Texas School of Law, describe investment positions that

⁵⁸ Henny Sender, *Hedge-Fund Lending to Distressed Firms Makes for Gray Rules and Rough Play*, WALL ST. J., July 18, 2005, at C-1.

⁵⁹ *Id.*

⁶⁰ *Id.*

⁶¹ *Id.*

⁶² *Id.*

⁶³ *Id.*

⁶⁴ *Id.*

⁶⁵ Partnoy & Skeel, *supra* note 6, at 1034-35.

⁶⁶ *Id.* at 1035.

increase in value if a reference entity's credit risk rises or suffers a credit event, as "negative economic ownership."⁶⁷ They argue that the use of CDSs in conjunction with derivatives that allow speculators to purchase the temporary use of rights that come with ownership of securities without buying those underlying securities may allow the pushing of a company into bankruptcy to trigger larger payoffs on CDS contracts.⁶⁸

While Hu and Black acknowledge that lack of disclosure requirements in the CDS market makes it difficult to determine the extent to which this strategy is used, there is evidence that it is used.⁶⁹ For example, the market for CDSs referencing certain firms has at times been up to ten times larger than the dollar amount of underlying debt.⁷⁰ Moreover, CDS contracts have begun to require buyers to act in the interest of creditors. This change in contract language suggests, according to Black and Hu, that buyers were not previously acting in the interest of creditors and might not do so in the future. How this contract language is enforced without disclosure, however, remains unclear.⁷¹ Further, Black and Hu cite conversations with bankruptcy judges who say they sometimes see strange courtroom behavior by creditors.⁷² One judge "described a recent case wherein a junior creditor complained of too *high* a valuation being assigned to the bankruptcy estate, for reasons the creditor did not offer."⁷³

B. SPURRING THE DECLINING HOUSING MARKET

CDSs might be partly responsible for inflaming the downturn in the national housing market. There is evidence to suggest that left unregulated these derivatives create a disincentive for mortgage service providers to work out new agreements with homeowners as an alternative to foreclosure.

In January 2008, Federal Reserve Chairman Benjamin S. Bernanke reported to the U.S. House of Representatives Committee on the Budget

⁶⁷ Henry T.C. Hu & Bernard Black, *Equity and Debt Decoupling and Empty Voting II: Importance and Extensions*, 156 U. PA. L. REV. 625, 637, 731 (2008).

⁶⁸ *See id.* at 730-732. Such a practice is commonly referred to as "equity or debt decoupling" depending upon the relevant market. "Equity or debt decoupling" include the full range of rights and obligations typically associated with shareholder status, but reduce a shareholder's economic exposure. *Id.* at 631, 728.

⁶⁹ *See id.* at 732-33.

⁷⁰ *Id.* at 733 n.265.

⁷¹ *Id.* at 733.

⁷² *Id.*

⁷³ *Id.*

that the housing market had declined significantly over the last two years and that the rates of foreclosures have added to an already elevated inventory of unsold homes.⁷⁴ “New home sales and housing starts have fallen by about half from their respective peaks,” he said.⁷⁵ The consequences of this market’s decline, Bernanke continued, would continue to be a drag on the overall economy.⁷⁶

CDS contracts are often sold by the same banks that package and service mortgage-backed securities.⁷⁷ This means that the banks responsible for evaluating the need for and organizing mortgage modifications to prevent foreclosures are the same institutions that would

⁷⁴ *The Economic Outlook: Hearing Before the H. Comm. on the Budget*, 110th Cong. 1 (2008) (testimony of Ben S. Bernanke, Chairman of the Federal Reserve), available at: <http://www.federalreserve.gov/newsevents/testimony/bernanke20080117a.htm>.

⁷⁵ *Id.*

⁷⁶ *Id.*

⁷⁷ Understanding the causes of this decline means understanding how the mortgage industry changed over the last several decades. Beginning in the early 1970s mortgage securitization allowed homebuyers access to the bond market and the deep pools of capital that came with such access. See Christopher L. Peterson, *Predatory Structured Finance*, 28 CARDOZO L. REV. 2185, 2198-2202 (2007). Whereas once mortgagors dealt only with the bank that held their debt, securitization turned banks into mere service providers. This shift changed the outlook of banks servicing these mortgages. Instead of profiting on income from mortgages, banks increasingly profited from fees derived from selling mortgage-backed securities and other financial products related to those securities. Among the consequences of this change is the complication of a bank’s role as a mortgage service provider. Owning the debt allowed banks to modify mortgage contracts at will when payments were missed to prevent foreclosure. Such loan modifications are widely recognized as an important tool to keep economic downturns and the subsequent likelihood of late mortgage payments from turning a flood of foreclosures into a deluge that would speed a declining housing market. See Kurt Eggert, *Comment on Michael A. Stegman et al.’s “Preventive Servicing is Good for Business and Affordable Homeownership Policy”*: *What Prevents Loan Modifications?*, 18 HOUSING POL’Y DEBATE 279, 282, 284 (2007). Securitization of mortgages turned banks into trustees of mortgage-backed bonds, requiring approval from bondholders before mortgage adjustments, known as “workouts,” could be executed. The process of mortgage securitization also created such diversity in terms of ownership rights that getting requisite bondholder approval became impractical in many circumstances. At the same time, these workouts were not impossible. *Id.* at 287. Banks, acting as trustees, might still be inclined to make them if drops in housing prices became more than regional. A national drop in housing prices would defeat the risk mitigating effects of a bond backed by a geographically diverse group of mortgages and give a bank incentive to attempt to rescue the entire bond. *Id.* Depending on the precise terms of the Service and Pooling agreements that created the bonds, the calculus of whether or not to take the trouble to attempt adjustments begins with comparing the percentage of defaulting mortgages that are contributing to a bond’s revenue stream with the cost of an adjustment. See Hu & Black, *supra* note 66, at 730.

pay out a CDS contract in the event of foreclosure. Obviously, such a situation presents a significant conflict of interest for these banks.⁷⁸

In June of 2007, Bear Stearns, a major trader of both CDS contracts and mortgage-backed securities, was accused of having such conflicting interests.⁷⁹ Hedge fund investors, like John Paulson, speculating on a drop in the housing market had purchased a large number of CDS contracts. These investors did not own any of the mortgage-backed securities to which the CDS contracts were tied.⁸⁰ Bear Stearns found that it would owe more in CDS payments than it would lose by making mortgage adjustments to prevent foreclosures and the resulting bond defaults. Despite the transaction costs of organizing such adjustments - which include seeking approval from large numbers of disparate investors with differing interests the bank began the process. CDS holders cried foul, accusing Bear Stearns of market manipulation.⁸¹ The question, according to press reports, was what motivated Bear Stearns to renegotiate sub-prime loans and enter into what Paulson called “uneconomic transactions?”⁸² Was the brokerage firm trying to keep homeowners in their houses or save itself from CDS losses?⁸³

The consequences of the Bear Stearns incident could be dire, though they merit more research. Mortgage holders who might have been able to benefit from a mortgage reorganization with the bank lost that chance and watched their houses go into foreclosure. Sellers saw additional properties added to the glut of housing on the market, forcing prices further down. It is arguable that CDS contracts kept workouts, one of the potential failsafe mechanisms of the mortgage industry, from being executed.

⁷⁸ See Eggert, *supra* note 76, at 290-91.

⁷⁹ See Gregory Zuckerman, Editorial, *Trader Made Billions on Subprime; John Paulson Bet Big on Drop in Housing Values; Greenspan Gets a New Gig, Soros Does Lunch*, WALL ST. J., Jan. 15, 2008, at A1; Saskia Scholtes, Editorial, *Fears Over Helping Hand for Mortgage Defaulters*, FIN. TIMES (London), May 31, 2007, at 1.

⁸⁰ Kate Kelly and Serena Ng, Editorial, *The Sure Bet Turns Bad: Funds Howl as Bear Stearns Buys Mortgages*, WALL ST. J., JUNE 7, 2007, at c3.

⁸¹ Roddy Boyd, Editorial, *Hedge Fund Bearish on Sub-Prime Relief*, N.Y. POST, June 5, 2007, at http://www.nypost.com/seven/06052007/business/hedge_fund_bear_ish_on_subprime_relief_business_roddy_boyd.htm.

⁸² *Id.*

⁸³ *Id.*

C. INVESTMENT BANKS: WINNING AND LOSING WITH CDSs

The banks themselves may be profiting by betting against their own securitized mortgages through CDS. Moreover, CDS might have contributed to the stunning collapse of one of Wall Street's most powerful investment banks.

In 2007, Goldman Sachs, another major trader of both CDS and mortgage-backed securities, made \$4 billion by betting that securities backed by home loans would fall in value.⁸⁴ While making these bets, Goldman was also underwriting bonds backed by these mortgages. Did Goldman keep churning out troubled bonds with the knowledge that it would profit from their decline in value using CDS?

In March of 2008, Bear Stearns finally succumbed to betting incorrectly on the housing market.⁸⁵ The firm's brokerage and hedge fund clients began withdrawing their accounts in droves as fear of Bear Stearns' lack of liquidity began to spread.⁸⁶ As a result, Bear Stearns, found itself in an increasingly precarious position.⁸⁷ The firm ended up agreeing to sell itself for \$2 (later raised to \$10) per share to J.P. Morgan Chase in a deal organized by the Federal Reserve.⁸⁸ Some traders speculate whether the clients withdrawing accounts from Bear Stearns used the CDS market to profit from the firm's demise.⁸⁹ A hedge fund betting heavily that Bear Stearns will fail has much less incentive to keep its business with Bear Stearns because withdrawing its business makes it more likely that its CDS will pay out.⁹⁰

Some reports also suggested that certain Bear Stearns bond holders planned to vote against allowing J.P. Morgan Chase to buy the troubled

⁸⁴ Kate Kelly, Editorial, *How Goldman Won Big on Mortgage Meltdown; A Team's Bearish Bets Netted Firm Billions; A Nudge from the CFO*, WALL ST. J., Dec. 14, 2007, at A1.

⁸⁵ Robin Sidel et al., Editorial, *The Week That Shook Wall Street: Inside the Demise of Bear Stearns*, WALL ST. J., Mar. 18, 2008, at A1.

⁸⁶ *Id.* See Zuckerman, *supra* note 78, at A1.

⁸⁷ See Sidel et al., *supra* note 82, at A1; Zuckerman, *supra* note 78, at A1.

⁸⁸ Sidel et al., *supra* note 82, at A1; Matthew Karnitschnig & David Enrich, Editorial, *Bear's Run-up Sets the Stage for Epic Clash; Speculators Ignite Rally, Driving Shares Up 23%; Disbelief on Deal Price*, WALL ST. J., Mar. 19, 2008, at C1; Andrew Ross Sorkin, Editorial, *JP Morgan Raises Bid for Bear Stearns to \$10 per share*, N.Y. Times, March 24, 2008.

⁸⁹ Gregory Zuckerman, Editorial, *Hedge Funds, Once a Windfall, Contribute to Bear's Downfall*, WALL ST. J., Mar. 17, 2008, at C1.

⁹⁰ *Id.*

firm, electing bankruptcy instead in order to allow CDS bets to pay off.⁹¹ Why attempt to salvage value when what might be lost to bankruptcy is less than what will be gained from CDSs as a result of bankruptcy?

D. MORAL HAZARD AND INSURANCE DOCTRINE

Whether bankruptcies or foreclosures, the potential activities described in section C all deal with what economists call moral hazard. Moral hazard can be defined as activity that reduces incentives to protect against loss or minimize the cost of a loss.⁹² Financial products that transfer wealth in the event of a loss give the buyer an incentive to bring about that loss, often in spite of the societal costs. A CDS potentially creates such an incentive or moral hazard since it creates awards when bad things –such as bankruptcies or foreclosures- happen. One way to think about developing policies to deal with that moral hazard is to evaluate the earliest methods. Those methods are found in the history of insurance law.

The doctrine of insurable interest invalidates insurance contracts in which buyers have no interest in the insured entity. It was created to counter moral hazard. The preamble of England’s Marine Insurance Act of

⁹¹ Karnitschnig & Enrich, *supra* note 85, at C1.

⁹² TOM BAKER, INSURANCE LAW AND POLICY 4 (Wolters Kluwer ed., Aspen Publishers 2d ed. 1959 (2008)). Moral hazard is a term and an idea that grew out of the insurance business. *See generally* Tom Baker, *On the Genealogy of Moral Hazard*, 75 Tex. L. Rev. 237 (1996). To price insurance contracts, insurers borrowed probability theory used to determine the complicated odds of the dice game known in 18th century England as “Hazard.” They applied this theory to vital statistics such as births, marriages, suicide, fires, storms, murder, sickness and calamity at sea. Similarly to predicting the outcome of a game of “Hazard,” the laws of large numbers allowed insurers to predict on the aggregate how often a ship would sink, a duke would die, or a house would be destroyed. The knowledge allowed insurers to sell their product at a price that would allow them to honor their commitments to customers, turn a profit and not go broke (at least most of the time). *See id.* at 245, 247. Former University of Connecticut School of Law Professor Tom Baker adds writes that fire insurers distinguished among physical hazards in two senses of the word. “There were hazards that caused fires (for example, lightning, short circuits, spontaneous combustion),” he wrote, “and there were hazards that affected the probability or magnitude of loss by fire (for example, the type of construction or use of a building).” *Id.* at 248. Later, Baker continues, insurers began using the term “moral” to distinguish both of these types of “hazard” from incentive that caused amoral behavior resulting in loss. *Id.* at 248. “[F]raud and interested carelessness were moral hazards that caused losses,” Baker explains, while “[b]ad character or habits, financial embarrassment, poor business practices and over-insurance were moral hazards that increased the probability of loss.” *Id.* at 248-249.

1746, which first codified the insurable interest requirement for the 18th century British Empire, lists the concerns of the legislators that passed it. It reads:

“WHEREAS, it hath been found by experience, that the making assurances, interest or no interest, or without further proof of interest than the policy, hath been productive of many pernicious practices, whereby great numbers of ships, with their cargoes, have either been fraudulently lost and destroyed, or taken by the enemy in time of war; and such assurances have encouraged the exportation of wooll, and the carrying on many other prohibited and clandestine trades, which by means of such assurances have been concealed, and the parties concerned secured from loss, as well to the diminution of the publick revenue, as to the great detriment of fair traders...”⁹³

Eighteenth Century British law is to a large extent the father of American common law and the doctrine of insurable interest is no exception. Nearly every state in the United States has codified insurable interest rules.⁹⁴ However, precise requirements of the doctrine often vary from state to state.⁹⁵

Closely related to the insured interest doctrine is the principle of indemnity. Some argue that indemnity is an outgrowth of the insured

⁹³ Marine Insurance Act, 1746, 19 Geo. 2, c. 37 (Eng.).

⁹⁴ CHRISTOPHER S. ARMSTRONG, AMERICA’S QUEST FOR A PROPER CONCEPT OF “INSURABLE INTEREST”: THE PERILS OF IGNORING THE IMPLICATIONS 3, (2002), http://www.rmstrnglaw.com/publications/Americas_%20Quest.pdf.

⁹⁵ *Id.*

There are two basic theories used to articulate the insured interest doctrine: the legal interest test and the factual expectancy test. American courts have generally recognized contract rights, property rights or legal liability to be insurable. See ROBERT H. JERRY & DOUGLAS R. RICHMOND, UNDERSTANDING INSURANCE LAW 283 (LexisNexis 2007). Property rights of any nature and quality will usually meet the requirement. In evaluating insurable interest based on contractual rights, courts usually look for the possibility of economic loss resulting from a contractual breach. Those subject to liability in the event of property damage or tort are also considered to have an insurable interest. *Id.* at 284-287.

The factual expectancy test is arguably a more generous test of an insured interest. The test simply inquires into whether the purchaser of insurance can expect a loss if the insured reference entity ceases to exist or expects a profit if the insured entity continues to exist. *Id.* at 289.

interest doctrine.⁹⁶ Insurance aims to do nothing more than reimburse. The principle of indemnity merely states that a contract for insured property cannot return to the buyer more than his interest in that property is worth. If a buyer of insurance could collect more than the property is worth, that additional amount would not be based on an insurable interest and the moral hazard doctrine attempts to avert that which would not be fully mitigated.⁹⁷

⁹⁶ Daniel Dumas, *Insurable Interest in Property Insurance Law*, 18 R.D.U.S. 407, 423 (1988); HOLMES & RHODES, *supra* note 21, at § 3.1 (“The indemnity principle is dependent upon and interconnected with the doctrine of insurable interest.”).

⁹⁷ Jerry & Richmond, *supra* note 92, at 277.

The extent to which insurance doctrine focuses on insurable interest or indemnity differs from jurisdiction to jurisdiction and country to country. The United Kingdom’s Law Commission, a statutory independent body created by Parliament to review the law and recommend reform, is currently reevaluating whether the insured interest doctrine is useful considering that the indemnity doctrine serves a similar purpose. *See* The Law Comm. & The Scot. Law Comm., *Insurable Interest, Issue Paper 4* (2008), (available at http://www.lawcom.gov.uk/docs/Insurance_Contract_Law_Issues_Paper_4.pdf).

In reviewing the current status of the insurable interest and indemnity doctrine it is important not to mistake the changes regarding life insurance as changes that affect insurance in general. Many jurisdictions have done away with the insurable interest doctrine as necessary for collecting on a life insurance policy. *See* Annotation, *Validity of assignment of life insurance policy to one who has no insurable interest in insured* 30 A.L.R 2d 1310, 1333. This change allows holders of life insurance to sell their policies before their death, allowing them to unlock much of the value they have paid into the policy. 30 A.L.R 2d at 1339-1340. The creation of a secondary market for life insurance contracts has been deemed legal. *See* BAKER, *supra* note 89, at 235-246. Also deemed legal is the controversial practice of employers taking out life insurance contracts on employees. *Id.* at 238-239. Courts evaluating this practice have ruled that the employers have an insurable interest in the lives of those who work for them. *Id.* at 238-239. Australia abandoned the insurable interest requirement for life insurance policies altogether in 1995 stating that the doctrine as a defense against moral hazard no longer holds sway. *See* The Law Comm. at 53-54.

Many of these changes are due to the differences between life insurance and other types of insurance. Life insurance is often not considered an indemnity contract because of the difficulty in valuing human life. HOLMES & RHODES, *supra* note 21. Moreover, courts deemed the public interest in allowing life insurance policy-holders to collect on their contracts before death to meet their needs in life outweighed the moral hazard of a buyer of the policy profiting through murder. *See* 30 A.L. R. 2d at 1333, 1339.

One recent argument against the insurable interest doctrine focuses on its use by insurers to invalidate contracts. *See* Jacob Loshin, *Insurance Law’s Hapless Busybody: A Case Against the Insurable Interest Requirement*, 117 YALE L.J. 475, 479 (2007). This scholar argues that the insured interest doctrine harms consumers who rely on contracts they believe are valid but are later found void by courts using a definition for the doctrine that is “erratic, ambiguous and inconsistent.” *Id.* at 487. The author argues that doing away with a legal insurable interest requirement would create more incentive for insurance companies to

Another insurance doctrine that might also be considered an outgrowth of the insurable interest and indemnity doctrines is subrogation. This doctrine seeks to avoid unjust enrichment on the part of the insured by substituting the insurer in place of the insured in regard to some claim or right the insured has against a third party regarding the insured's loss.⁹⁸ When an insurer asserts a subrogation right he is viewed as "standing in the shoes" of the insured.⁹⁹ Application of the doctrine bars the insured from filing a claim on a loss and then seeking compensation on that loss through other means, such as a tort suit.¹⁰⁰

These doctrines still serve as legal efforts to ensure that insurance helps cushion the effects of existing risks and does not create new risks. If applied to CDSs, they would prevent the creation of the negative economic interests discussed and eliminate the potential profit from the destruction of value.

III. FAILING TO MAKE A CONVINCING DISTINCTION

Given the similarities between CDSs and traditional insurance and the context with which the insurable interest and indemnity principles are applied, it is appropriate to reevaluate the arguments that CDSs are not insurance contracts.

investigate potential moral hazard and not write policies for buyers who are likely deliberately to bring about the event insured against. *Id.* at 506-508.

It is also important to remember that the origins of insurable interest are also closely related to the 18th and 19th century legislative aversion to gambling in Anglo-Saxon countries and the insurance business' interest in separating itself from gaming activities. The history is sufficient to argue - as some of the sources referenced above do - that preventing gambling was the chief aim of the implementation of insurable interest as a legal doctrine. For the purposes of this discussion, gambling is considered to be part of the group of moral hazard that the doctrine seeks to avoid. However, given the changes in much of society's views on gambling it is arguable that the premises on which insurable interest is based is no longer valid. *See Dumais, supra* note 93 at 410-417.

Despite the ways in which the insurable interest and indemnity doctrines have evolved in certain parts of the world and criticisms of them, they are both alive and well as legal principles that discourage the destruction of value in order to collect on a property insurance contract.

⁹⁸ HOLMES & RHODES, *supra* note 21, §3.1 at 334.

⁹⁹ *Id.*

¹⁰⁰ *Id.* at 335-36.

A. SCHWARTZ' ARGUMENT

Schwartz' propositions apply the same reasoning applied in the Potts' opinion and the advisory letter issued by the New York Department of Insurance.¹⁰¹ Therefore, challenging Schwartz' propositions should also serve to challenge Potts and the New York Department of Insurance's analysis.

First, Schwartz argues that "[w]here a party enters a contract for contingent recovery possessing no economic interest in protecting the covered property from loss or damage, the contract is not insurance."¹⁰² Thus, according to Schwartz, CDSs should not be labeled insurance because there is no insurable or economic interest requirement with respect to CDS contracts.¹⁰³ Insurance contracts, however, did not always require that the buyer possess an insurable or economic interest in protecting the covered property. Rather, the legislative and judicial intent in requiring insurable interest is to limit the moral hazard insurance contracts create.¹⁰⁴ A CDS creates the same kind of moral hazard and therefore should possibly be regulate as insurance. Using Schwartz' reasoning, insurance contracts before the adoption of the insurable interest requirement were not insurance contracts. Therefore Schwartz' first proposition does not prove CDS are not insurance.

Secondly, Schwartz argues that "[w]hen the contract for recovery fails to reference property that the purchasing party has economic incentive to protect from loss or damage, the contract is not insurance."¹⁰⁵ Similar to the first proposition, Schwartz's second proposition also seeks to define insurance using the insured interest doctrine. Schwartz acknowledges in discussing the second proposition that the insured interest doctrine is intended to mitigate moral hazard.¹⁰⁶ CDSs allow buyers to speculate, according to Schwartz, whether or not they bear any risk related to the reference entity and consequently are not insurance.¹⁰⁷ This feature of CDSs distinguishes it from insurance only in the sense that modern insurance law prevents using insurance contracts to create a negative economic interest in a given entity. As discussed in the preceding

¹⁰¹ See Schwartz, *supra* note 2 at 200; see also *supra* text accompanying notes 21, 27.

¹⁰² Schwartz, *supra* note 2, at 200.

¹⁰³ See *id.* at 189.

¹⁰⁴ Jerry & Richmond, *supra* note 92, at 276.

¹⁰⁵ Schwartz, *supra* note 2, at 200.

¹⁰⁶ See *id.* at 190.

¹⁰⁷ *Id.*

paragraph, this is simply a difference in how two types of contracts are regulated as opposed to a difference in the contracts themselves. Given the evidence that CDSs create moral hazard similar to early insurance contracts, policy makers should consider applying the same regulation to CDSs as applied to insurance.

Third, Schwartz argues that “[w]hen recovery under a contract can be had without substantiating any actual loss or damage the contract is not insurance.”¹⁰⁸ Therefore, according to Schwartz, a CDS is not insurance because a credit event triggering a payout to a CDS buyer does not have to constitute a loss on the part of the buyer.¹⁰⁹ The indemnity doctrine was instituted to prevent using an insurance contract to create a negative economic interest in the insured entity. CDSs not being subject to this requirement does not mean CDSs are not insurance. It only means CDSs are not regulated the same way as a standard insurance contract.

Fourth, Schwartz argues that where the party can recover an amount that exceeds expenses caused by loss or damage, the contract is not insurance.¹¹⁰ CDSs allow a buyer to recoup, upon the occurrence of a credit event, amounts that bear little or no relationship to the buyer’s loss. Consequently, Schwartz argues CDSs are not insurance.¹¹¹ Again, this argument uses the indemnity doctrine to define insurance when indemnity is merely a form of regulation restraining the use of insurance.

Fifth, Schwartz argues that where a contract for recovery allows physical settlement, the contract is not insurance.¹¹² While insurance contracts usually result in the insurer paying the insured a cash amount based on the loss, parties to a CDS contract can designate either cash or physical settlement.¹¹³ The possibility of physical settlement, where the obligation provided by the buyer to the seller in exchange for the payout amount is different from the reference obligation, would not be allowed in a standard insurance contract.¹¹⁴ By collecting on an insurance contract, the insured often hands over to the insurance company any right attached to the entity he or she had insured. This transfer of rights is called

¹⁰⁸ *Id.* at 200.

¹⁰⁹ *See id.* at 193.

¹¹⁰ *Id.* at 200-01.

¹¹¹ Schwartz, *supra* note 2, at 193.

¹¹² *Id.* at 200-01.

¹¹³ *Id.* at 194.

¹¹⁴ *Id.* at 195.

subrogation.¹¹⁵ This difference means CDS cannot be defined as insurance, according to Schwartz.¹¹⁶ Again, Schwartz has identified a distinction in the contract's legal treatment and not in the contract's effects. If a CDS contract creates similar effects as an insurance contract that is not subject to subrogation, then policy-makers must assess whether subrogation should apply to CDSs.

Sixth, Schwartz argues that where a contract for recovery provides for cross-payment netting under a master agreement, the contract is not insurance.¹¹⁷ Under the ISDA Master Agreement, CDS trades between accounts can be netted, meaning that instead of working through each transaction, market participants can settle the net balance outstanding between them.¹¹⁸ This aspect of the CDS market is merely a testament to the success of the ISDA in organizing consensus among its members. An insurance company might be able to achieve the same result if it deducted premiums owed by an insured on one policy from the amount the insured was scheduled to collect from a different policy. This last characteristic identified by Schwartz simply describes the manner in which an insurance exchange, unencumbered by the insured interest, indemnity or subrogation doctrines, might organize itself to achieve maximum efficiency. It is hardly a characteristic distinguishing CDS from insurance.

B. NIRENBERG AND HOFFMAN'S ARGUMENT

The analysis presented by Nirenberg and Hoffman, presents a more subtle argument. It utilizes Holmes' three tests; (1) Substantial Control; (2) Principal Object; and (3) Regulatory Value to determine whether CDS should be classified as insurance.¹¹⁹

Under the Substantial Control Test, insurance is any contract by which one contracting party (the insurer) for a valuable consideration (the premium) given by the other party (the insured) assumes the other party's fortuitous risk of loss or liability and then distributes the risk or liability

¹¹⁵ See Subrogation Administration, What Subrogation?, <http://www.subrogation.com/what/main.html> (last visited Oct. 4, 2008).

¹¹⁶ Schwartz, *supra* note 2, at 201; See Subrogation Administration, What Subrogation?, <http://www.subrogation.com/what/main.html> (last visited Oct. 4, 2008).

¹¹⁷ *Id.* at 200-01.

¹¹⁸ *Id.* at 195-96.

¹¹⁹ See *infra* text accompanying notes 103-107.

among a similarly situated group of parties pursuant to the same distribution plan.¹²⁰

Applying this standard to CDSs, there is a contract (the CDS agreement) by which one contracting party (the seller) for valuable consideration (the contracted payment obligation) tendered by the other party (the buyer) assumes the other party's risk of loss or liability (the reference security becoming substantially devalued or worthless).¹²¹ But, they continue, whether the risk of loss or liability is fortuitous depends on the facts and circumstances of the transaction.¹²² Similarly, they argue, distribution of the risk by the CDS seller among buyers does occur, but not always.¹²³ Nirenberg and Hoffman conclude that CDSs being deemed insurance based on the substantial control test depends on the circumstances of the particular transaction.¹²⁴

The Principle Object Test inquires whether the elements of risk transference and distribution of a fortuitous insured event are central to and a relatively significant feature of the commercial transaction.¹²⁵ Nirenberg and Hoffman again find that this determination varies between CDS transactions as one buyer might be buying to hedge risk, meaning he is buying insurance, whereas another might be buying to speculate, meaning he is not buying insurance.¹²⁶

The Regulatory Value Test inquires whether a particular commercial transaction should be regulated in the public interest.¹²⁷ More specifically, the test makes the following inquiries: 1) What is the private interest sought to be protected in the commercial transaction? 2) Who is the party assuming the risk transferred and is the protected interest indigenous to that party? 3) Is the protected interest indigenous to the state and all its interests? 4) Does the value of the indigenous interest invoke the purposes and policies of state insurance regulation for all its citizens?¹²⁸

Nirenberg and Hoffman provide a similar answer to the first two inquiries as Potts and Schwartz. They reason that because CDSs do conform to the requirements of the insurable interest and indemnity doctrines they

¹²⁰ Nirenberg & Hoffman, *supra* note 14, at 11; HOLMES & RHODES, *supra* note 21, at § 1.4.

¹²¹ Nirenberg & Hoffman, *supra* note 14, at 12.

¹²² *Id.* at 10, 12.

¹²³ *Id.* at 12.

¹²⁴ *Id.* at 10, 12.

¹²⁵ *Id.* at 11; HOLMES & RHODES, *supra* note 21, at § 1.4.

¹²⁶ Nirenberg & Hoffman, *supra* note 14, at 12-13.

¹²⁷ HOLMES & RHODES, *supra* note 21, at § 1.4.

¹²⁸ *Id.*

are not insurance.¹²⁹ As argued above, this analysis is faulty as it distinguishes CDS from insurance based on its purpose rather its effects. In evaluating the second two inquiries, Nirenberg and Hoffman assume that CDSs “affect neither the health nor the safety of the public, nor any other interest indigenous to the state or its citizens.”¹³⁰ As discussed in part two of this paper, there is evidence that CDSs create negative economic interests that give CDS buyers incentive to destroy value in the economy. Policy-makers decided to check similar incentives created by early insurance contracts and should think about doing so with regard to CDSs.

CONCLUSION

Arguments against recognizing CDSs as insurance fail to recognize the moral hazard created by CDSs. These arguments disregard the purpose of the insured interest and indemnity doctrines. Therefore, the differential treatment of CDSs and insurance merits review by policy-makers.

The moral hazard created by CDSs described above might only be potential. Dispositive evidence showing speculators destroy value to profit on CDS speculation has not been found. However, analysis of the issue is difficult due to a lack of disclosure requirements in the OTC derivatives market, through which CDSs are traded. Some argue that simply creating more disclosure rules would mitigate any potential moral hazard.¹³¹ An alternative or supplemental measure might be the application of an insurable interest or indemnity requirement.

Given the similarities between an old problem (moral hazard in the early insurance market) and a potential new one (moral hazard in CDS markets), policy-makers must analyze the consequences of classifying CDSs as insurance for regulatory purposes. There are some strong arguments regarding the benefits of CDSs and the dangers of government regulation.¹³² Given the immense size of the CDS market more research is needed. Moreover, given the similarities between CDSs and insurance, more emphasis should be placed on studying insurance law and policy in evaluating the future of CDSs.

¹²⁹ Nirenberg & Hoffman, *supra* note 14, at 13-14.

¹³⁰ Nirenberg & Hoffman, *supra* note 14, at 15.

¹³¹ Hu & Black, *supra* note 66, at 682 - 684.

¹³² See Greenspan, *supra* note 19.

**A TAX TREATY THAT DOESN'T TAX?
THE UNIQUE HISTORY OF THE UNITED
STATES-BERMUDA TAX TREATY AND THE
SUBSEQUENT PROBLEMS FACING THE UNITED
STATES INSURANCE INDUSTRY**

*Yelena Tsvaygenbaum**

ABSTRACT

This casenote addresses the history and potential problems of the 1986 US-Bermuda Tax Treaty, which narrowly focuses on the taxation of insurance premiums. Since Bermuda itself has no income tax, this unequal treaty gives the island state an advantage over the USA. The original reasons for entering into such a treaty have been eliminated, and the lack of tax information and possibility of tax evasion from non-Bermuda residents present problems for the future of US-Bermuda relations. Renegotiation of the treaty may be a prudent idea, in order to remedy these problems and increase taxable incomes. Since Bermuda's flexible environment for reinsurance and insurance is attractive globally, its market is a benefit to the United States, although US reinsurers are bound by higher taxes. However, domestic concern about Bermuda's insurance industry include concerns about tax loopholes in acquisition and corporate inversion, attack by the IRS under §845(b), and overcharging. Various federal bills have been proposed to "level the playing field," appealing for changes in state legislation on reinsurance may be the best idea to increase economic activity domestically.

In 1986, Bermuda and the United States signed the United States-Bermuda Tax Treaty. This treaty is unique because unlike all other tax treaties it does not alleviate double taxation. One of the major goals of tax

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treaties is to alleviate double taxation for companies and individuals that pay taxes in multiple countries. Bermuda, however, does not tax income, thus no double taxation is possible. Furthermore, unlike most treaties, the tax treaty is very narrow in scope - it covers only the taxation of insurance premiums. Why should the United States have a narrow treaty with Bermuda? The first part of the article will try to answer that question by providing an overview of the treaty and reviewing its legislative history. The second part of the article will discuss the insurance industry in Bermuda after treaty ratification, specifically the current problems the U.S. insurance industry faces as a result of the tax environment in Bermuda.

PART I. LEGISLATIVE HISTORY OF UNITED STATES-BERMUDA TAX TREATY

A. OVERVIEW OF THE UNITED STATES-BERMUDA TAX TREATY¹

Under certain circumstances, the United States-Bermuda Tax Treaty provides for relief from taxation of insurance business profits. The business profits of a Bermudian insurance company will not be taxed in the United States unless a company has a permanent establishment² in the

¹ Convention Between the Government of the United States of America and the Government of the United Kingdom of Great Britain and Northern Ireland (On Behalf of the Government of Bermuda) Relating to the Taxation of Insurance Enterprises and Mutual Assistance in Tax Matters, U.S.-Berm., Jul. 11, 1986, T.I.A.S. No. 11,676 [hereinafter U.S.-Bermuda Tax Treaty]; *Treasury Department Technical Explanation of Bermuda Tax Treaty*, TAX NOTES TODAY, Sept. 29, 1986, available at LEXIS, 86 TNT 195-12.

² A permanent establishment is defined as:

[A] regular place of business through which the business of an enterprise of insurance is wholly or partly carried on. The term "permanent establishment" . . . include[s] especially a place of management, a branch, an office, and premises used as a sales outlet. The term "permanent establishment" . . . also include[s] the furnishing of services, including consultancy, management, technical and supervisory services, within a Covered Jurisdiction by an enterprise of insurance through employees or other persons but only if: (a) activities of that nature continue within the Jurisdiction for a period or periods aggregating more than 90 days in a twelve-month period, provided that a permanent establishment shall not exist in any taxable year in which such services are rendered in that Jurisdiction for a period or periods

United States. The tax treaty also provides relief from Bermudian taxation to American insurance companies unless the companies have a permanent establishment in Bermuda.³ In practice, no relief from taxation is needed because Bermuda does not tax income.

Even if an American insurance company has a permanent establishment in Bermuda, it will not incur an income tax in Bermuda. Thus, the relief from taxation is a concession by the United States, not Bermuda. Furthermore, by agreeing to only tax a permanent establishment of a Bermudian insurance company, the United States provides a greater benefit to Bermuda-based companies than enjoyed by U.S.-based companies. Under the regular U.S. Code, the business profits of a domestic insurance company are taxed when the insurer has a trade or business carried on in the United States and the business profits are effectively connected with the trade or business.⁴ In contrast, under the treaty, the business profits of a Bermudian insurance company are taxed by the United States when the insurer has a fixed place of business in the United States and the insurer's income is attributable to that fixed place of business.⁵ Thus, a Bermudian insurance company, unlike a U.S.-based company, has to be more than engaged in a trade or business in the United States before the United States can tax its business profits. The difference in taxation between a U.S.-based company and a Bermuda-based company is due to the fact that foreign companies in the United States are taxed only on their source income (income earned in the United States), while domestic companies are taxed on a world-wide basis.

The relief from taxation granted to Bermuda-based companies includes two exceptions. Relief is only granted if more than 50% of a resident company's stock is owned by a U.S. citizen, a U.S. resident, or a Bermuda resident. The purpose of the qualifying provision is to prevent treaty

aggregating less than 30 days in the taxable year; or (b) the services are performed within the Jurisdiction for an associated enterprise.

U.S.-Bermuda Tax Treaty, *supra* note 1, at art. 3. See also *Treasury Department Technical Explanation of Bermuda Tax Treaty*, TAX NOTES TODAY, Sept. 29, 1986, available at LEXIS, 86 TNT 195-12.

³ U.S.-Bermuda Tax Treaty, *supra* note 1, at art. 4; *Treasury Department Technical Explanation of Bermuda Tax Treaty*, TAX NOTES TODAY, Sept. 29, 1986, available at LEXIS, 86 TNT 195-12.

⁴ S. FOREIGN RELATIONS COMM., TAX CONVENTION WITH THE UNITED KINGDOM (ON BEHALF OF BERMUDA), S. REP. NO. 100-23, at 14-15 (1988).

⁵ *Id.* at 15-16.

shopping.⁶ However, it is much lower than the qualifying provision under the 1981 United States Model Tax Treaty, which requires 75% of a company's stock to be held by individuals in the country of residence.⁷ The second exception which is also meant to prevent treaty shopping provides for no tax relief on resident's income when a resident uses the income in substantial part to make distributions to people who are not U.S. citizens, U.S. residents or Bermuda residents.⁸ There is an exception to the exception – if there is substantial and regular trading on a public stock exchange, tax relief is allowed for companies where U.S. citizens, U.S. residents, or Bermuda residents own less than 50% of the stock.⁹ Thus, publicly traded companies satisfy the requirements for tax relief. The treaty also contains a waiver of the U.S. excise tax.¹⁰ An excise tax is a tax imposed on insurance premiums paid to foreign insurers.

The treaty also includes a savings clause and a nondiscrimination clause. The savings clause allows the United States to reserve their right to tax their own residents and citizens as if the treaty was not in force.¹¹ The savings clause is traditionally placed into tax treaties to ensure that the U.S. tax burden for U.S. residents and U.S. citizens is not unintentionally reduced.¹² The nondiscrimination clause provides that neither country may

⁶ Treaty shopping is a tax avoidance strategy where a company that resides in a country without a treaty with the United States routes income through a jurisdiction with a favorable tax treaty with the United States. Thus, the company receives tax benefits under the tax treaty to which it was not directly entitled. AM. LAW INST., INTERNATIONAL ASPECTS OF UNITED STATES INCOME TAXATION II: PROPOSALS ON UNITED STATES INCOME TAX TREATIES 150-151 (1992).

⁷ U.S. Model Income Tax Convention, art. 16, ¶ 210.16, Jun. 16, 1981, 1 TAX TREATIES (CCH). When the United States-Bermuda Tax Treaty was ratified, the 1981 Model Tax Treaty was the most recent model tax treaty. Subsequent model tax treaties have lowered the 75% threshold to 50% making them comparable to the U.S.-Bermuda Tax Treaty. See U.S. Model Income Tax Convention, art. 22, ¶ 210.22 Sep. 20, 1996, 1 TAX TREATIES (CCH); U.S. Model Income Tax Convention, art. 16, ¶ 209.16, Nov. 15, 2006, 1 TAX TREATIES (CCH).

⁸ U.S. Model Income Tax Convention, art. 16, ¶ 211.16, Jun. 16, 1981, 1 TAX TREATIES (CCH).

⁹ *Id.*

¹⁰ The treaty is reciprocal. Any benefit provided to Bermuda is also provided to United States. *Id.* at ¶ 211.02. Thus, in theory, there is also a waiver of Bermuda excise taxes on U.S. insurance premiums. However, Bermuda does not have an excise tax.

¹¹ U.S.-Bermuda Tax Treaty, *supra* note 1, art. 4(1); *Treasury Department Technical Explanation of Bermuda Tax Treaty*, TAX NOTES TODAY, Sept. 29, 1986, available at LEXIS, 86 TNT 195-12.

¹² Ernest R. Larkins, *U.S. Income Tax Treaties in Research and Planning: A Primer*, 18 VA. TAX REV. 133, 186-187 (1998).

tax a permanent establishment that is a resident of the other country less favorably than it taxes its own resident insurance entities that carry on the same activities.¹³ Therefore a Bermudian permanent establishment cannot be taxed more severely in the United States than a similar U.S. insurance company.

The treaty also provides for mutual assistance on tax matters. The purpose of a mutual assistance provision is to prevent or decrease tax avoidance.¹⁴ Bermuda agrees to aid United States and vice versa in tax information gathering. In the past, Bermuda's bank secrecy laws have proved to be an obstacle to enforcement efforts in cases involving U.S. persons with business dealings in Bermuda. The agreement provides a comprehensive set of exchange of information rules. The mutual assistance provision, however, is narrower in scope than the 1981 United States Model Tax Treaty. For example, under the tax treaty, the exchange-of-information rules are not effective for taxable years prior to 1977 for matters other than tax fraud or tax evasion.¹⁵ "Matters other than tax fraud and evasion" are defined as civil tax matters with the exception of civil fraud.¹⁶ Another limitation under the treaty is that Bermuda can refuse to provide documents that were created after the treaty went into force, if providing such documents causes a breach of confidentiality.¹⁷ Confidential information is defined as information protected by Bermuda statutory and common law.¹⁸ The post-entry-into-force limitation does not apply when a document is created before the treaty went into force, but is still relevant after the treaty was ratified.¹⁹

Congress ratified the treaty with two reservations. First, the waiver of the insurance excise tax was set to sunset on January 1, 1990.²⁰ Second, the treaty permits the U.S. government to impose insurance excise taxes

¹³ U.S.-Bermuda Tax Treaty, *supra* note 1, art. 4(7); *See also* S. FOREIGN RELATIONS COMM., TAX CONVENTION WITH THE UNITED KINGDOM (ON BEHALF OF BERMUDA), *supra* note 4, at 20.

¹⁴ Larkins, *supra* note 12, at 205.

¹⁵ *Testimony of Alan L. Fischl on Bermuda Tax Treaty Before Joint Tax Committee*, TAX NOTES TODAY, Sept. 29, 1986, available at LEXIS, 86 TNT 195-7.

¹⁶ *Id.*

¹⁷ *Id.*

¹⁸ *Id.*

¹⁹ *Id.*

²⁰ *Metzenbaum Amendment Kills Provisions in Barbados and Bermuda Tax Treaties to Waive Some Excise Taxes on Insurance Premiums*, TAX NOTES TODAY, Oct. 14, 1988, available at LEXIS, 88 TNT 209-42.

unless future agreements explicitly override this provision.²¹ The purpose of the treaty amendments was to ensure that the waiver of the excise tax was temporary and would not be granted in the future without explicit intent to do so.²²

B. WHY MAKE THE TREATY?

Tax treaties remove impediments to international investment and to the free flow of capital generally.²³ There are two purposes of a tax treaty: to prevent tax avoidance and evasion and to reduce international double taxation.²⁴ Neither purpose was the primary reasons behind the United States-Bermuda Tax Treaty.

The Bermuda government sought a tax treaty with the United States because the United States signed a tax treaty with Barbados. Bermuda wanted similar benefits that Barbados received from the United States under the United States-Barbados tax treaty. The United States-Barbados Tax Treaty eliminated U.S. excise tax imposed on insurance premiums paid to Barbadian insurers by including the U.S. excise tax in the “Taxes Covered” section of the tax treaty.²⁵ The inclusion of the U.S. excise tax in the “Tax Covered” treaty section is not unusual as it is included in the 1981 Model Tax Treaty, (the most recent model tax treaty at the time of the United States-Barbados Tax Treaty ratification) and subsequent model tax treaties.²⁶

An insurance excise tax is imposed on premiums which are not subject to net-basis taxation, but are attributable to U.S.-based risks.²⁷ In other words, United States imposes an excise tax when a company that does not

²¹ *Id.*

²² See *infra* Part I.B, for information on excise taxes.

²³ *Testimony of Alan L. Fischl on Bermuda Tax Treaty Before Joint Tax Committee, supra* note 15.

²⁴ *Id.*

²⁵ Convention Between Barbados and the United States of America for the Avoidance of Double Taxation and the Prevention of Fiscal Evasion with Respect to Taxes on Income, U.S.-Barb., art. 2.1.a, Dec. 31, 1984, T.I.A.S. No. 11,090.

²⁶ See U.S. Model Income Tax Convention, art. 2, ¶ 211.02, Jun. 16, 1981, 1 TAX TREATIES (CCH); U.S. Model Income Tax Convention, art. 2, ¶ 210.02, Sep. 20, 1996, 1 TAX TREATIES (CCH); U.S. Model Income Tax Convention, art. 2, ¶ 209.02, Nov. 15, 2006, 1 TAX TREATIES (CCH).

²⁷ U.S. DEP’T. OF TREASURY, REPORT TO CONGRESS ON THE EFFECT OF U.S. REINSURANCE CORPORATIONS OF THE WAIVER BY TREATY OF THE EXCISE TAX ON CERTAIN REINSURANCE PREMIUMS 7 (1990) [hereinafter Treasury Excise Tax Study].

have a trade or business in the U.S. either insures or reinsures risks located in the United States.²⁸ The purpose of the excise tax is to ensure that all premiums tied to risks located in the United States are taxed (in this way, while foreign insurers that insure U.S.-based risks have a U.S. trade or business are taxed on a net basis, foreign insurers that insure U.S.-based risks and *do not* have a U.S. trade or business are taxed via the excise tax).²⁹

Although, a waiver of the insurance excise tax has been included in treaties with countries such as the United Kingdom, France, and Italy,³⁰ Barbados was the first country to receive the waiver that did not itself have an excise tax on insurance premiums. Thus, the waiver of tax was not needed to alleviate double taxation in Barbados. The Treasury Department acknowledged that the waiver of the excise tax was an unintended effect of the Barbados treaty.³¹ Bermuda, a competitor of Barbados in the insurance industry, asked the United States to confer a similar benefit on it. Alan Fischl, a Legislation Attorney, testified before the Joint Committee on Taxation during a hearing on the proposed United States-Bermuda Tax Treaty, that because Barbados and Bermuda were competing centers for insuring non-domestic risks, fairness would indicate that insurance-related treaty benefits granted to one country should be extended to the other.³²

The United States also believed that having a tax treaty with Bermuda would be beneficial for the United States-Bermuda diplomatic relations. During the Senate Foreign Relations Committee Bermuda Tax Treaty Hearing, Navy representatives spoke in a closed session on the security benefit of the treaty.³³ Non-confidential security reasons for ratifying the United States-Bermuda Tax Treaty were discussed by James Medas, the Deputy Assistant Secretary for the European and Canadian Affairs in the Department of State. He testified that there were strong security reasons

²⁸ This is most apparent in reinsurance contracts, where a foreign reinsurer contracts to indemnify a portion of the insurer's claims based in the U.S. For reinsurance premiums, the rate of the excise tax is 1%. I.R.C. § 4371 (2002).

²⁹ Treasury Excise Tax Study, *supra* note 27, at 7.

³⁰ *Testimony of Mindy Pollack on Bermuda Tax Treaty Before Senate Foreign Relations Committee*, TAX NOTES TODAY, Sept. 29, 1986, available at LEXIS, 86 TNT 195-11.

³¹ *Testimony of Alan L. Fischl on Bermuda Tax Treaty Before Joint Tax Committee*, *supra* note 15.

³² *Id.*

³³ *Senate Foreign Relations Committee Agenda for Bermuda Tax Treaty Hearing*, TAX NOTES TODAY, Sept. 29, 1986, available at LEXIS, 86 TNT 195-8.

for the United States-Bermuda Tax Treaty.³⁴ The military bases which occupy about 10% of the entire island provide an “an excellent vantage point to observe extremely vital areas of the Atlantic and in conjunction with bases in Iceland and the Azores make an indispensable contribution to our security.”³⁵ J. Roger Mentz, the Assistant Secretary of the Tax Policy Department of the Treasury, agreed with the Department of State, stating that the important national security interest was a *primary* motivating factor leading to the negotiation of the United States-Bermuda Tax Treaty.³⁶ He added that the uniqueness of the treaty is directly attributable to concerns over national security.³⁷ Furthermore, Mentz stated before the Senate Foreign Relations Committee that the treaty would be a major step towards establishing a network for exchange of tax information between the United States and the Caribbean.³⁸

Due to these reasons, in 1986 the Senate ratified the tax treaty. The “indispensable contribution” Bermuda made to U.S. security in the mid-1980s may be doubtful, however. Less than a decade after the Senate Foreign Relations Committee heard testimony from Medas and Mentz, a government report described the U.S. military bases in Bermuda as rest and relaxation oases for senior naval officials and their families.³⁹ In 1995, President Clinton announced that the U.S. bases in Bermuda would close.⁴⁰ He cited the end of the Cold War, budget deficits, and *the bases’ reputation of being a vacation location for naval officers* as reasons for closing the bases in Bermuda.⁴¹ Thus, the claim that Bermuda represented a strong security interest in the mid-1980s is probably overstated.

Even before the announcement that the U.S. naval bases in Bermuda would close, the tax treaty was not without controversy. There were three

³⁴ *Testimony of James Medas on Bermuda Tax Treaty Before Senate Foreign Relations Committee*, TAX NOTES TODAY, Sept. 29, 1986, available at LEXIS, 86 TNT 195-9.

³⁵ *Id.*

³⁶ *Mentz’s September 25, 1986 Statement to the Senate Foreign Relations Committee Concerning Bermuda Tax Treaty*, TAX NOTES TODAY, Sept. 29, 1986, available at LEXIS, 86 TNT 195-10.

³⁷ *Id.*

³⁸ *Id.*

³⁹ Frank J. Parker, *Closing Bermuda’s U.S. Naval Bases*, 22 REAL EST. ISSUES 28, 30 (Aug. 1997).

⁴⁰ *Id.* at 29.

⁴¹ *Id.* at 30 (emphasis added).

main criticisms of the treaty⁴² - (1) there was no need to enter into a treaty because there was no double taxation;⁴³ (2) the exchange of information clause was not as comprehensive as that in other treaties;⁴⁴ and (3) the Treasury Department should study whether the U.S. reinsurance companies are at a competitive disadvantage to foreign companies due to the waiver of excise taxes on insurance premiums before the United States ratifies the United States-Bermuda Tax Treaty.

The last criticism was especially a concern for the Reinsurance Association of America (RAA). The Assistant General Counsel of RAA, Mindy Pollack, commented on the impact the Bermuda treaty would have on the domestic reinsurance market.⁴⁵ During her testimony before the Senate Foreign Relations Committee, Pollack urged Congress to wait until the Treasury Department studied the impact of excise tax waivers on the domestic reinsurance market before ratifying the treaty.⁴⁶ Subsequently, Congress passed a tax bill that required the Treasury Department to study the competitive effect of U.S. treaties on the U.S. reinsurance corporations' in comparison to foreign reinsurance corporations when the treaties include a waiver of the excise tax on insurance premiums [hereinafter the Treasury Excise Tax Study].⁴⁷ The Treasury planned to renegotiate the Bermuda treaty if the Treasury Excise Tax Study indicated that waivers of insurance excise taxes cause a disadvantage to U.S. companies.⁴⁸

Senator Dodd of Connecticut argued that instead of granting a benefit to other countries, the inadvertent mistake provided in the tax treaty with Barbados – the waiver of the insurance excise tax - should be deleted from

⁴² *Rostenkowski Letter to Treasury Secretary Baker Regarding United States-Bermuda Tax Treaty*, TAX NOTES TODAY, July 22, 1986, available at LEXIS, 86 TNT 144-5.

⁴³ In fact, the U.S. had never negotiated a treaty with a country that did not have income taxes. *Testimony of Alan L. Fischl on Bermuda Tax Treaty Before Joint Tax Committee*, *supra* note 15.

⁴⁴ Bermuda can refuse to provide documents that were created after the treaty went into force if providing such documents causes a breach of confidentiality. For discussion on the Exchange of Information Clause, see *supra* Part I.A. at 5-6.

⁴⁵ *Testimony of Mindy Pollack on Bermuda Tax Treaty Before Senate Foreign Relations Committee*, *supra* note 30.

⁴⁶ *Id.*

⁴⁷ Tax Reform Act 1986, Pub. L. No. 99-514, § 1244, 100 Stat. 2085, 2581 (1986). For the Excise Tax Study, see *infra* text accompanying notes 57-61.

⁴⁸ *Comments of Treasury Secretary Mentz on U.S.-Bermuda Tax Treaty*, TAX NOTES TODAY, Oct. 6, 1986, available at LEXIS, 86 TNT 200-3.

the United States-Barbados Tax Treaty.⁴⁹ Renegotiating the treaty would remove the competitive disadvantage currently facing the Bermudian insurance industry.⁵⁰ The Treasury Department believed that renegotiating the treaty with Barbados less than a year after the ratification of the United States-Barbados Tax Treaty would impair American credibility as a treaty partner.⁵¹ The Barbados Ambassador to the United States, Peter Laurie, urged Congress to await the results of the Treasury Excise Tax Study to see whether a waiver of the excise tax on the insurance premiums places the United States at a disadvantage.⁵² The Barbados ambassador believed that agreements such as the United States-Barbados Tax Treaty provide successful examples of cooperation between the United States and countries in the Caribbean.⁵³ He feared that renegotiating the tax treaty only a few months after it was ratified would be viewed as a lack of cooperation between the parties upsetting the relationship between the United States and countries in the Caribbean.⁵⁴ On the other hand, Senator Dodd believed that placing Barbados and Bermuda on equal competitive positions by extending the excise tax waiver to Bermuda would only compound the problem because a waiver would only reduce U.S. tax revenue.⁵⁵ Congress agreed with the Senator. While ratifying the United States-Bermuda Tax Treaty in 1988, Congress passed legislation that sunset the waiver of the excise tax with respect to premiums paid or credited on or after January 1, 1990 in both Barbados and Bermuda.⁵⁶

The Treasury released the Treasury Excise Tax Study on the impact of the waiver of excise taxes on the domestic insurance market in March 1990, after the excise tax on insurance premiums was reinstated in Bermuda and Barbados.⁵⁷ The Treasury Excise Tax Study revealed that the

⁴⁹ *Sens. Byrd, Dodd, & Pell Urge Treasury to Renegotiate Barbados Treaty Rather than Altering Bermuda Treaty*, TAX NOTES TODAY, Oct. 22, 1986, available at LEXIS, 86 TNT 211-6.

⁵⁰ *Id.*

⁵¹ *Comments of Treasury Secretary Mentz on U.S.-Bermuda Tax Treaty*, *supra* note 48.

⁵² *Barbados Tells Senators that Renegotiating the U.S.-Barbados Tax Treaty Could Upset the U.S.-Caribbean Policy*, TAX NOTES TODAY, Nov. 13, 1986, available at LEXIS, 86 TNT 226-3.

⁵³ *Id.*

⁵⁴ *Id.*

⁵⁵ *Sens. Byrd, Dodd, & Pell Urge Treasury to Renegotiate Barbados Treaty Rather than Altering Bermuda Treaty*, *supra* note 49.

⁵⁶ *Metzenbaum Amendment Kills Provisions in Barbados and Bermuda Tax Treaties to Waive Some Excise Taxes on Insurance Premiums*, *supra* note 20.

⁵⁷ Treasury Excise Tax Study, *supra* note 27, at 1.

United States is at a slight disadvantage when it offers a waiver of insurance excise taxes to foreign jurisdictions which charge low or no tax on insurance premiums.⁵⁸ The Treasury Excise Tax Study also pointed out that depending on the reinsurance market, the cost of the excise tax is passed down to U.S. consumers that pay the premiums.⁵⁹ Thus, a waiver of the excise tax, although it might disadvantage domestic reinsurers, may actually provide a savings to U.S. consumers.⁶⁰ The Treasury Excise Tax Study cautioned, however, that it did not factor in the various regulatory requirements and non-tax aspects affecting firms in foreign countries.⁶¹

C. WHAT TO DO WITH THE TREATY?

The primary reasons motivating the United States and Bermuda to enter into a tax treaty no longer hold. Bermuda wanted the waiver of the excise taxes on insurance premiums. The waiver sunset two years after the treaty ratification. The United States entered into the treaty due to a concern over security interests in Bermuda. After the end of the Cold War and the closing of the naval bases in Bermuda, the strong security reasons no longer exist. The only pertinent aspect of the treaty is the mutual assistance provision. However as discussed in Part I.A, the provision is limited because it allows Bermuda to refuse to provide documents that were created after the treaty went into force, if providing such documents causes a breach of confidentiality.

As Bermuda has a favorable tax environment, third parties may try to engage in tax evasion or tax avoidance in their resident country by transferring income to Bermuda. The United States may try to renegotiate the treaty to receive better tax information. Renegotiation, however, will not change the fact that Bermuda does not tax income. The United States could terminate the treaty completely, sending the policy message that the United States will not make treaties with countries that do not tax.⁶²

Another possibility is to renegotiate the treaty so that Bermudian companies that are managed and controlled in the United States will be taxed (under the treaty only Bermudian companies that have a permanent

⁵⁸ *Id.* at 3.

⁵⁹ *Id.* at 2.

⁶⁰ *Id.*

⁶¹ *Id.*

⁶² STAFF OF JOINT COMM. ON TAXATION, 110TH CONG., PRESENT LAW AND ANALYSIS RELATING TO SELECTED INTERNATIONAL TAX ISSUES 65 (Comm. Print 2007), <http://www.house.gov/jct/x-85-07.pdf>.

establishment in the United States are taxed).⁶³ The “managed and controlled” test would greatly impact the taxation of captive insurance companies, which are domiciled in Bermuda due to Bermuda’s historic expertise and regulatory system, but are managed domestically.⁶⁴ However, it is politically infeasible to implement the “managed and controlled” test because the Internal Revenue Code uses the place of incorporation test to define residence. Thus, implementing the “managed and controlled” test would require a change in legislation. Furthermore, it would go against U.S. policy and past precedent.⁶⁵

Even if the United States-Bermuda Tax Treaty is terminated or renegotiated, companies could still circumvent tax laws. Tax planners could aid companies to set up insurance entities in such a way that the companies do not have a permanent establishment or carry on trade or business in the United States, thus avoiding net income taxation.⁶⁶

According to the Joint Committee on Taxation, terminating the treaty would have little practical effect on the industry because reinsurance companies can organize in such a manner that they do not engage in a trade or business in the United States.⁶⁷ Thus, the United States should try to renegotiate the treaty. United States should seek a stronger mutual assistance provision and a change of how business profits of Bermudian entities are taxed in the United States. A stronger mutual assistance provision that allows the United States access to confidential information from Bermuda would aid United States to track down and prosecute those companies and individuals that avoid or evade taxes.

The treaty could also allow the United States to tax income of Bermudian insurance entities that have a trade or business in the United States. U.S. taxation of foreign entities whose resident country does not

⁶³ STAFF OF JOINT COMM. ON TAXATION, 109TH CONG., OPTIONS TO IMPROVE TAX COMPLIANCE AND REFORM TAX EXPENDITURES 180 (Comm. Print 2005), <http://www.house.gov/jct/s-2-05.pdf>; John Kelly, Note, *Haven or Hell: Securities Exchange Listing Standards and Other Proposed Reforms as a Disincentive for Corporate Inversion Transactions*, 14 MINN. J. GLOBAL TRADE 199, 201 (2004).

⁶⁴ A captive insurance company is a closely held insurance company that is controlled by its insureds. TOWERS PERRIN, TILLINGHAST, CAPTIVE INSURANCE COMPANY GLOSSARY 3, (2004) http://www.towersperrin.com/tp/getwebcachedoc?webc=TILL/USA/2004/200409/Captive_Insurance_Company_Glossary.pdf.

⁶⁵ Reuven S. Avi-Yonah, *For Haven’s Sake: Reflections on Inversion Transactions*, 27 TAX NOTES INT’L 225, 229 (2002).

⁶⁶ STAFF OF JOINT COMM. ON TAXATION, *supra* note 62, at 13.

⁶⁷ *Id.*

have a tax treaty with the United States is based on a U.S. trade or business threshold. This threshold provides a greater tax base than provided under the current tax treaty. Under the United States-Bermuda Tax Treaty, the United States can only tax profits attributable to permanent establishments of Bermudian insurance companies. A permanent establishment requires a company to have a fixed place of business in the United States, which is a higher threshold than requiring a company to have a trade or business in the United States.⁶⁸ Although there is a concern that tax planners could even circumvent the “trade or business” requirement due to the nature of the insurance industry,⁶⁹ it would still capture more taxable income than under the current permanent establishment standard. Another way the United States could increase taxable income would be to tax profits earned from insuring U.S. risks by Bermudian companies. The treaty could define taxable income from a permanent establishment as any income earned that is attributable to insuring US-based risks. Thus, both domestic and Bermudian insurance companies would be taxed at the same rate for insuring US-based risks. Bermuda may not agree to such a provision because it would greatly increase the tax burden of Bermudian companies.

PART II. POST-BERMUDA TAX TREATY RATIFICATION: THE REINSURANCE INDUSTRY

A. BERMUDA'S INSURANCE INDUSTRY: AN OVERVIEW

Bermuda's insurance industry is divided into insurance, making up 35% of the industry, and reinsurance, making up 65% of the industry.⁷⁰ Half of all risks insured are of American origin and one third of all risks are of European origin.⁷¹ More than half (about 60%) of the policies sold in Bermuda are for property insurance and reinsurance.⁷² Most importantly, Bermuda is a major global center for reinsurance.⁷³

⁶⁸ See *supra* Part I.A; U.S.-Bermuda Tax Treaty, *supra* note 1, art. 3.

⁶⁹ Especially in reinsurance, a substantial transaction can be carried out without having a business location in the U.S. *Reinsurance Association Supports Increase in Excise Tax on Reinsurance Ceded to Foreign Reinsurers*, TAX NOTES TODAY, Feb. 22, 1990, available at LEXIS, 90 TNT 41-47.

⁷⁰ Donald Kremer, *Reinsurance Company CEO Testifies on Impact of Increased Taxes*, TAX NOTES TODAY, Sept 27, 2007, available at LEXIS, 2007 TNT 188-35 [hereinafter *Reinsurance Company CEO Testifies*].

⁷¹ *Id.*

⁷² *Id.*

⁷³ The other global reinsurance centers are New York, London, and Zurich. *Id.*

Reinsurance is a type of insurance arrangement that transfers risk from an insurer to a reinsurer.⁷⁴ The relationship between the reinsurer and the original insurer, known as the cedent, is contractual.⁷⁵

Policyholders pay premiums to their primary insurer, and that insurer, as the reinsured, in turn pays to the reinsurer a certain percentage of those premiums as consideration. Since the reinsurer does not incur the normal cost of writing primary insurance, such as administrative expenses and commissions paid to agents, the reinsurer can profitably reinsure the risks for only a percentage of the premiums paid to the primary insurer.⁷⁶

Furthermore, the reinsurer pays the original insurer, known as the cedent, a commission.⁷⁷ The commission compensates the ceding company for its acquisition and operating costs.⁷⁸ It also reflects the anticipated profitability of the business.⁷⁹ Through reinsurance, insurance companies can insure a greater amount of risk, including risk that is less desirable, providing insurance to a greater number of customers. The transfer of risk also helps make the coverage more affordable.⁸⁰ Numerous U.S. insurers cede more than half of their business to reinsurers. Most of these reinsurers are domiciled abroad.⁸¹

The Bermuda regulatory system allows companies, to form, license and start underwriting insurance in a matter of a few months.⁸² In the United States however, it is very hard to start up an insurance company because insurance is regulated by states, and each state has its own licensing requirements.⁸³ Rules between states are often contradictory, and it is

⁷⁴ BARRY R. OSTRAGER & MARY KAY VYSKOCIL, MODERN REINSURANCE LAW AND PRACTICE 1-4 (2d ed. 2000).

⁷⁵ *Id.*

⁷⁶ *Bluewater Ins. Ltd. v. Balzano*, 823 P.2d 1365, 1367 (Colo. 1992), *quoted in* BARRY R. OSTRAGER, *supra* note 74 at 1-1, 1-5.

⁷⁷ *Reinsurance Company CEO Testifies*, *supra* note 70.

⁷⁸ *Id.*

⁷⁹ *Id.*

⁸⁰ *Id.*

⁸¹ For certain lines of insurance the proportion between foreign-based reinsurers and domestic reinsurers is even greater. For example, two-thirds of all hurricane and earthquake reinsurance purchased by U.S. insurers is from foreign reinsurance companies. *Id.*

⁸² *Id.*; Forming a company in Bermuda imposes very little limitations. There is limited case law that interprets the meaning and application of the major aspects of Bermuda corporate law. As of 2002, Bermuda had 12,000 companies, most of which had no assets, personnel, operations, or substantial economic ties with Bermuda. Orsolya Kun, *Corporate Inversions: The Interplay of Tax, Corporate, and Economic Implications*, 29 DEL. J. CORP. L. 313, 346 (2004).

⁸³ *Reinsurance Company CEO Testifies*, *supra* note 70.

almost impossible to be licensed in all 50 states.⁸⁴ Bermuda and Bermudian reinsurers, on the other hand, have a special expertise in providing reinsurance.⁸⁵ Bermuda, unlike the United States, is not subject to regulatory price controls or coverage mandates.⁸⁶ Capital is not trapped in “red tape” that limits the insurer’s ability to enter or exit various markets.⁸⁷ Thus, Bermuda is a popular choice to purchase reinsurance from or form reinsurance companies.

Bermuda also provides an utmost favorable environment for responding to insurance crises, where timeliness is essential.⁸⁸ For example, in the mid-1980s, U.S. businesses faced a shortfall in liability insurance coverage. At the time, it was the biggest insurance industry crisis of the 20th century.⁸⁹ In reaction to the crisis, investors tried to form a new U.S. liability company called the American Slip.⁹⁰ After three years of trying to start up a new insurance company, the effort was abandoned because the company failed to secure enough state licenses to conduct business on a national level.⁹¹ Meanwhile, Bermuda’s flexible regulatory environment allowed insurance companies ACE and XL to form in a matter of few months to provide specially crafted, excess liability insurance products to fulfill the need for liability insurance.⁹² Since the mid-1980s liability insurance market crisis, there have been three more crises which provided a wave of insurance company formations – Hurricane Andrew and the property insurance crises of 1992-1994; the 9/11 tragedy and the ensuing financial market turmoil in 2001-2002; and the insurance market crunch following Hurricanes Katrina, Rita, and Wilma in 2005.⁹³

Bermuda’s insurance industry is beneficial to the U.S. insurance industry because it provides a favorable and readily available marketplace from which to purchase insurance and reinsurance policies. Over the years however, the domestic insurance industry has shown concern over the favorable tax environment Bermuda provides. U.S. reinsurers are subject to much higher taxes than Bermuda-based reinsurers. U.S. reinsurers pay income taxes on their premium investment income, while Bermudian

⁸⁴ *Id.*

⁸⁵ *Id.*

⁸⁶ *Id.*

⁸⁷ *Id.*

⁸⁸ *Id.*

⁸⁹ *Reinsurance Company CEO Testifies, supra note 70.*

⁹⁰ *Id.*

⁹¹ *Id.*

⁹² *Id.*

⁹³ *Id.*

reinsurers are only subject to U.S. income taxes when they have a permanent establishment in the United States. Only the income attributable to the permanent establishment is subject to the U.S. income tax. Unless there is a permanent establishment in the United States, Bermuda-based reinsurers are only subject to the 1% excise tax on reinsurance premiums of U.S.-based risks. Another concern is the tax avoidance transactions between a Bermuda-based reinsurer and its U.S.-based cedent when the two parties are related entities. Domestic insurers believe that there is an industry-wide problem of non-arm's length premium pricing and tax avoidance transactions between related entities.⁹⁴ U.S. companies complain that the favorable tax treatment for Bermudian companies and potential for tax avoidance makes it hard to compete with Bermudian reinsurers.⁹⁵

B. DOMESTIC CONCERN OVER THE REINSURANCE INDUSTRY IN BERMUDA: UNITED STATES TAX BASE EROSION

The U.S. insurance companies, such as The Hartford, have shown concern over the tax practices in the reinsurance industry in Bermuda.⁹⁶ The first concern is reinsurers overcharging when providing reinsurance to a related entity. A related insurer agrees to pay above market price for reinsurance because it routes income from a high-tax jurisdiction, the United States, to a no-tax jurisdiction, Bermuda. Because the insurer and reinsurer are related entities, the income remains under control in the same economic family, while decreasing the amount of income subject to U.S. taxation. Another concern is that a Bermudian reinsurer and its U.S. affiliate-cedent can scheme together in a tax avoidance plan where the transaction shifts income from the United States, a high-tax jurisdiction, to Bermuda, a no-tax jurisdiction, with minimal risk transfer. Both of these practices would provide greater tax savings for Bermuda reinsurers that could provide a competitive advantage over the U.S.-based reinsurers.⁹⁷ The Bermuda reinsurance industry asserts that such concerns are

⁹⁴ Jon Almeras and Ryan J. Donmoyer, *Insurers Approach U.S. Congress to Fix Bermuda*, 20 TAX NOTES INT'L 1388, 1390 (2000).

⁹⁵ *See id.*

⁹⁶ *Id.* at 1388.

⁹⁷ Ben Seessel, Comment, *The Bermuda Reinsurance "Loophole" A Case Study of Tax Shelter and Tax Havens in the Globalizing Economy*, 32 U. MIAMI INTER-AM. L. REV. 541, 559-61 (2001).

unfounded due to the requirement under I.R.C. § 482 and I.R.C. § 845(b) that premiums be charged at arm's length prices.⁹⁸

I.R.C. § 482 allows the Secretary of the Treasury to reallocate funds including gross income, deductions, credits, or allowances between companies that are owned and controlled by the same parent.⁹⁹ The purpose of § 482 is to ensure that integrated businesses properly reflect income attributable to controlled transactions and to prevent tax avoidance regarding such transactions.¹⁰⁰ The principal behind § 482 is the arm's length standard – “[i]n determining the true taxable income of a controlled taxpayer, the standard to be applied in every case is that of a taxpayer dealing arm's length with an uncontrolled taxpayer.”¹⁰¹ Some analysts of the Bermuda reinsurance industry believe that § 482 is not applicable to the reinsurance industry because insurance regulators require reinsurance premiums to reflect an arm's length price.¹⁰² Thus, even if the reinsurer and the insurer are both owned by the same parent, the insurer would pay a reinsurance premium at a market price, as if it was a transaction between unrelated entities. Since the insurance regulators require that reinsurance premiums be set at market prices, the taxable income of related insurers and reinsurers escapes § 482 scrutiny.¹⁰³ U.S. insurers and their supporters, however, assert that despite the arm's length requirement, reinsurance is still sold at non-market rates to related entities.¹⁰⁴ Furthermore, they claim that § 482 does not provide adequate audit techniques to effectively police an industry-wide problem of undercharging premiums to related entities.¹⁰⁵

Section 845 (b) provides the Treasury Department authority to “reallocate items and make adjustments in reinsurance transactions to

⁹⁸ *Reinsurance Company CEO Testifies*, *supra* note 70.

⁹⁹ I.R.C. § 482 (2002).

¹⁰⁰ I.R.C. § 482 (2002); *Bermuda Triangle: Tax Havens, Treaties and U.S. P&C Insurance Competitiveness*, TAX NOTES TODAY, January 8, 2002, available at LEXIS, 2002 TNT 5-24 (2002).

¹⁰¹ *Bermuda Triangle: Tax Havens, Treaties and U.S. P&C Insurance Competitiveness*, *supra* note 100 (internal quotations omitted).

¹⁰² Seessel, *supra* note 97, at 559.

¹⁰³ *U.S. Steel Corp. v. Comm'r*, 617 F.2d 942, 947 (2d Cir. 1980) (holding that if a taxpayer can show that the price he was charged would have been the same in an independent transaction with an unrelated party, then the taxpayer is free from § 482 allocation despite evidence that suggests that the transaction has shifted tax liability among related entities); Lee A. Sheppard, *Would Imputed Income Prevent Escape to Bermuda*, 86 TAX NOTES 1663, 1664 (2000) (“Reinsurers charge the same as an unrelated comparable price, which is a winning argument under section 482”).

¹⁰⁴ Almeras, *supra* note 94, at 1389-90.

¹⁰⁵ *Id.*

prevent tax avoidance or evasion.”¹⁰⁶ Reallocation can occur as a result of transaction of either related or unrelated parties. Tax avoidance may occur when the tax benefits received from a transaction is disproportionate to the risk transferred between parties.¹⁰⁷ For example, a Bermuda company in comparison to its domestic affiliate enjoys greater tax benefits because it pays no income taxes.¹⁰⁸ Tax avoidance may occur when a transaction between a domestic insurer and its related Bermudian reinsurer transfers minimal risk but large amounts of income, in the form of a reinsurance premium.¹⁰⁹ The overpayment of premium is a scheme to shift income from a high-tax jurisdiction to a no-tax jurisdiction.¹¹⁰ “Long-tail” reserves – insurance policies that incur claims long after the premium is paid – can also support a finding of tax avoidance because there is a potential for the reinsurer to earn significantly higher income from the long-term premium investment while incurring a small amount of risk.¹¹¹

The Tax Court, however, limited Section 845(b) in *Trans City Life Insurance Company v. Commissioner*.¹¹² In *Trans City Life Insurance Co.*, Trans City Life entered into a reinsurance agreement with Guardian Life, an unrelated entity, which ceded some of its insurance policies to Trans City Life. As a result of this reinsurance agreement, Trans City Life qualified for a “small life insurance company deduction” under I.R.C. §806.¹¹³ The IRS, however, denied Trans City Life the deduction, concluding that the tax benefit was disproportionate to the risk transferred under the reinsurance agreement, causing a tax avoidance effect.¹¹⁴ In its analysis, the IRS compared the small risk fees incurred by Trans City Life under the reinsurance agreement to the tax savings claimed under the small life insurance company deduction.¹¹⁵ The Tax Court disagreed with IRS’s analysis. The Tax Court claimed that the appropriate comparison is between the exposure of loss, which Trans City Life acquired under the reinsurance agreement with Guardian Life and the tax savings claimed under the

¹⁰⁶ I.R.C. § 845(b) (2002); STAFF OF JOINT COMM. ON TAXATION, *supra* note 62, at 21.

¹⁰⁷ Seessel, *supra* note 97, at 554.

¹⁰⁸ *Id.* at 555; Insurance companies make their profit on investing premiums that are received many years prior to a claim payment.

¹⁰⁹ *Id.* at 555.

¹¹⁰ *Id.* at 544-46.

¹¹¹ *Id.* at 544.

¹¹² *Tran City Life Ins. Co. v. Comm’r*, 106 T.C. 274 (1996).

¹¹³ *Id.* at 278.

¹¹⁴ *Id.* at 276.

¹¹⁵ *Id.*

deduction.¹¹⁶ The exposure of loss was measured by the difference between the face value of the reinsurance agreement and the loss reserves (the investment income) backing the reinsurance agreement. Under that comparison, the Tax Court claimed that the risk incurred was not disproportionate to the tax savings.¹¹⁷

Due to the Tax Court's decision in *Trans City Life Insurance Co.*, market-priced reinsurance agreements generally will not be subject to §845(b) attack.¹¹⁸ However, the IRS has officially refused to follow the Tax Court's decision in *Trans City Life Insurance Co.*¹¹⁹ Its non-acquiescence is due to its disagreement with the Tax Court on the definition of risk.¹²⁰ The Tax Court concluded that risk transfers exist when there is a possibility of loss.¹²¹ In contrast, the IRS concluded that no real risk transfer for tax purposes occurred between parties in a reinsurance agreement when the possibility of loss is remote to the reinsurer.¹²² Due to the IRS' non-acquiescence, reinsurers may still be subject to attack by the IRS under §845(b).

The third concern domestic insurers have over the Bermuda insurance industry is that companies are domiciled in Bermuda in order to avoid paying U.S. taxes all together. Specifically, they argue that the U.S. tax code contains a "loophole" that allows for U.S. tax base erosion. The "loophole" refers to a transaction that restructures U.S.-based insurance companies into Bermuda-based entities in order to avoid U.S. taxation. The "loophole," also referred to as a corporate expatriation, has existed in the tax code for a long time, but was never used until 1999.¹²³ The U.S. insurers have appealed to Congress to fix the "loophole" because it allows companies to move to Bermuda to avoid paying U.S. taxes.¹²⁴ Reinsurers, however argue that they are not in Bermuda to avoid taxes, pointing out that they are subject to the U.S. excise tax on gross premiums regardless of

¹¹⁶ *Id.* at 308-310.

¹¹⁷ *Id.* at 309.

¹¹⁸ Seessel, *supra* note 97, at 557.

¹¹⁹ Action on Decision CC-1997-011.

¹²⁰ Non-acquiescence is "an agency's policy of declining to be bound by lower-court precedent that is contrary to the agency's interpretation of its organic statute, but only until the Supreme Court has ruled on the issue." BLACK'S LAW DICTIONARY 1076 (8th ed. 2004).

¹²¹ *Tran City Life Ins. Co.*, 106 T.C. at 308-10.

¹²² *Id.* at 310-11

¹²³ *Bermuda Triangle: Tax Havens, Treaties and U.S. P&C Insurance Competitiveness*, *supra* note 100 (internal quotations omitted).

¹²⁴ Almeras, *supra* note 94, at 1388.

whether they incur a net profit or a loss.¹²⁵ Even while paying the excise tax, a Bermuda-based reinsurer is at a greater advantage than the U.S.-based reinsurer because a Bermuda-based company can avoid paying U.S. taxes on the investment income.

The “loophole,” which facilitates the tax advantage, covers two types of transactions – expatriation/inversion and acquisition. The inversion occurs when a U.S.-based insurer reorganizes itself as a U.S. subsidiary of a Bermuda-based holding company. Shareholders of the former U.S. parent company (now the U.S. affiliate) receive shares in the Bermudian corporation in exchange for their old shares of stock.¹²⁶ Companies such as PXRE, Folks America Re, and Everest Re, have restructured to become a subsidiary of a Bermuda-domiciled holding company.¹²⁷ SEC filings of companies that re-domesticate in Bermuda make it clear that the tax advantage was a major benefit.¹²⁸

There are three forms of inversions – stock inversions, asset inversions, and drop down inversions.¹²⁹ Stock inversion transactions occur when a newly-formed foreign holding company purchases stock of the U.S.-based parent company and the U.S. parent becomes the subsidiary of the new foreign parent.¹³⁰ The shareholders exchange their U.S. parent stock for new foreign parent stock.¹³¹ Asset inversion transaction occurs when a U.S. parent transfers its assets to a new foreign parent before being

¹²⁵ *Reinsurance Company CEO Testifies*, *supra* note 70.

¹²⁶ Hale E. Sheppard, *Fight or Flight of U.S.-Based Multinational Businesses: Analyzing the Causes for, Effects of, and Solutions to the Corporate Inversion Trend*, 23 *NW. J. INT'L L. & BUS.* 551, 553 (2003).

¹²⁷ Bermuda-domiciled holding companies have been compared to “banks” with subsidiaries, where each subsidiary borrows from its “bank.” *Reinsurance Company CEO Testifies*, *supra* note 70. Under a bank-subsiary scenario, there is a potential for earning stripping. Earning stripping is the practice of moving income from a high tax jurisdiction to a low or no-tax jurisdiction to avoid paying high taxes. It is achieved when a U.S. company makes a deductible interest payment to a foreign company. The net tax benefit will be the difference between the foreign tax imposed on the interest income and the U.S. tax saved by obtaining the deduction for interest expense. Kun, *supra* note 82, 338-9. Unlike earning stripping, reinsurance requires a true transfer of risk and an arm’s length premium price. *Reinsurance Company CEO Testifies*, *supra* note 70. Therefore, under a reinsurance agreement, a Bermuda-based holding reinsurance company does not engage in earning stripping.

¹²⁸ *Bermuda Triangle: Tax Havens, Treaties and U.S. P&C Insurance Competitiveness*, *supra* note 100 (internal quotations omitted).

¹²⁹ Kelly, *supra* note 63, at 201.

¹³⁰ *Id.*

¹³¹ *Id.*

liquidated.¹³² Shareholders exchange their stock of the U.S. parent for stock of the new foreign parent.¹³³ The drop down transaction is a combination of stock inversion and asset inversion transactions.¹³⁴

An inversion is not a tax-free transaction. Under I.R.C. §357, the offshore move is treated as a sale or exchange.¹³⁵ Thus companies that are restructuring via a corporate inversion must recognize an unrealized gain on their assets. The offshore move can be very costly, but that depends on the fair market value of the assets and the company's adjusted basis in the assets.¹³⁶ The inversion is most beneficial for smaller or new U.S. companies which want to reorganize under Bermuda law.¹³⁷ U.S.-based long standing insurance companies cannot invert to Bermuda because they would be liable for billions of dollars in capital gains taxes.¹³⁸

The second aspect of the loophole is acquisition. Acquisition works when a Bermuda based company buys a U.S. insurer.¹³⁹ For example, ACE, a Bermuda-based company acquired Capital Re, a U.S. company. If a U.S. company becomes a domestic subsidiary of a foreign company, by either inversion or acquisition, it is no longer subject to direct U.S. taxation on a residence basis. Instead, direct investment income in the U.S. is subject to a 30% tax at the source, insurance premiums are subject to a 4% tax, and reinsurance premiums are subject to a 1% tax.¹⁴⁰ Tax avoidance occurs when a domestic affiliate reinsures a premium sold in this country to their off-shore parent.¹⁴¹ A foreign parent, unlike a U.S. parent, will not pay taxes on its investment income. The Hartford, and other U.S.-based insurers are concerned about the unlevel playing field.¹⁴²

¹³² *Id.*

¹³³ *Id.*

¹³⁴ *Id.* at 201-202.

¹³⁵ I.R.C. §357 (2002).

¹³⁶ Almeras, *supra* note 94, at 1388.

¹³⁷ Seessel, *supra* note 97, at 544.

¹³⁸ David Cay Johnston & Joseph B. Treaster, *Insurers Want U.S. to Curb Competitors' Fund Transfers to Bermuda*, N.Y. TIMES (East Coast Late Edition), Sep 26, 2007, at C4.

¹³⁹ Almeras, *supra* note 94, at 1388.

¹⁴⁰ *Id.* at 1389.

¹⁴¹ *Id.*

¹⁴² *Id.* at 1388.

ILLUSTRATIONS OF CORPORATE INVERSIONS AND ACQUISITIONS

INVERSION

Country	Scenario 1	Scenario 2a	Scenario 2b
United States	U.S. Insurance Parent Company, "ABC Co"	U.S. Insurance Parent Company, "ABC Co"	ABC RE Subsidiary, "ABC Co"
Bermuda	Unrelated Reinsurance Company, "Bermuda RE"	ABC Co Subsidiary, "ABC RE"	Bermuda Parent Company, "ABC RE"

In Scenario 1, a U.S.-based insurance company contracts with an unrelated reinsurance company domiciled in Bermuda. ABC Co pays Bermuda RE insurance premiums in exchange for Bermuda RE insuring part of ABC Co risks. Because Bermuda RE is insuring risks located in the United States but does not have a trade or business in the United States, it does not pay the U.S. taxes on the investment income earned from the insurance premiums on a net basis. Instead, it pays a 1% excise tax on the reinsurance premium received.

In Scenario 2a, a U.S.-based insurance company sets up a reinsurance subsidiary in Bermuda. ABC Co pays its own subsidiary ABC RE insurance premiums in exchange for reinsuring part of its risks. ABC Co forms a subsidiary in Bermuda for the sole purpose of facilitated the corporate inversion transaction. Then ABC Co inverts itself (Scenario 2b) – ABC RE becomes the parent company and ABC Co becomes its subsidiary. The corporate structure turns upside down - the foreign subsidiary becomes the parent and the parent becomes the subsidiary. This results in the reinsurer being subject to only a 1% tax on the reinsurance premiums via the excise tax.

ACQUISITION

Country	Scenario 1	Scenario 2
United States	U.S. Reinsurance Parent Company, "ABC RE"	"Bermuda Insurance-ABC RE" (now with a Bermuda parent)
Bermuda	Unrelated Insurance Company, "Bermuda Insurance"	Parent Insurance Company, "Bermuda Insurance"

In an acquisition, a Bermuda insurance company which insures U.S.-based risks contracts with a U.S. company to reinsurer part of its risk (scenario 1). The U.S. reinsurance company pays a 30% direct tax on reinsurance premiums received for risks located in the United States. In the

second scenario, the unrelated insurance company, purchases the U.S. reinsurance company. The newly acquired U.S. reinsurance company is structured so that it is not a permanent establishment and thus completely escapes U.S. direct taxation.¹⁴³ Similar to the inversion example above, the Bermuda-based company is only subject to the 1% excise tax on reinsurance premiums.

Corporate inversions have been criticized as being “unpatriotic.”¹⁴⁴ In response to criticism of corporate expatriations, as part of the Homeland Security Act of 2002, Congress forbade the Department of Homeland Security to contract with companies that have expatriated through a corporate inversion.¹⁴⁵ The contract ban, however, generally does not extend to domestic subsidiaries of newly inverted entities.¹⁴⁶ Thus, the Department of Homeland Security can still contract with an expatriated company as long as it contracts with the company’s domestic subsidiary. Furthermore, the statute is limited by three exceptions. The statute allows a waiver of the contract ban if the waiver is required for the interest of security, if the waiver prevents the loss of jobs, or if the waiver prevents the Government from incurring additional costs.¹⁴⁷ After much criticism that the exceptions made the statute ineffective, Congress amended the statute by eliminating the “loss of jobs” and “additional costs” exceptions.¹⁴⁸ The “interest in homeland security” exception remains in the statute.¹⁴⁹ Even with the amendment, the legislation has been criticized as primarily symbolic – a way for Congress to appear doing something without actually changing anything.¹⁵⁰ The Homeland Security Act has little, if any effect on an expatriated corporation’s ability to enter into government contracts because the Department of Homeland Security can

¹⁴³ See discussion *supra*, Part I.A - business profits of a Bermudian company are exempted from U.S. taxation unless the Bermuda company has a Permanent Establishment in the U.S. If there is a U.S.-based permanent establishment, the Bermuda Company will be taxed only on the business profits attributable to the permanent establishment (source-basis taxation). U.S.-Bermuda Tax Treaty, *supra* note 1, arts. 3-4.

¹⁴⁴ Michael S. Kirsch, *The Congressional Response to Corporate Expatriations: The Tension Between Symbols and Substance in the Taxation of Multinational Corporations*, 24 VA. TAX REV. 475, 482 (2005).

¹⁴⁵ Homeland Security Act of 2002, Pub. L. No. 107-296, 835, 116 Stat. 2135, 2227 (2002) (codified as amended at 6 U.S.C. 395 (2003)), amended by Homeland Security Act Amendments of 2003, Pub. L. No. 108-7, 101(2), 117 Stat. 526, 628 (2003).

¹⁴⁶ Kirsch, *supra* note 144, at 512-13.

¹⁴⁷ *Id.* at 498.

¹⁴⁸ *Id.*

¹⁴⁹ *Id.*

¹⁵⁰ *Id.* at 511-12.

still contract with an expatriated company by either hiring a domestic subsidiary of the company or ruling the contract is in the best interest of homeland security.¹⁵¹

Corporate inversions may also alter the brand image of a company.¹⁵² For example a Connecticut based toolmaker, Stanley Works, rejected reincorporating in Bermuda because of public disapproval.¹⁵³ Brand image concerns are unlikely, however, in the reinsurance industry because reinsurers do not directly deal with the end consumer, the policy holder. Most policy holders will never know if and by whom their policy has been reinsured.

C. “LEVELING THE PLAYING FIELD” BETWEEN UNITED STATES
AND BERMUDA INSURERS OR COMBATING THE UNITED
STATES TAX BASE EROSION

According to U.S. insurers, the favorable tax treatment in Bermuda makes it difficult for U.S.-based insurers to compete with Bermuda companies. The Tax Reform Act of 1986 increased significantly the U.S. tax burden of domestic property and casualty reinsurers by requiring insurance companies to discount their loss reserve deductions.¹⁵⁴ The legislation had no effect on foreign reinsurers, who continued to be subject to a 1% excise tax on premiums paid to reinsure U.S. risks.¹⁵⁵ The problem was temporarily compounded by the United States-Bermuda treaty which for a short period of time waived the excise tax.¹⁵⁶

A more significant change since the Tax Reform Act of 1986 is the increase in corporate inversions – U.S. insurance companies becoming Bermuda-based companies and the formation of new Bermuda-based insurance companies which directly compete with U.S.-based insurers. Thus, the difference in tax treatment provides a great disadvantage for U.S. insurers, especially U.S.-based property and casualty insurers. Furthermore, U.S.-based companies are concerned about “sham”

¹⁵¹ *Id.*

¹⁵² Victor Fleischer, *Brand New Deal: The Branding Effect of Corporate Deal Structures*, 104 MICH. L. REV. 1581, 1582 (2006).

¹⁵³ *Id.* at 1582.

¹⁵⁴ *Reinsurance Association of America’s Testimony at Ways and Means Hearing on Foreign Income Tax Bill*, TAX NOTES TODAY, Jul. 23, 1992, available at LEXIS, 92 TNT 150-102.

¹⁵⁵ *Id.*

¹⁵⁶ *See supra* Part I.

reinsurance companies, where transactions occur on a non-arm's length price.

Congress has debated how to level the playing field between domestic and foreign insurance companies. The three major proposals are (1) to increase the excise tax, which is the only tax imposed on foreign reinsurers, (2) to subject reinsurance transactions between related entities to a greater tax, or (3) to tax the newly expatriated company as if it were still a domestic company.

Proposed bill, H.R. 5270, which is supported by the domestic reinsurers and the RAA increases the excise tax of reinsurance premiums.¹⁵⁷ Foreign companies which (re)insure risk located in the United States, but do not have a trade or business in the United States are subject to a 4% excise tax on insurance premiums and a 1% excise tax on reinsurance premiums. The proposed bill would increase the reinsurance excise tax to 4% from 1%, to bring it up to par to the insurance premium excise tax.¹⁵⁸ The RAA argues that the Tax Reform Act of 1986 substantially increased taxes on domestic reinsurers, effectively creating a tax preference for non-resident foreign companies selling reinsurance to the U.S. market.¹⁵⁹ Thus, the RAA concludes, an increase in the excise tax would neither disadvantage foreign competitors nor interfere with the international flow of reinsurance corporations.¹⁶⁰ The Treasury Excise Tax Study,¹⁶¹ however, found that raising the excise tax from 1% to 4% would give U.S. companies a significant advantage over foreign companies that were located in high-tax jurisdictions, such as the United Kingdom and Germany.¹⁶² However increasing the excise tax to 4% would not offset the competitive advantage enjoyed by tax-haven-based reinsurers for long-tail lines of business.¹⁶³

¹⁵⁷ H.R. 5270, 102d Cong. (1992); *Reinsurance Association of America's Testimony at Ways and Means Hearing on Foreign Income Tax Bill*, *supra* note 154.

¹⁵⁸ *Reinsurance Association of America's Testimony at Ways and Means Hearing on Foreign Income Tax Bill*, *supra* note 154.

¹⁵⁹ *Reinsurance Association Supports Increase in Excise Tax on Reinsurance Ceded to Foreign Reinsurers*, *supra* note 69.

¹⁶⁰ *Id.*

¹⁶¹ For background discussion on the Treasury Excise Tax Study *see supra* Part I, at 19-21.

¹⁶² Treasury Excise Tax Study, *supra* note 27, at 3; *Bermuda Triangle: Tax Havens, Treaties and U.S. P&C Insurance Competitiveness*, *supra* note 100 (internal quotations omitted).

¹⁶³ Treasury Excise Tax Study, *supra* note 27, at 13-14; *Bermuda Triangle: Tax Havens, Treaties and U.S. P&C Insurance Competitiveness*, *supra* note 100, 80-81 (internal

Unsurprisingly, foreign reinsurers oppose H.R. 5270. An increase in the excise tax raises concerns over the diminishing economic stability in the Caribbean insurance industry.¹⁶⁴ The Government of Barbados testified before the Ways and Means Committee during the hearing on H.R. 5270 that a provision that increases the excise tax would hinder the U.S. domestic insurance market because the tax would make increase the cost of insurance in the United States and in turn make it more costly for U.S. firms to enter into alternative reinsurance markets.¹⁶⁵ Barbados further argued that the excise tax provision is barred by the United States-Barbados treaty (and tax treaties with most other foreign countries) because it discriminates against premiums paid to persons in a foreign country as opposed to those paid to persons based in the United States.¹⁶⁶ Not all differences in tax treatment between foreign and domestic entities, however, amount to improper discrimination.¹⁶⁷ Discrimination only occurs when similarly situated entities are taxed differently.¹⁶⁸ If two entities are not similarly situated, a difference in taxation does not result in discrimination.¹⁶⁹ In this case, foreign reinsurers and domestic reinsurers are not similarly situated because domestic reinsurers are taxed on a worldwide basis, while foreign reinsurers are not.¹⁷⁰ Foreign reinsurers that have a U.S. trade or business are taxed on a source-basis, while foreign reinsurers that do not have a U.S. trade or business are taxed via the excise tax.¹⁷¹ As the tax base between domestic reinsurers and foreign reinsurers is different, a difference in taxation does not result in discrimination.

Other proposed bills include H.R. 4192 and H.R. 1755. These bills modify the tax code so that transactions between related entities are taxed higher than transactions between unrelated entities. The 106th Congress

quotations omitted). A long-tail line of business refers to insurance coverage for a risk that is not realized until a significant time has passed. An example of long-tail line of business is liability coverage for a company, which used asbestos in its product in the 1970s, but didn't receive any claims until 1990s. Another example is life insurance, where policy holders purchase insurance years prior to their death.

¹⁶⁴ *Government of Barbados' Testimony at Ways and Means Hearing on Foreign Income Tax Bill*, TAX NOTES TODAY, Jul. 23, 1992, available at LEXIS, 92 TNT 150-103.

¹⁶⁵ *Id.*

¹⁶⁶ *Id.*

¹⁶⁷ *Bermuda Triangle: Tax Havens, Treaties and U.S. P&C Insurance Competitiveness*, *supra* note 100 (internal quotations omitted).

¹⁶⁸ *Shaffer v. Carter*, 252 U.S. 37, 56 (1920).

¹⁶⁹ *Id.* at 56, 57.

¹⁷⁰ Treasury Excise Tax Study, *supra* note 27, at 7.

¹⁷¹ *Id.*

proposed H.R. 4192, that provided for an amendment to §845.¹⁷² The bill proposed altering the treatment of a related-party reinsurer. Thus, if a domestic person directly or indirectly reinsures a U.S. risk with a related foreign reinsurer (as opposed to an unrelated entity), then the investment income of the domestic insurer shall be increased and the domestic company will be subject to a greater tax.¹⁷³ The proposed plan would not affect reinsurance arrangements between unrelated parties.¹⁷⁴ This will impede an affiliated transaction whose purpose is to effectively move money from one entity to another within the same economic family. The 107th Congress proposed the Reinsurance Tax Equity Act of 2001 (H.R. 1755).¹⁷⁵ The proposed bill was an amendment to §832(b)(4). The U.S. tax code allows a property and casualty insurance company to deduct reinsurance premiums paid from gross premiums written on insurance contracts during the taxable year.¹⁷⁶ The amendment provides under certain circumstances a denial for the deduction of reinsurance premiums paid for direct or indirect reinsurance of U.S. risks with “related insurers.”¹⁷⁷ Thus if an insurer pays a reinsurer which is also its subsidiary, the reinsurance premium, the insurer cannot deduct the amount when calculating its gross premium amount for tax purposes.

The latest proposed bill is H.R. 3884, which amends §7701 in its treatment of foreign holding companies.¹⁷⁸ If a domestic company through a corporate inversion becomes a foreign holding company, it will still be treated as a domestic company for tax purposes provided that after an inversion more than 80% of the company is still owned by former shareholders.¹⁷⁹

Although Congress has tried to level the playing field between U.S.-based and Bermuda-based reinsurers, none of the proposed bills have become statute. U.S. reinsurers should continue to lobby Congress for a legislative fix of tax avoidance in the reinsurance industry. However, the

¹⁷² H.R. 4192, 106th Cong. (2000); STAFF OF JOINT COMM. ON TAXATION, *supra* note 62, at 56.

¹⁷³ H.R. 4192, 106th Cong. (2000); STAFF OF JOINT COMM. ON TAXATION, *supra* note 62, at 56.

¹⁷⁴ Almeras, *supra* note 94, at 1390.

¹⁷⁵ STAFF OF JOINT COMM. ON TAXATION, *supra* note 62, at 56.

¹⁷⁶ H.R. 1755, 107th Cong. (2001); STAFF OF JOINT COMM. ON TAXATION, *supra* note 62 at 56.

¹⁷⁷ STAFF OF JOINT COMM. ON TAXATION, *supra* note 62, at 56.

¹⁷⁸ H.R. 3884, 107th Cong. (2002); *Preventing Corporate Inversions*, TAX NOTES TODAY, Apr. 2, 2002, available at LEXIS, 2002 TNT 63-2.

¹⁷⁹ *Preventing Corporate Inversions*, *supra* note 178.

fix may be worse than the problem of tax avoidance because tax legislation may provide unintended tax disadvantages to legitimate reinsurance transactions. Furthermore, legislation that impedes tax benefits enjoyed in other countries may send a negative message that more powerful countries such as the U.S. can dictate the tax policy of smaller and less powerful foreign jurisdictions.

Another approach is for the U.S. reinsurance industry to pressure insurance regulators to ensure that reinsurance transactions are made under an arm's length standard. Furthermore, stricter insurance regulation practices may decrease the potential for "shell corporations" that try to operate as reinsurers. An additional approach to limit "shell corporations" is for the Treasury Department to renegotiate the United States-Bermuda Tax Treaty to increase greater exchange of information (specifically access to confidential information from Bermuda).

Lastly, U.S. reinsurers should try to form a favorable regulatory system domestically for reinsurance companies. As insurance is regulated individually by each state, U.S. reinsurers may appeal to individual states to pass legislation favorable to reinsurance companies in exchange for an increase in economic activity in that state. This is the best approach because states are always looking to bring in more business. Moreover it would decrease the domestic insurers' reliance on the reinsurance market in Bermuda.

**AFRICAN AMERICAN HOMEOWNERSHIP AND THE
DREAM DEFERRED: A DISPARATE IMPACT ARGUMENT
AGAINST THE USE OF CREDIT SCORES IN
HOMEOWNERSHIP INSURANCE UNDERWRITING**

*Latonia Williams**

ABSTRACT

This casenote argues that African-American homeownership is disparately impacted by the discriminatory use of credit scores in homeowner insurance underwriting, asserting a violation of § 3604 of the Fair Housing Act and advocating Congressional action banning this practice. The history of the “American Dream” of homeownership has historically been denied to African-Americans as a result of discriminatory Federal Housing Administration (FHA) policies through homeowner’s insurance underwriting. While the 1950’s and 1960’s revised such blatantly racist policies, modern insurance underwriting practices have *de facto* replaced official policy, with similar disparate and disenfranchising results. Risk classification and methods of credit scoring used by insurance underwriters reinforce historically vulnerable positions of African-Americans in society by denying them opportunities to become homeowners, a disparate discriminatory impact under the Fair Housing Act. Congressional action is therefore necessary to correct this impact and free African-Americans to achieve homeownership.

INTRODUCTION

“Housing is more than shelter; housing helps determine access to job networks, educational opportunities, and to the extent that homes are the largest assets most people have, financial security.”¹

* J.D. Candidate, University of Connecticut School of Law, 2009. I am grateful to Professors Tom Baker, Karen Demeola, Bethany Berger, and Jon Bauer for their invaluable guidance and contributions to this Note. I am also grateful to my family for their love and support.

¹ National Urban League Policy Institute, *Fair Housing Fact Sheet*, Apr. 30, 2007, <http://www.nul.org/publications/policyinstitute/factsheet/2007-Fair-Housing-Fact-Sheet.pdf>.

Many say homeownership is the key to the American Dream. It represents what many work for in hopes of reaching a certain level of prosperity in their lives. Probably more importantly, homeownership/landownership has always represented a level of power and prestige only held by few in the United States. The importance of protecting private property has constantly been at the forefront of the discussion regarding rights of the citizens and the powers of government.

The Fifth Amendment provides that no person shall, “be deprived of life, liberty, or property, without due process of law. . . .”² Thus, the resulting philosophy of property that supports the United States democratic system rests largely on the importance of individual liberties, limits on government power, and the right of the people to own property. This broad notion of property has gone beyond tangible ownership of private property to include liberty interests and the limits on government intrusion on these interests.³ Effectively, property ownership creates, “a bundle of rights and relationships which give rise to entitlements...”⁴ However, along with creating rights, property ownership has also created a method of limiting the rights of minorities, specifically African Americans.

Despite the end of legally-imposed segregation and the expansion of opportunities for African Americans, there continues to be discrimination in a broad range of social settings for Blacks.⁵ Given the history of slavery and segregation based on law and custom, research has documented that race-based discrimination has affected and continues to affect a broad range of social outcomes for African Americans.⁶

Discrimination against Blacks in America originated with chattel slavery. Specifically, for two and a half centuries, millions of Blacks were stripped of their lands, religions, cultural heritage and property to become the property of white slaveholders.⁷ Though slavery was formally abolished through the Civil War and the Reconstruction Amendments, the abolition “failed to eliminate the legal vestiges of racial oppression or redress the devastating consequences of slavery on those who had suffered

² U.S. CONST. amend. V.

³ Bruce A. Reznik, *Property Rights in a Market Economy*, ECONOMIC REFORM TODAY, 29-30 (1996), available at http://www.cipe.org/publications/ert/e19/E19_11.pdf.

⁴ *Id.*

⁵ A COMMON DESTINY: BLACKS AND AMERICAN SOCIETY (Gerald D. Jaynes & Robin M. Williams eds., 1989).

⁶ *Id.*

⁷ Kim Forde-Mazrui, *Taking Conservatives Seriously: A Moral Justification for Affirmative Action and Reparations*, 92 CAL. L. REV. 683, 742 (2004).

under its regime.”⁸ Instead, a system of laws was established that accorded Blacks very few rights.⁹

In regards to housing, Black Americans were residentially segregated. Freedom for emancipated Blacks was severely restricted by “laws which imposed upon the colored race onerous disabilities and burdens, and curtailed their rights in the pursuit of life, liberty, and property to such an extent that their freedom was of little value.”¹⁰

It was not until 1968 that Congress passed the Fair Housing Act, barring racial discrimination in the sale, rental, or financing of housing.¹¹ The effect of the Fair Housing Act should have been to end discrimination and unfair pricing in the housing market. “However, despite the enactment of national antidiscrimination laws in the 1960s, Black Americans continue to experience social and economic disadvantage in significant disproportion to their numbers.”¹² In fact, the social and economic condition of many poor Blacks is considered to have worsened in many respects as the twentieth century came to a close.¹³

The question thus presents itself: how is it possible that African Americans continue to face disadvantages in housing when federal law prevents disparate treatment of Blacks in regards to housing? The answer is clear. Although there are many aspects of the law preventing the disparate and discriminatory treatment of African Americans, there is very little legal control over those things that have a disparate impact on African American homeownership.¹⁴

This Note aims look into this issue. Specifically, this note will focus on homeowners insurance and how risk-based pricing has created a disparate impact that effectively lessens African American homeownership. Whereas prior works have focused primarily on measuring racial disparities in pricing of homeowners insurance policies, here, I seek to demonstrate

⁸ *Id.* at 699. Forde-Mazrui also notes that “[h]ad America prohibited all discrimination and provided the necessary resources and opportunities for the four million impoverished and illiterate former slaves to uplift their condition, the effects of slavery might well have dissipated by now.” *Id.* I disagree with this argument. The effects of slavery are far reaching and are unlikely—in my opinion—to have been remedied by now, even with all possible resources.

⁹ *Id.* at 700.

¹⁰ *Regents of University of California v. Bakke*, 438 U.S. 265, 390 (1978) (quoting *Slaughter-House Cases*, 83 U.S. 36 (1872)).

¹¹ 42 U.S.C. § 3601-3619.

¹² Forde-Mazrui, *supra* note 7, at 695.

¹³ *Id.* at 703-04.

¹⁴ The disparities relating to this issue will be discussed in more detail *infra* Part III.

how such pricing has structurally prevented African Americans from reaching the American Dream of homeownership.

Because of the importance of the home to individual net worth, discrimination involving homeownership is one of the most damaging forms of inequity.¹⁵ “[M]ost conservatives accept or are willing to assume a causal connection between black disadvantage and past discrimination...”¹⁶ but fail to recognize the role that present disadvantage plays a role in the failure of the African American to reach the American Dream. This Note seeks to show the ways that contemporary risk-based home insurance pricing feeds off this history to continue to impede African American homeownership.

Part I examines the American Dream and its significance. Part I will conclude with why housing is the single strongest representation of the Dream. Part II will look at the African American fight to attain the Dream. The section will look at the history of housing discrimination in the United States and how the effect of such discrimination has withstood time.

Part III will evaluate how risk based pricing—although not overtly discriminatory—has a disparate discriminatory effect on African Americans. This section will look more in depth into what exactly are the standards for homeowner’s premium pricing and how statistics show that credit based pricing has a disparate impact on African Americans. Part IV addresses the standards of a disparate impact argument under the Fair Housing Act. Part IV will also argue that disparate impact claims against the use of credit scores in insurance underwriting can affectively be brought under § 3604 of the Fair Housing Act. Lastly, Part V will argue that there should be Congressional action banning the use of credit scoring in insurance pricing.

BACKGROUND

A HISTORY OF THE DREAM IN THE UNITED STATES

The concept of the American Dream is one that encompasses an ideal of success and achievement. The term itself was coined in 1931 by James

¹⁵ National Urban League Policy Institute, *supra* note 1.

¹⁶ Forde-Mazrui, *supra* note 7, at 706.

Truslow Adams.¹⁷ In his text, *The Epic of America*, Adams defines the American Dream as:

that dream of a land in which life should be better and richer and fuller for everyone, with opportunity for each according to ability or achievement. It is a difficult dream for the European upper classes to interpret adequately, and too many of us ourselves have grown weary and mistrustful of it. It is not a dream of motor cars and high wages merely, but a dream of social order in which each man and each woman shall be able to attain to the fullest stature of which they are innately capable, and be recognized by others for what they are, regardless of the fortuitous circumstances of birth or position.¹⁸

As Adams notes, the idea of attaining the Dream is based on an ideal of merit and achievement. It focuses on the ideology that individuals are able to attain success in their lives through hard work and dedication.

DEFINING THE AMERICAN DREAM

Notwithstanding the fact that the term “American Dream” was coined in the early 1930’s, the idea of the Dream had a much earlier beginning. The American Dream dates back to the European settlers of the sixteenth century and is historically rooted in the idea of the United States as a “new nation of immigrants.”¹⁹ With the colonial settlements came the dream of fulfillment, individual freedom, and the chance to succeed in the New World.²⁰

Historical documents show a clear history of the pursuit of the Dream. The Declaration of Independence states that:

[w]hen in the Course of human events it becomes necessary for one people to dissolve the political bands which have connected them with another and to assume among the powers of the earth, the separate and equal station to which the Laws of Nature and of

¹⁷ LIBRARY OF CONGRESS, *What is the American Dream?*, <http://memory.loc.gov/learn/lessons/97/dream/thedream.html> (last visited Oct. 10, 2008).

¹⁸ JAMES TRUSLOW ADAMS, *THE EPIC OF AMERICA* 214-15 (1931).

¹⁹ STEPHEN J. MCNAMEE & ROBERT K. MILLER JR., *THE MERITOCRACY MYTH* 2 (2004).

²⁰ *Id.*

Nature's God entitle them, a decent respect to the opinions of mankind requires that they should declare the causes which impel them to the separation. We hold these truths to be self-evident, that all men are created equal, that they are endowed by their Creator with certain unalienable Rights, that among these are Life, Liberty and the *pursuit of Happiness*.²¹

The phrase "pursuit of happiness" has become synonymous with the American Dream,²² and the idea of immigrating to the United States in hopes of having an equal chance to succeed as determined by individual merit and hard work.²³ However, the idea of the American Dream has since been broadened by some to include native-born Americans in its definition.²⁴

Although the origin of the American Dream is clear, there has never been one set definition as to what it really means to obtain the Dream. In fact, the Dream is much more clearly understood as a set of ideals that have been able to shift with the times. Obtaining the American Dream has transformed from being defined generally through success and achievement to a more precise definition that involves the attainment of specific representations of achievement.²⁵ It has even been argued that when most speak of the American Dream today, they mean "buying a big house, driving an expensive automobile, and making a lot of money."²⁶

The strongest example of the transformation of the perception of achievement is the connection of the American Dream to obtaining wealth. Wealth is defined as an individual's economic value in the form of material possessions and resources. Differing from income, wealth represents

²¹ THE DECLARATION OF INDEPENDENCE para. 1-2 (U.S. 1776) (*emphasis added*).

²² See JIM CULLEN, THE AMERICAN DREAM: A SHORT HISTORY OF AN IDEA THAT SHAPED A NATION 38 (2003).

²³ See MCNAMEE & MILLER, *supra* note 19, at 4.

²⁴ There are some who believe that the concept of achieving the American Dream only fits into the context of immigrating to America. This Note does not take this standpoint and instead looks at the American Dream as something that is pursued by both immigrants to the United States and native born Americans.

²⁵ "Whereas the American Dream was once equated with certain principles of freedom, it is now equated with things. The American Dream has undergone a metamorphosis from principles to materialism." *Today's American Dream*, 2007, available at <http://www.todaysamericandream.com>. (quoting JOHN E. NESTLER, THE AMERICAN DREAM (1973)).

²⁶ *Id.*

financial resources and the ownership and control of those resources.²⁷ Because wealth entertains the elements of ownership and control and it serves as a form of social mobility,²⁸ it is understandable why wealth would be a representation of achieving the American Dream. “[W]ealth allows families to secure advantages....”²⁹

THE DREAM AND HOMEOWNERSHIP

*It is the law of property that controls the distribution of wealth in society; consequently, there must be the most intimate relation between that society’s economic and social characteristics and the rules, practices and institutions of its property law.*³⁰

To many, the United States is “a nation of homeowners.”³¹ The quote above illustrates that fitting squarely with the concept of wealth as a representation of achieving the American Dream is the concept of property ownership; specifically homeownership. Property and the ideals of property ownership—one of the strongest identifiers of wealth³²—have had a long history in the United States. Home equity represents the largest reservoir of wealth among America’s middle class.³³ However, the

²⁷ Thomas M. Shapiro, *Race, Homeownership and Wealth*, 20 WASH. U. J.L. & POL’Y 53, 53-54 (2006).

²⁸ *Id.* at 56.

²⁹

“Like the American Dream broadly construed, this one of the good life exists in a series of variations. The most common form was cast in the form of commercial success. For hundreds of years, American readers and writers have had tireless appetites for tales of poor boys (and, later, girls) who, with nothing but pluck and ingenuity, created financial empires that towered over the national imagination....”

Id. at 55. See also, CULLEN, *supra* note 22, at 59-60.

³⁰ JOHN CHRISTMAN, THE MYTH OF PROPERTY: TOWARD EGALITARIAN THEORY OF OWNERSHIP 28 (1994) (quoting John Henry Merryman).

³¹ Florence Wagman Roisman, *Teaching About Inequality, Race, and Property*, 46 ST. LOUIS U. L.J. 665, 668-69 (2002).

³² Shapiro, *supra* note 27, at 54.

³³ See *id.* at 59 (noting that “home wealth accounts for 60% of the total wealth among America’s middleclass.”). See also U.N. COMM. ON THE ELIMINATION OF RACIAL DISCRIMINATION [CERD], *Residential Segregation and Housing Discrimination in the United States: Violation of the International Convention on the Elimination of All Forms of Discrimination*, ¶ 34, (Dec. 2007) (prepared by Micheal B. de Leeuw, et al.) (available at ww2.ohchr.org/english/bodies/cerd/docs/ngos/usa/USHRN27.pdf).

connection of the American Dream with homeownership did not come about until the mid twentieth century.³⁴ In fact, it is said that the correlation of homeownership with achieving the American Dream and social success was promoted by realtors.³⁵ Whether or not this association was something that was created by realtors, it is clear that it has stuck in the minds of Americans.

The creation of this “nation of homeowners” was very highly promoted by government policy.³⁶ In the late 19th and early 20th centuries, barely forty-five percent of the United States housing units were owner-occupied.³⁷ During this period, owning a home was something primarily for the “relatively well-to-do.”³⁸ It was not until the 1930’s and the New Deal that agencies such as the Home Owners Loan Corporation (“HOLC”),³⁹ the Federal Housing Association (“FHA”),⁴⁰ and the Veteran’s Administration (“VA”)⁴¹ began to facilitate and encourage broader homeownership.

These programs opened doors for more White individuals to own homes in the United States and helped to create the middle class.⁴² Unfortunately, “these same policies and practices left the African-American community behind at the starting gate.”⁴³ This had the effect of freezing many African Americans out of “the greatest wealth building opportunities in American history.”⁴⁴

³⁴ JEFFREY M. HORNSTEIN, A NATION OF REALTORS: A CULTURAL HISTORY OF THE TWENTIETH-CENTURY AMERICAN MIDDLE CLASS 202-03 (2005).

³⁵ *Id.* at 203.

³⁶ Wagman Roisman, *supra* note 31, at 675-76.

³⁷ *Id.* at 676.

³⁸ *Id.*

³⁹ HOLC’s primary purpose was to refinance homes to prevent foreclosure. It was usually used to extend loans from shorter, expensive payments of 15 year loans to lower payments of 30 year loans. *See generally*, Alan S. Binder, *From the New Deal, A Way Out A Mess*, N.Y. Times, Feb. 24, 2008, <http://www.nytimes.com/2008/02/24/business/24view.html?pagewanted=print> (last visited November 22, 2008).

⁴⁰ FHA is a federal agency formed as part of the National Housing Act of 1934. Its goals were to improve housing standards and conditions; to provide an adequate home financing system through insurance of mortgage loans; and to stabilize the mortgage market. *See generally* U.S. Department of Housing and Urban Development, *What is the Federal Housing Administration?*, <http://www.hud.gov/offices/hsg/fhahistory.cfm> (last visited November 22, 2008).

⁴¹ Wagman Roisman, *supra* note 31, at 676.

⁴² Shapiro, *supra* note 27, at 67-68.

⁴³ *Id.* at 68.

⁴⁴ *Id.* at 67.

THE AFRICAN AMERICAN FIGHT FOR THE DREAM

THE ISSUE: HOUSING POLICIES WITH CLEAR DISCRIMINATORY
TREATMENT*FHA and “Racial Homogeneity”*

As was expected, many of these governmental policies to increase homeownership were very color restricted; especially that of the FHA.⁴⁵ In fact, the FHA’s Underwriting Manual specifically instructed that the presence of “inharmonious racial or nationality groups” made a neighborhood’s housing undesirable for insurance and explicitly recommended racially restrictive covenants.⁴⁶ One portion of the manual notes that, ““if a neighborhood is to retain stability, it is necessary that properties shall continue to be occupied by the same social and racial classes”⁴⁷ Policies such as this made it clear that racial minorities were not the groups aimed at gaining a benefit from the newly created federal programs. As Florence Wagman Roisman notes in her article *Teaching About Inequality, Race and Property*,

FHA adopted a racial policy that could well have been culled from the Nuremberg laws. From its inception FHA set itself up as the protector of the all white neighborhood. It sent its agents into the field to keep Negroes and other minorities from buying houses in white neighborhoods. FHA “not only insisted on social and racial ‘homogeneity’ in all of its projects as the price of insurance but became the vanguard of white supremacy and racial purity--in the North as well as the South.”⁴⁸

The federal policies put into place to assist potential buyers in obtaining homeownership can be contrasted with public housing program that came just a few years later. In 1937, the United States Housing Act of 1937 was enacted.⁴⁹ This represented the origins of what is now know as public housing.⁵⁰ The purpose of the U.S. Housing Act was to provide

⁴⁵ See U.N. COMM. ON THE ELIMINATION OF RACIAL DISCRIMINATION [CERD], *supra* note 33, at ¶ 5.

⁴⁶ Wagman Roisman, *supra* note 31, at 677 (quoting KENNETH T. JACKSON, CRABGRASS FRONTIER: THE SUBORDINATION OF THE UNITED STATES 208 (1985)).

⁴⁷ *Id.* at 677-78.

⁴⁸ *Id.* at 678 (footnotes omitted).

⁴⁹ Codified as 42 U.S.C. § 1437 to 1437bbb-8 (2000).

⁵⁰ Paul R. Lusignan, *Public Housing in the United States, 1933-1949* 1 CULTURAL RESOURCE MGMT. 36, 37, available at <http://crm.cr.nps.gov/archive/25-01/25-01-16.pdf>.

affordable housing to the urban poor.⁵¹ However, in effect, the government created a two-tiered housing policy that held very strong racial correlations.⁵² Blacks were kept out of homeownership and thus forced into public housing. As Wagman Roisman notes, “the two ‘tiers held racial significance; the upper tier nourished a growing, virtually all-white constituency while public housing struggled to support primarily a fragment of the minority community with which it became identified.’”⁵³

Homeowners Insurance Underwriters and “ the Immoral Blacks ”

Along with the FHA’s discriminatory practices and the birth of public housing, the push to deny housing to African Americans was also prevalent in regards to homeowners insurance. Insurance in America dates back as far as the 1790s.⁵⁴ Discriminatory underwriting unfortunately also dates back this far.⁵⁵ As noted by Brian Glenn in his article *Shifting the Rhetoric of Insurance Denial*,

[o]ne insurance textbook noted that the underwriter’s job was made easier by the risk report that contained information “as to the applicant’s racial descent . . . and it must be specifically stated whether he is Anglo-Saxon, Greek, Hebrew, Italian, Negro, or of other racial or national origin.” Knowing the applicant’s nationality, one can only suppose, provided the underwriter with useful information about whether or not the applicant was a good

⁵¹ *Id.*

[L]ocal public housing authorities were given primary responsibility for initiating, designing, building, and operating their own housing projects, while the newly created United States Housing Authority (USHA) provided program direction, financial support, and technical and design assistance. With these new federal funding mechanisms and policies in place, the USHA spurred local public housing authorities to construct more than 370 projects, which housed nearly 120,000 families at a cost of approximately \$540 million.

⁵² Wagman Roisman, *supra* note 31, at 676. *See also* U.N. COMM. ON THE ELIMINATION OF RACIAL DISCRIMINATION [CERD], *supra* note 33, at ¶¶ 8-9.

⁵³ Wagman Roisman, *supra* note 31, at 676.

⁵⁴ *See* Brian J. Glenn, *The Shifting Rhetoric of Insurance Denial*, 34 LAW & SOC’Y REV. 779, 781 (2000).

⁵⁵ *See id.* at 789-90.

risk Data on lynchings was used to show that immorality [of Blacks] was on the increase, and since immorality led to increase in illness, it was clear that slavery was much better for the health of the black man than freedom. With blacks, attempts at education were a waste of time, since decades of freedom had only proved that the race was incorrigible.⁵⁶

Such texts—many of which were available at the time—had a goal of proving that African Americans were uninsurable and could not be insured under the risk pools of Whites.⁵⁷

THE RESOLUTION: ANTI-DISCRIMINATORY TREATMENT LAWS

It took a great deal of advocating to gain even simple strides in the direction of equal opportunity in homeownership for African Americans.⁵⁸ In 1949, it was announced that FHA would refuse to issue mortgage insurance on properties “bound by racially restrictive covenants recorded after February 15, 1950.”⁵⁹ However, the FHA took many actions that showed a contrasting intent. For example, FHA’s executive board made sure to note that “it should be made entirely clear that violation [of the new rules] would not invalidate insurance.”⁶⁰ Along with FHA’s refusal was refusal by some administrations to help facilitate the reduction of housing disparities between Blacks and Whites. “President Truman rejected a request that he ‘bar FHA aid to any segregated housing’ [Similarly,] the Eisenhower Administration reject[ed] demands that FHA require open occupancy in its insured projects”⁶¹

These discriminatory practices in housing were seen until President Kennedy’s Executive Order 11063 in 1962 and the 1968 Fair Housing Act.⁶² Nevertheless, by the early 1970s, a large gap was already visible. Eleven million Americans had purchased dwellings because of FHA and VA financing.⁶³ Almost all of those millions of loans went to Whites and

⁵⁶ See *id.* at 789-90 (citations omitted).

⁵⁷ *Id.* at 791.

⁵⁸ See Wagman Roisman, *supra* note 31, at 679-681.

⁵⁹ *Id.* at 679.

⁶⁰ *Id.* at 679-80.

⁶¹ *Id.* at 680 (internal citation omitted).

⁶² *Id.* at 680-81; See Exec. Order No. 11,063, 27 Fed. Reg. 11527 (Nov. 20, 1962); See also 42 U.S.C. § 3601 et seq.

⁶³ *Id.* at 681.

were only available to Whites.⁶⁴ It is estimated that less than two percent of the housing financed with federal mortgage assistance was available to African Americans.⁶⁵

In regards to insurance, by the late 19th century, many states had made it illegal to charge higher rates based on race.⁶⁶ With the illegality of risk classifications based on race, insurers had to find other ways to classify groups. Thus began the “actuarial science” of risk classification that is said to statistically prove a person’s insurance risk.

Even with the change in FHA models and insurance risk classifying, the effect of the years of discriminatory treatment was apparent. Whites continued to climb the social ladder in regards to wealth and African Americans were forced to stay behind, effectively depriving them of the advantages of particular homes and property appreciation and excluding them from suburban areas.⁶⁷ Contrastingly, the public support provided by the FHA and VA allowed “whites who previously lacked the means to remove themselves to racially homogeneous communities to do so.”⁶⁸ Moreover, the homes purchased by Whites with this FHA and VA helped to provide an invaluable opportunity for wealth appreciation.⁶⁹

Whites witnessed the values of their homes increase considerably, especially during the 1970s when housing prices tripled.⁷⁰ Correlatively, those African Americans who had been barred from the housing market by FHA policies and later sought to become first-time homebuyers faced rising housing costs that curtailed their ability to purchase the kind of home they desired.⁷¹ The effects of this can still be seen today. Although the African American homeownership rates have increased, the disparities continue to show the effects of the past.

Along with the clear economic and homeownership effects, there have also been damaging social effects tied to these housing disparities. The African American identity has effectively become a reflection of stigma regarding dense and overcrowded urban areas. Research on implicit bias and cultural stereotyping suggests that Americans hold persistent beliefs linking African Americans and other disadvantaged minority groups to

⁶⁴ *Id.*

⁶⁵ *Id.*

⁶⁶ Glenn, *supra* note 54, at 791.

⁶⁷ Wagman Roisman, *supra* note 31, at 681.

⁶⁸ *Id.*

⁶⁹ *Id.* at 682.

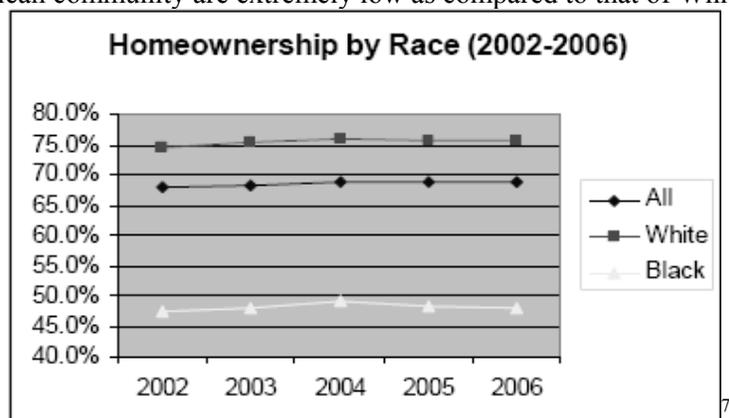
⁷⁰ *Id.*

⁷¹ *Id.*

many social images, including but not limited to crime, violence, disorder, welfare, and undesirability as neighbors.⁷² The identity of the urban city and public housing has been transformed into a collective stigma affecting the Blacks living in these cities. This negative cultural stereotyping has been shown to account for White Americans' widespread unwillingness to share residential space with Blacks and other minority groups.⁷³ Somehow, crime, poverty, and welfare have become equated more so with the minority groups negatively affected by them than with the public housing system that perpetuated them in the first place.

A NEW FORM OF DISCRIMINATION: INSURANCE UNDERWRITING AND THE DISPARATE IMPACT ARGUMENT

The below 2007 report of homeownership by race created by the National Urban League illustrates that homeownership rates in the African American community are extremely low as compared to that of Whites.



⁷² Robert J. Sampson & Stephen W. Raudenbush, *Seeing Disorder: Neighborhood Stigma and the Social Construction of "Broken Windows"*, 67 SOC. PSYCHOL. Q. 319, 320 (2004).

⁷³ *Id.* at 321.

⁷⁴ Nat'l Urban League Pol'y Inst., *supra* note 1. In 2006, the national homeownership rate was 68.8%. However, the homeownership rate of Blacks was 47.9%, which is staggeringly low as compared to that of Whites who have a homeownership rate of 75.8%. *Id.* What may be even more notable is that as of the time this data was collected, Blacks have the lowest homeownership rate of all races within the United States. See U.S. CENSUS BUREAU, HOMEOWNERSHIP RATES BY RACE AND ETHNICITY OF HOUSEHOLDER: 1994 to 2006 (2006), available at <http://www.census.gov/hhes/www/housing/hvs/annual06/ann06t20.html> (last visited Oct. 3, 2008).

Despite Title VIII of the Civil Rights Act of 1968 (the Fair Housing Act),⁷⁵ Title VI of the Civil Rights Act of 1964,⁷⁶ Executive Order 11063,⁷⁷ and many other state and federal laws that prevent housing discrimination, there is still a clear racial inequality in regards to homeownership.⁷⁸ In 2006, the African American homeownership rate was 47.9% while the White homeownership rate continued to be above 75%.⁷⁹ This staggering disparity cannot and should not be solely attributed to past discrimination.

In looking to closing the homeownership gap with the intent of closing the wealth gap between African Americans and Whites, discriminatory institutional patterns must also be considered.⁸⁰ One such clear pattern concerns insurance underwriting. Because of the role insurance plays in an individual's ability to obtain a mortgage—thus, the ability to obtain a home—insurance is strongly connected with racial homeownership disparities.

As noted above,⁸¹ it is illegal to price insurance based on racial classifications.⁸² However, insurance companies—through their underwriting process—have created a process of risk classification of individuals that has a disparate impact on African American homeownership. Disparate impact results when a business's policy or practice, although neutral on its face, has a disproportionate negative

⁷⁵ The Fair Housing Act prohibits discrimination in the sale, rental, and financing of dwellings, and in other housing-related transactions, based on race, color, national origin, religion, sex, familial status and handicap. *See* 42 U.S.C.A. § 3604 (2008).

⁷⁶ Title VI prohibits discrimination on the basis of race, color, or national origin in programs and activities receiving federal financial assistance. *See* 42 U.S.C.A. § 2000(d) (2008).

⁷⁷ Executive Order 11,063 prohibits discrimination in the sale, leasing, rental, or other disposition of properties and facilities owned or operated by the federal government or provided with federal funds. *See* Exec. Order No. 11,063, 27 Fed. Reg. 11,527 (Nov. 20, 1962).

⁷⁸ Dana L. Kaersvang, *The Fair Housing Act and Disparate Impact in Homeowners Insurance*, 104 MICH. L. REV. 1993, 1995 (2006).

⁷⁹ Nat'l Urban League Pol'y Inst., *supra* note 1.

⁸⁰ Shapiro, *supra* note 27, at 66.

⁸¹ *See supra* Part II.

⁸² Note that although race based pricing is illegal, there have been recent instances of such blatant behavior within insurance companies. *See, e.g., Louisiana v. Guidry*, 489 F.3d 692 (2007). However, this Note will not deal with such pricing behavior. This Note focuses specifically on risk based pricing that is labeled as non-discriminatory but has a discriminatory effect.

impact on a protected group.⁸³ Under this theory, the business's motive in treating applicants differently may or may not be about race or another prohibited basis, however the effect is that the protected class is adversely impacted.⁸⁴ To understand this argument, the process of insurance underwriting must first be explained.

Underwriting is a process by which the insurer determines what applicants should be accepted by the company and which programs such applicants fit under.⁸⁵ This system is classified as one based on risks. Because insurance companies desire certain groups more than others in order to keep their risk pool down, those who do not fit the underwriter's vision of the ideal member of society have a difficult time obtaining desired coverage.⁸⁶ Blacks seem to fit squarely into this category of the undesired group. As Brian Glenn notes:

[t]he idea of judging an applicant by her or his race or standing in society appears to have been replaced by mathematically justified matrices that rate individuals according to their risks and charge them the appropriate premium. But even though the stereotypes have formally disappeared from the rating systems, they still exist and are used to exclude certain groups from coverage. Rather than replacing these stories about undesired groups, the numbers, data, and forms merely hide the fact that applicants are still judged according to their standing in society. The difference between the old era of underwriting and the current one is that the appearance of subjectivity has been hidden behind a process that appears objective, mitigating the denied applicants the opportunity to develop awareness that they have been excluded on the basis of subjective opinions about their lifestyles.⁸⁷

Thus, the process of risk selection has allowed a great deal of discrimination to continue. Outwardly, risk based pricing resembles a game of numbers, statistics, and objectivity. However, when one considers

⁸³ CHI CHI WU, NATIONAL CONSUMER LAW CENTER, CREDIT SCORING AND INSURANCE: COSTING CONSUMERS BILLIONS AND PERPETUATING THE ECONOMIC AND RACIAL DIVIDE, 18, (2007), <http://www.consumerlaw.org/reports/content/InsuranceScoring.pdf>.

⁸⁴ *Id.*

⁸⁵ Glenn, *supra* note 54, at 780.

⁸⁶ *Id.*

⁸⁷ *Id.* at 792-93.

the effect that many of these pricing criteria have on minorities, it is clear that the objective test has many subjective levels of discrimination.

To explain, underwriting guidelines are hardly ever illustrated as prejudiced or based on stereotypes.⁸⁸ However, if one considers the wide range of practices used, the reason for the pricing differential between African Americans and Whites is evident.⁸⁹ For example, homeowners insurance becomes more costly—and eventually unavailable—depending on the age of a home. Insurers are less likely to insure older homes.⁹⁰ When looking at the ratio of individuals who live in older homes, African Americans are disproportionately more likely to own older homes than Whites.⁹¹ Next, looking at the market value of homes, insurance companies usually create a minimum value threshold under which insurance will not be available. Again, African Americans are more likely to buy inexpensive homes and because insurance is necessary to secure a mortgage, a cyclical effect preventing homeownership is created.⁹² Insurance companies also adjust premiums by geographical area. Although blatant redlining is now illegal, this same effect of drawing lines around certain neighborhoods is created when insurance companies price homeowner's insurance premiums based on crime rates, vacant buildings and the percentage of owner-occupied dwellings in a neighborhood.⁹³

Moreover, insurance companies never completely abandoned their subjective pricing methods. Insurance agents have the opportunity to use their own biases when these subjective criteria are in play.⁹⁴ Consider the language insurance companies use such as “requiring that the insured ‘be a person of integrity and financial stability who takes pride in his property.’”⁹⁵ Such subjectivity leaves much room for bias; a bias that should not be present within an arguably objective standard.

⁸⁸ *Id.* at 801.

⁸⁹ “When insurance is available, blacks pay more per dollar of insurance than do Whites, even when controlling for income.” Kaersvang, *supra* note 78, at 1995-96 (footnotes omitted).

⁹⁰ *Id.* at 1996.

⁹¹ *Id.*

⁹² *Id.*

⁹³ *Id.*

⁹⁴ Kaersvang, *supra* note 78 at 1997.

⁹⁵ *Id.* at 1997 (footnotes omitted).

THE PRIMA FACIE CASE: CREDIT SCORING AND THE
DISPARATE IMPACT ARGUMENT

The use of credit scores in insurance pricing can be challenged under § 3604 of the Fair Housing Act. The Fair Housing Act (“the Act”) was passed as Title VIII of the Civil Rights Act of 1968. Although the Supreme Court has not authoritatively stated that disparate impact claims are covered under the Act, there is a consensus amongst the circuit courts that disparate impact does apply.⁹⁶

Section 3604(a) of the Act makes it unlawful “[t]o refuse to sell or rent after the making of a bona fide offer, or to refuse to negotiate for the sale or rental of, *or otherwise make unavailable or deny*, a dwelling to any person because of race. . . .”⁹⁷ Whereas, § 3604(b) states that it is unlawful “[t]o discriminate against any person in the terms, conditions, or privileges of sale or rental of a dwelling, *or in the provision of services or facilities in connection therewith*, because of race. . . .”⁹⁸ Courts have found that property insurers are covered under both of these provisions,⁹⁹ and the US Department of Housing and Urban Development (“HUD”) supports this position. In regulations published in 1989, HUD notes that prohibited activities related to dwellings include “[r]efusing to provide municipal services or property or hazard insurance for dwellings or providing such services or insurance differently because of race. . . .”¹⁰⁰

⁹⁶ See, e.g., *Edwards v. Johnston County Health Dept.*, 885 F.2d 1215, 1223 (4th Cir. 1989); *Nat’l Ass’n. for the Advancement of Colored People v. Huntington*, 844 F.2d 926 (2d Cir. 1988); *Keith v. Volpe*, 858 F.2d 467, 482–84 (9th Cir. 1988); *Hanson v. Veterans Admin.*, 800 F.2d 1381, 1386 (5th Cir. 1986); *Arthur v. City of Toledo*, 782 F.2d 565, 574–75 (6th Cir. 1986); *Betsey v. Turtle Creek Assoc.*, 736 F.2d 983, 986–88 (4th Cir. 1984); *Smith v. Clarkton*, 682 F.2d 1055, 1065 (4th Cir. 1982); *Metro. Hous. Dev. Corp. v. Arlington Heights*, 558 F.2d 1283, 1290 (7th Cir. 1977).

⁹⁷ 42 U.S.C.S. § 3604(a) (2000) (emphasis added).

⁹⁸ 42 U.S.C.S. § 3604(b) (2000) (emphasis added).

⁹⁹ See, e.g., *Nat’l. Ass’n. for the Advancement of Colored People v. Am. Fam. Mut. Ins. Co.*, 978 F.2d 287, 301 (7th Cir. 1992) (holding that “[s]ection 3604 applies to discriminatory denials of insurance, and discriminatory pricing, that effectively preclude ownership of housing because of the race of the applicant.”).

¹⁰⁰ 24 C.F.R. §§ 100.70(b), 100.70(d)(4) (2008). See also ROBERT G. SCHWEMM, HOUSING DISCRIMINATION LAW AND LITIGATION § 10:4 (2008).

ARTICULATING THE STANDARD

The first step in making a prima facie case for disparate impact is to identify a rule or policy that, while neutral on its face, has an adverse effect on members of a protected class. This Note will focus on the use of credit scores in insurance pricing as the identified policy.

Although the courts agree that a plaintiff must make a prima facie case, there is a split amongst the circuits regarding the standard applied for outlining a prima facie claim under the Fair Housing Act. The First, Second, Third, Fifth, Eighth and Fourth Circuits have employed what is referred to as a “pure effects” or “effects only” test.¹⁰¹ Under this standard, the plaintiff must first identify a policy attributable to the defendant that has a “substantially greater adverse impact” on minorities.¹⁰² The burden then shifts to the defendant to “prove a business necessity sufficiently compelling to justify the challenged practice.”¹⁰³

There is debate as to whether the inquiry stops here, however. In the 1989 decision of *Wards Cove Packing Co. Inc., v. Atonio*,¹⁰⁴ the Supreme Court held that the burden of persuasion remains with the plaintiff. The Court noted that in discriminatory impact cases under Title VII,¹⁰⁵ the employee must prove not only a disparate impact, but also that the employer has no reasonable business justification for its discriminatory practices.¹⁰⁶ Thus, the defendant need only prove that its business practice serves a legitimate business goal.¹⁰⁷ After this, the plaintiff has the burden “to show that other tests or selection devices, without a similarly undesirable racial effect, would also serve the [defendant’s] legitimate interest . . . Such a showing would be evidence that the employer was using

¹⁰¹ See, e.g., *Wadley v. Park at Landmark LP*, 264 Fed. Appx. 279, 281 (4th Cir. Va. 2008); *Casa Marie, Inc. v. Super. Ct. of P.R. Dist. of Arecibo*, 988 F.2d 252, 259 (1st Cir. 1993); *Familystyle of St. Paul, Inc. v. St. Paul*, 923 F.2d 91, 94 (8th Cir. 1991); *United States v. Mitchell*, 580 F.2d 789, 791 (5th Cir. 1978); *Resident Advisory Bd. v. Rizzo*, 564 F.2d 126, 149 (3d Cir. 1977).

¹⁰² *Betsey v. Turtle Creek Assocs.*, 736 F.2d 983, 988 (4th Cir. 1984).

¹⁰³ *Id.* See also *Resident Advisory Bd. v. Rizzo*, 564 F.2d 126, 148-49 (3d Cir. 1977); JOHN P. RELMAN, HOUSING DISCRIMINATION PRACTICE MANUAL DATABASE § 2:25 (2007).

¹⁰⁴ *Wards Cove Packing Co. Inc., v. Atonio*, 490 U.S. 642, 659-60 (1989).

¹⁰⁵ 42 U.S.C.S. § 2000e-2 (1999).

¹⁰⁶ *Wards Cove*, 490 U.S. at 659-60.

¹⁰⁷ *Id.*

its tests merely as a ‘pretext’ for discrimination.”¹⁰⁸ These twin burdens of production and persuasion are extremely difficult for a plaintiff to meet.

The *Wards Cove* standard should not apply to claims brought under the Fair Housing Act. Congress expressly overruled the *Wards Cove* standard, as it related to Title VII, in the Civil Rights Act of 1991.¹⁰⁹ However, the standard was upheld, as it related to the Age Discrimination in Employment Act (“ADEA”), in *Smith v. City of Jackson*.¹¹⁰ Nonetheless, in upholding the *Wards Cove* standard in *Smith*, the Supreme Court noted that, “textual differences between the ADEA and Title VII make it clear that even though both statutes authorize recovery on a disparate-impact theory, the scope of disparate-impact liability under the ADEA is narrower than under Title VII.”¹¹¹ The Court also noted that “Congress’ decision to limit the coverage of the ADEA by including the RFOA provision is consistent with the fact that age, unlike race or other classifications protected by Title VII, not uncommonly has relevance to an individual’s capacity to engage in certain types of employment.”¹¹² In contrast to the ADEA, the language of the Fair Housing Act is quite similar to that of Title VII and contains no narrowing provisions.¹¹³ Because the Fair Housing

¹⁰⁸ *Albemarle Paper Co. v. Moody*, 422 U.S. 405, 425 (1975) (citations omitted). *See also Wards Cove*, 490 U.S. at 660.

¹⁰⁹ *See* Pub.L. No. 102-166, 105 Stat. 1071, 42 U.S.C. § 1981 (1991) note (stating that “the decision of the Supreme Court in *Wards Cove Packing Co. v. Atonio*, 490 U.S. 642 (1989) has weakened the scope and effectiveness of Federal civil rights protections.”).

¹¹⁰ *Smith v. City of Jackson*, 544 U.S. 228, 241 (2005).

¹¹¹ *Id.* at 240. ADEA contains a provision “permitting any ‘otherwise prohibited’ action ‘where the differentiation is based on reasonable factors other than age.’” *Id.* at 233.

¹¹² *Id.* at 240.

¹¹³ *Compare* 42 U.S.C.S. § 2000e-2(a) (1999) stating:

[i]t shall be an unlawful employment practice for an employer: (1) to fail or refuse to hire or to discharge any individual, or otherwise to discriminate against any individual with respect to his compensation, terms, conditions, or privileges of employment, because of such individual’s race, color, religion, sex, or national origin; or (2) to limit, segregate, or classify his employees or applicants for employment in any way which would deprive or tend to deprive any individual of employment opportunities or otherwise adversely affect his status as an employee, because of such individual’s race, color, religion, sex, or national origin,

with 42 U.S.C.S. § 3604 (2000) stating:

Act is more like Title VII, the distinction the Supreme Court found between ADEA and Title VII should not be applicable to cases brought under the Fair Housing Act. Accordingly, I argue that the standard that will apply in cases brought under the Fair Housing Act will place the burden on the defendant to prove a business necessity for its acts or policies.

In contrast to the “effects only” test, the Seventh Circuit has created a four factor test for disparate impact claims brought under the Fair Housing Act. The test was enunciated in *Metropolitan Housing Development Corp. v. Village of Arlington Heights*.¹¹⁴ Similar to the *Betsey* standard, the plaintiff has the burden of producing evidence that the challenged act or policy has a disparate racial effect. However, instead of formally shifting the burden to the defendant, the court engages in a balancing test that looks at (1) the strength of the plaintiff’s showing of discriminatory effect; (2) whether there exists some evidence of discriminatory intent; (3) the defendant’s interest in taking the allegedly discriminatory action; and (4) whether the plaintiff seeks to compel the defendant affirmatively to provide housing or merely to refrain from interfering with others who wish to provide housing.¹¹⁵ The *Arlington Heights* standard, which exhibits a need to balance the plaintiff’s interests with that of the defendant, has been most commonly used in municipal zoning cases.¹¹⁶

The Sixth and Tenth Circuits have adopted a standard similar to the one announced in *Arlington Heights*. These circuits have enumerated a three-factor test, which includes all but the second *Arlington Heights* factor regarding discriminatory intent,¹¹⁷ thus, relieving some of the burden placed on the plaintiff.

it shall be unlawful (a) [t]o refuse to sell or rent after the making of a bona fide offer, or to refuse to negotiate for the sale or rental of, or otherwise make unavailable or deny, a dwelling to any person because of race, color, religion, sex, familial status, or national origin [; or] (b) [t]o discriminate against any person in the terms, conditions, or privileges of sale or rental of a dwelling, or in the provision of services or facilities in connection therewith, because of race, color, religion, sex, familial status, or national origin.

¹¹⁴ *Metro. Hous. Dev. Corp. v. Vill. Of Arlington Heights*, 558 F.2d 1283, 1290 (7th Cir. 1977).

¹¹⁵ *Id.*

¹¹⁶ RELMAN, *supra* note 103, § 2:25. *See, e.g.*, *Potomac Group Home Corp. v. Montgomery County*, 823 F. Supp. 1285, 1295-96 (D. Md. 1993).

¹¹⁷ *See, e.g.*, *Arthur v. City of Toledo*, 782 F.2d 565, 575 (6th Cir. 1986).

APPLYING THE STANDARD

The Prima Facie Case

Although the four-factor *Arlington Heights* test, the modified three-factor test, and the “effects only” tests are different in theory, in practice, all tests “require the plaintiff to demonstrate a discriminatory effect and, if that is shown, require the defendant to justify its practices.”¹¹⁸ It has been noted that it is unlikely that the different methods will produce substantially different results.¹¹⁹ Therefore, for consistency and because it has been adopted in more circuits, the following analysis will focus on applying the “effects only” test to a disparate impact claim against the use of credit scoring in insurance underwriting.

A claimant may allege, under § 3604, that the use of credit scores in insurance pricing discriminates against African Americans.¹²⁰ The statistical disparities between homeownership rates of Whites and African Americans evidence this disparate impact.¹²¹ Low credit scores tend to be correlated with low-income neighborhoods and certain minority communities;¹²² thus leading to the likelihood that those with lower credit scores will have higher insurance rates or not be able to procure insurance at all. One noteworthy study regarding credit scoring is diagramed below:

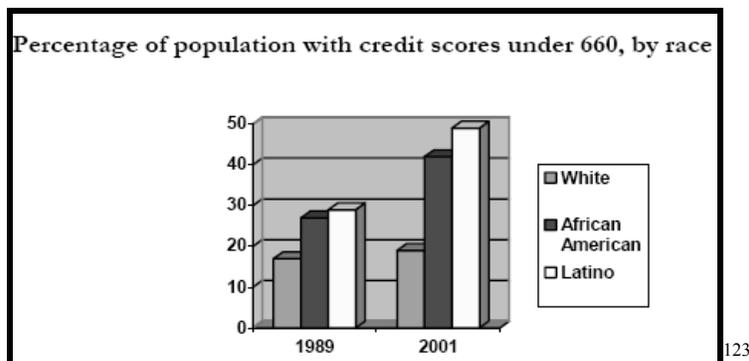
¹¹⁸ John F. Stanton, *The Fair Housing Act and Insurance: An Update and the Question of Disability Discrimination*, 31 HOFSTRA L. REV. 141, 186 (2002).

¹¹⁹ *Id.* See also SCHWEMM, *supra* note 100, at § 10:7.

¹²⁰ The key to proving a disparate impact claim is “statistical evidence showing that the defendant’s policy or practice has a greater impact on protected class members than on others.” SCHWEMM, *supra* note 100, § 10:6. See, e.g., *Keith v. Volpe*, 858 F.2d 467, 484 (9th Cir. 1988) (finding disparate impact where defendant’s action “had twice the adverse impact on minorities as it had on whites”); *Betsey v. Turtle Creek Assocs.*, 736 F.2d 983, 988 (4th Cir. 1984) (noting that a prima facie case of disparate impact was established where 74.90% of the minorities were affected, while only 26.40% of the whites were affected); *Smith v. Town of Clarkton*, 682 F.2d 1055, 1064-65 (4th Cir. 1982) (noting that a decision that “fell 2.65 times more harshly on [the] black population than on the white [population]” left “no doubt” of adverse impact).

¹²¹ See *supra* text accompanying footnotes 75-82.

¹²² NORMA P. GARCIA, SCORE WARS: CONSUMERS CAUGHT IN THE CROSSFIRE. THE CASE FOR BANNING THE USE OF CREDIT INFORMATION IN INSURANCE 3 (2006) (available at <http://www.consumersunion.org/pdf/ScoreWars.pdf>).



This diagram reflects data that was compiled during a study conducted in 2004 by the Joint Center for Housing Studies at Harvard University.¹²⁴ This study was based on a simulation of credit scores using 200,000 credit files purchased by the Federal Reserve Board, matched with data from the triennial Survey of Consumer Finances.

The cut-off for what is considered “good credit” is a score of 660 or above.¹²⁵ Research indicated that, for the period of 1989 to 2001, although the median credit score had increased for the general population, tremendous divergence in credit scores also took place during this time.¹²⁶ Credit scores for Whites increased significantly during the 1990s, from 727 to 738, while the median credit scores for African Americans dropped from 693 to 676 and for Latinos from 695 to 670.¹²⁷ More staggeringly, “[t]he percentage of African Americans with credit scores under 660 . . . grew from 27% to 42% and for Latinos it grew from 29% to 49%; while among whites it rose only slightly from 17% to 19%.”¹²⁸ These facts show clear evidence of credit score differentials based on race.

Moreover, a 2006 study conducted regarding this issue was produced by the Brookings Institution.¹²⁹ An examination of quarterly samples of 25 million anonymous consumer credit reports and scores for every U.S. County between 1999 and 2004 found that, “counties with relatively high

¹²³ WU, *supra* note 83, at 14.

¹²⁴ *See id.* at 13.

¹²⁵ *See id.*

¹²⁶ *See id.*

¹²⁷ *See id.*

¹²⁸ WU, *supra* note 83, at 13.

¹²⁹ *Id.* at 14.

proportions of racial and ethnic minorities are more likely to have lower average credit scores.”¹³⁰ The report noted that:

 this association reflects the numerous, historical disparities between races in the access to the availability of high quality education, well-paying jobs, and access to loans, among other factors. But the presence of this relationship does raise important questions that should be explored through further research, particularly in instances where information in reports are being used in nontraditional, under-researched market application, like screening job applicants and pricing insurance.¹³¹

Blacks have become the undesired group in regards to obtaining insurance and have had a difficult time in search of coverage.¹³² The outward numbers game played by insurers has created an effect of lessening the number of African Americans that have been able to obtain homeowner’s insurance coverage.¹³³ As noted by the Seventh Circuit Court of Appeals, “[n]o insurance, no loan; no loan, no house; lack of insurance thus makes housing unavailable.”¹³⁴ Thus, statistical proof shows racial disparities created by insurance scoring in homeowner’s insurance. This impact can and should be challenged under the Fair Housing Act.¹³⁵

SHIFTING THE BURDEN TO FIND BUSINESS NECESSITY

Under the “effects only” standard, the burden will shift to the insurer to defend its policy by showing a “business necessity.”¹³⁶ However, an insurance company will not be able to prove a business necessity for the use of credit scores.¹³⁷ The insurance industry is known for using credit

¹³⁰ GARCIA, *supra* note 122, at 7.

¹³¹ *Id.*

¹³² *See supra* text accompanying notes 81-94.

¹³³ *Id.*

¹³⁴ Nat’l Ass’n for the Advancement of Colored People v. Am. Family Mut. Ins. Co., 978 F.2d 287, 297 (1992).

¹³⁵ *See WU, supra* note 83, at 20.

¹³⁶ Resident Advisory Board v. Rizzo, 564 F.2d 126, 148 (3d Cir. 1977).

¹³⁷ This argument makes the assumption that the *Wards Cove* decision will not apply to a claim brought under the Fair Housing Act; thus, the burden of persuasion will not shift back to the plaintiff. *See supra* text accompanying notes 104-112.

information in determining insurance risk classifications.¹³⁸ Although insurance companies claim that this provides speed and efficiency, credit scores also have racial connections.¹³⁹ As was noted in a report by the Consumers Union of the U.S., Inc. titled *Score Wars: Consumers Caught in the Crossfire. The Case for Banning the Use of Credit Information in Insurance*, “[e]ven though credit information can be ‘race and income neutral’ on its face, credit information can function as a proxy for race and income. Whether discrimination results from intentional conduct or is inadvertent, its impact must be carefully considered and addressed.”¹⁴⁰

The use of credit scores in the underwriting process is based on three “intuitive” claims.¹⁴¹ First, the insurance industry claims that credit scores are indicative of personal responsibility because “it is intuitive and reasonable to believe that the responsibility required to prudently manage one’s finances is associated with other types of responsible and prudent behaviors, for example proper maintenance of homes and automobiles and safe operation of cars.”¹⁴² Second, “it is intuitive and reasonable to believe that financially stable individuals are likely to exhibit stability in other areas of their lives.”¹⁴³ Finally, credit scores are claimed to be indicative of “financial stress [that] could lead to stress, distractions or other behaviors that produce more losses, such as deferral of car or home maintenance.”¹⁴⁴

Despite these allegedly “intuitive” claims it is unlikely, that an insurer will meet the burden of persuasion in arguing that the use of credit scores is essential to the business of insurance. “[T]he defendant insurer should be held to a significant burden of demonstrating some relationship between its underwriting criteria and protection of the interests it urges as matters of business necessity.”¹⁴⁵

Greater regulation will not endanger the insurance marketplace.¹⁴⁶ In fact, some states have already made efforts to regulate the use of credit

¹³⁸ GARCIA, *supra* note 122, at 1.

¹³⁹ *Id.* at 3.

¹⁴⁰ *Id.* at 6-7.

¹⁴¹ Ian O’Neil, *Disparate Impact, Federal/State Tension, and the Use of Credit Scores by Insurance Companies*, 19 LOY. CONSUMER L. REV. 151, 155-56 (2007).

¹⁴² *Id.* at 155.

¹⁴³ *Id.*

¹⁴⁴ *Id.* at 155-56.

¹⁴⁵ Christopher P. McCormack, Note, *Business Necessity in Title VIII: Importing An Employment Discrimination Doctrine into the Fair Housing Act*, 54 FORDHAM L. REV. 563, 601 (1986).

¹⁴⁶ GARCIA, *supra* note 122, at 23.

scores in insurance pricing.¹⁴⁷ These states continue to have healthy insurance markets.¹⁴⁸ Thus, the argument of protecting the marketplace can be countered.¹⁴⁹

Hawaii was one of the first to pass a law banning the use of credit information.¹⁵⁰ In 1973, Hawaii made any use of credit information illegal in all automobile insurance policies.¹⁵¹ In 2002, Maryland's homeowner insurance statute was amended to establish limitations on the use of credit history.¹⁵² Under Maryland's statute, there are "prohibitions on particular payment plans, or refusal to underwrite, renew or cancel policies based in whole or in part on credit information."¹⁵³

Similar to Maryland, in 2004, Oregon enacted a statute regulating the use of credit scores in insurance pricing.¹⁵⁴ Oregon's law prohibits insurers from being able to cancel or refuse to renew existing policies "based in whole or in part on credit information."¹⁵⁵ Washington also has a similar provision to that of the formerly mentioned laws.¹⁵⁶ Also, Utah and Georgia have enacted prohibitions against the use of credit scores in the process of insurance underwriting.¹⁵⁷

Additionally, although California has only enacted laws restricting the use of credit scores in regards to automobile insurance, the California Department of Insurance has taken a strong stance in opposition of its use in homeowner's insurance underwriting as well.¹⁵⁸ In an August 2004 report, the Department noted that it, "does not allow use of credit or insurance scores in underwriting homeowner's insurance. This is because the insurance companies have failed to demonstrate that credit scores are not discriminatory toward protected classes such as women, the elderly, the poor, and racial/ethnic groups."¹⁵⁹ In fact, in June of 2005, the Department and Allstate entered into a \$30 Million settlement to refund \$30 million in policy credits and premium returns to eligible California policyholders who

¹⁴⁷ *Id.* at 18. *See also* WU, *supra* note 83, at 18.

¹⁴⁸ GARCIA, *supra* note 122, at 23.

¹⁴⁹ *See id.*

¹⁵⁰ *Id.* at 18.

¹⁵¹ *Id.*

¹⁵² *Id.*

¹⁵³ GARCIA, *supra* note 122, at 18.

¹⁵⁴ *Id.*

¹⁵⁵ *Id.*

¹⁵⁶ *Id.*

¹⁵⁷ O'Neil, *supra* note 141, at 163.

¹⁵⁸ GARCIA, *supra* note 122, at 18.

¹⁵⁹ *Id.*

had been affected by several of Allstate's practices, including the "use of 'Financial Stability' criteria, a form of credit scoring, to underwrite property coverage, resulting in the placement of some consumers in a program with higher rates."¹⁶⁰

Disparate impact challenges to the use of credit scores by insurers are proper under the Fair Housing Act. The purpose of the Act is to ensure housing opportunities to groups that face discrimination in the market. Bringing disparate impact claims against use of credit scores serves this purpose and should be upheld by the Supreme Court.

THE MCCARRAN-FERGUSON ACT AND STATE PREEMPTION

The McCarran-Ferguson Act, 15 U.S.C. 1012, is a United States federal law passed by Congress in 1945 in response to and overruling the Supreme Court in *U.S. v. South-Eastern Underwriters*, 322 U.S. 533 (1944).¹⁶¹ The McCarran-Ferguson Act does not itself regulate insurance,

¹⁶⁰ *Id.*

¹⁶¹ *See* *U.S. v. South-Eastern Underwriters*, 322 U.S. 533 (1944) (holding that insurance can be regulated by the federal government via the Commerce Clause). Delivering the opinion of the court, Justice Hand noted:

This business [of insurance] is not separated into 48 distinct territorial compartments which function in isolation from each other. Interrelationship, interdependence, and integration of activities in all the states in which they operate are practical aspects of the insurance companies' methods of doing business. A large share of the insurance business is concentrated in a comparatively few companies located, for the most part, in the financial centers of the East. Premiums collected from policyholders in every part of the United States flow into these companies for investment. As policies become payable, checks and drafts flow back to the many states where the policyholders reside. The result is a continuous and indivisible stream of intercourse among the states composed of collections of premiums, payments of policy obligations, and the countless documents and communications which are essential to the negotiation and execution of policy contracts. Individual policyholders living in many different states who own policies in a single company have their separate interests blended in one assembled fund of assets upon which all are equally dependent for payment of their policies. The decisions which that company makes at its home office -- the risks it insures, the premiums it charges,

nor does it mandate that states regulate insurance.¹⁶² However, it does empower Congress to pass laws that will have the effect of regulating the “business of insurance.”¹⁶³

The most significant provision of the McCarran-Ferguson Act states that, “[n]o Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance.”¹⁶⁴ The relevant issue here becomes whether the use of the Fair Housing Act to preempt credit based underwriting would violate the McCarran Ferguson Act.

This question was answered by the Fifth Circuit in the renowned *Dehoyos* case. In *Dehoyos v. Allstate Corp.*, 345 F.3d 290 (5th Cir. 2003), the court noted that homeowners insurance is covered by the Fair Housing Act.¹⁶⁵ Moreover, the court held that the McCarran-Ferguson Act did not preempt a claim that the use of credit scores by the Allstate Indemnity Company violated the anti-discrimination measures of the Fair Housing Act.¹⁶⁶ As the court noted, while the Fair Housing Act is not directly related to the business of insurance, application of the Act’s provisions did not frustrate or conflict with any articulated state policy or law.¹⁶⁷ Thus, under the *Dehoyos* decision, the issue of federal preemption is nonexistent.

the investments it makes, the losses it pays -- concern not just the people of the state where the home office happens to be located. They concern people living far beyond the boundaries of that state.

Id. at 541-42.

¹⁶² See 15 U.S.C.A. § 1012.

¹⁶³ 15 U.S.C.A. § 1011 (declaring “that the continued regulation and taxation by the several States of the business of insurance is in the public interest, and that silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States.”).

¹⁶⁴ See 15 U.S.C.A. § 1012(b).

¹⁶⁵ O’Neil, *supra* note 141, at 169. See also WU, *supra* note 83, at 20.

¹⁶⁶ O’Neil, *supra* note 141, at 169.

¹⁶⁷ WU, *supra* note 83, at 20. See also *Humana Inc. v. Forsyth*, 525 U.S. 299, 313-14 (1999) (noting that when a federal law does not directly conflict with a state regulation, and when application of the federal law would not frustrate any declared state policy or interfere with a state’s administrative regime, the McCarran-Ferguson Act does not preclude its application). The court noted that because the Racketeer Influenced and Corrupt Organizations Act (RICO) advances the interest of the state of Nevada in combating insurance fraud, and does not frustrate any articulated Nevada policy, the McCarran-Ferguson Act does not block the respondent policy beneficiaries’ recourse to RICO. *Id.*

One main argument regarding the *Dehoyos* decision is that it is only applicable when there is no state law or regulation in place to contradict that of the federal law and thus would be ineffective.¹⁶⁸ However, thirty-five states have created regulations requiring that the insurance departments have a filing of the insurer's insurance scoring methodologies.¹⁶⁹ These regulatory measures can be considered evidence of the pursuit to control and lessen the negative use of credit scores in the process of insurance underwriting.

When following the decision in *Dehoyos*, the Fair Housing Act in no way invalidates, impairs, or supersedes any law enacted by any state for the purpose of regulating the business of insurance. The Supreme Court has defined the terms invalidate and supersede as follows: "the term 'invalidate' ordinarily means 'to render ineffective, generally without providing a replacement rule or law.' And the term 'supersede' ordinarily means 'to displace (and thus render ineffective) while providing a substitute rule.'"¹⁷⁰ If the assumption is correct that these thirty-five states which have regulatory measures do so to prevent the negative use of credit scores in insurance pricing, then the Fair Housing Act will not and cannot displace nor render such laws ineffective. Instead, the Fair Housing Act serves alongside each state's regulatory policy to advance similar interests.

A CALL TO ACTION: THERE SHOULD BE CONGRESSIONAL ACTION LIMITING THE USE OF CREDIT SCORES IN INSURANCE UNDERWRITING

In addition to arguing in support of a disparate impact argument against the use of credit scores in insurance underwriting, this Note also makes a Congressional call to action. Homeownership is of critical importance. By early 2009, homeownership in the United States is set to decline.¹⁷¹ Although this issue seems to be an important topic to the current

¹⁶⁸ See, e.g., William Goddard, *Swimming in the Wake of Dehoyos: When Federal Courts Sail into Disparate Impact Waters, Will State Regulation of Insurance Remain Above the Waves?*, 10 CONN. INS. L.J. 369, 390 (2006) (noting Judge Edith Jones' dissent in *Dehoyos* "that carefully points out that at the time the action was commenced, Texas and Florida had not adopted statutes regulating credit scoring in insurance, but have done so since.").

¹⁶⁹ *Id.*

¹⁷⁰ *Humana Inc.*, 525 U.S. at 307 (citations omitted).

¹⁷¹ Editorial, *The American Dream in Reverse*, N.Y. TIMES, Oct. 8, 2007 available at <http://www.nytimes.com/2007/10/08/opinion/08mon1.html> (last visited Nov. 18, 2008).

administration, mortgaging practices and foreclosure relief have become the focal point.¹⁷² President Bush noted in August of 2007 that the FHA would soon be proposing a new program called FHA-Secure that would allow American homeowners who have good credit history but cannot afford their current payments to refinance into FHA-insured mortgages.¹⁷³ The guideline went into effect July 2008. However, the program will only serve as temporary assistance to the problems of the current housing market. Also, in December of 2007, President Bush signed into law H.R. 3648, the Mortgage Forgiveness Debt Relief Act of 2007, to help homeowners who are struggling with rising mortgage payments.¹⁷⁴

However, the focus should not only be on decreasing the foreclosure rates within the United States. There must also be governmental action to increase homeownership opportunities. In its December 2007 report, the Committee on the Elimination of Racial Discrimination (“CERD”) called to attention the United State government’s inability to resolve race based housing disparities.¹⁷⁵ According to the treaty signed by the United State at the International Convention on the Elimination of All Forms of Discrimination (“ICERD”), the United States government has an obligation to eliminate all discriminatory actions in housing, “including those that are discriminatory in effect regardless of intent....”¹⁷⁶

The courts cannot and should not have to maintain the full burden of remedying the discriminatory effects of the use of credit scoring. Therefore, to effectuate the government’s obligation under ICERD, this Note proposes that Congress adopt the model law created by the Consumers Union of U.S., Inc. and the United States Public Interest Research Group. The Model Law Regulating the Use of Credit-Based Information in Insurance Underwriting and Pricing (“the Model Law”) was adapted from the Maryland Insurance Code § 27-501.¹⁷⁷ The applicable language of the Model Law states that “an insurer may not require a

¹⁷² *Id.*

¹⁷³ George W. Bush, President Bush Discusses Homeownership Financing (August 31, 2007), *available at* <http://www.whitehouse.gov/news/releases/2007/08/20070831-5.html>.

¹⁷⁴ Press Release, George W. Bush, President Bush Signs H.R. 3648, the Mortgage Forgiveness Debt Relief Act of 2007 *available at* <http://www.whitehouse.gov/news/releases/2007/12/20071220-6.html> (creating a “three-year window for homeowners to refinance their mortgage and pay no taxes on any debt forgiveness that they receive”).

¹⁷⁵ *See de Leeuw, supra* note 33, at ii.

¹⁷⁶ *Id.* at 1-2 (citing International Convention on the Elimination of All Forms of Discrimination art. 5 §§ (d)(v), (e)(iii)).

¹⁷⁷ GARCIA, *supra* note 122, at 24.

particular payment plan for an insured for coverage under a private passenger or homeowner's insurance policy based on the credit history of the insured."¹⁷⁸ Moreover, with respect to residential property, and other personal lines of insurance, an insurer may not:

- (i) refuse to underwrite, cancel, refuse to renew a risk, or increase the renewal premium based, in whole or in part, on the credit history of an applicant or insured;
- (ii) rate a risk based, in whole or in part, on the credit history of an applicant or insured in any manner, including: the provision or removal of a discount and assigning the insured or applicant to a rating tier; placing an insured or applicant with an affiliated company;
- (iii) require a particular payment plan based, in whole or in part, on the credit history of the insured or applicant; or
- (iv) use, in whole or in part, insurance scores or consumer reports, as a basis to make a written or oral solicitation of insurance that is not initiated by the consumer."¹⁷⁹

Federal legislative action is the most valuable method to counter the effect that the use of credit scoring has on African American homeownership. The states mentioned in Part III.B.2 seem to be progressive in understanding and taking steps to counter the disparate impact of insurance credit scoring.¹⁸⁰ Many states have taken some stride towards monitoring or limiting the use of credit scores in insurance pricing.¹⁸¹ Also, as noted above, thirty-five states have created regulations regarding insurance scoring methodologies.¹⁸² This could be viewed as a consensus that something must be done. Regulatory monitoring alone is not a large enough step towards resolving the issue. Moreover, a federal law banning the use of credit scores will eliminate the need to bring disparate impact claims under the Fair Housing Act and create uniformity amongst the courts. When there are issues regarding discrimination, there is a need for uniformity. Otherwise, the fundamental concerns about the

¹⁷⁸ *Id.*

¹⁷⁹ *Id.* at 24-25.

¹⁸⁰ *Cf. id.* at 19.

¹⁸¹ O'Neil, *supra* note 141, at 162-63.

¹⁸² *Id.*

use of credit information in insurance decisions will continue to be largely unaddressed and African American consumers will remain unprotected.¹⁸³

CONCLUSION

There is a large gap between the net worth of homeowner's and renters in the United States.¹⁸⁴ Data calculated from the Federal Reserve's Survey of Consumer Finances shows that as of January of 2006 for individuals with a net income of \$80,000 and up, homeowners averaged net worth is \$451,200 while renters only averaged a net worth of \$87,400.¹⁸⁵ In regards to income of \$50,000 to \$79,999, owners averaged a net worth of \$194,610 while renters averaged \$25,000.¹⁸⁶ Similarly, for an income level of \$30,000 to \$49,999 the average net worth was \$126,500 for owners and \$10,600 for renters.¹⁸⁷ For individuals with income of \$16,000 to \$29,999, owners had an average net worth of \$112,600 and renters averaged \$4,240.¹⁸⁸ Even within the lowest income level of individuals taking in under \$16,000 annually, homeowners averaged a net worth of \$73,000 while renters averaged a \$500 net worth.¹⁸⁹ This data makes it clear that homeownership has a very significant effect on net worth and wealth. With the lowest homeownership rate in the nation,¹⁹⁰ these statistics are very critical to the African American community's inability to obtain wealth.

The use of credit scores in insurance pricing has a very substantial effect on African American homeownership rates. Without laws preventing the use of credit scores in insurance underwriting (currently) in place, African Americans will continue to fight a losing battle. It is time to note this effect, acknowledge disparate impact and extend protection beyond that of prohibiting discriminatory treatment.

The African American identity is plagued by the inability to realize the American Dream. If disparate impact is not acknowledged, African Americans will continue to be prisoners of a dream forever deferred. Homeownership should not be a dream for some races while it is a reality

¹⁸³ See GARCIA, *supra* note 122, at 23.

¹⁸⁴ *Why It's Smarter to Buy than Rent*, FREE MONEY FINANCE, Jan. 16, 2006, available at http://www.freemoneyfinance.com/2006/01/why_its_smarter.html (last visited Nov. 18, 2008).

¹⁸⁵ *Id.*

¹⁸⁶ *Id.*

¹⁸⁷ *Id.*

¹⁸⁸ *Id.*

¹⁸⁹ *Id.*

¹⁹⁰ See U.S. Census Bureau, *supra* note 74.

for others; especially not when it is so significant in creating opportunities, and securing a standard of living.¹⁹¹

¹⁹¹ THOMAS M. SHAPIRO, THE HIDDEN COST OF BEING AFRICAN AMERICAN: HOW WEALTH PERPETUATES INEQUALITY 34 (2004).

COGSWELL V. AMERICAN TRANSIT INSURANCE COMPANY

Maggie Flanagan

ABSTRACT

This casenote examines the 2007 case of *Cogswell v. American Transit Insurance Company*, which involves a clash between Connecticut insurance claims and a New York insurance company that was not licensed to do business in Connecticut. Under the precedent of *International Shoe*, constitutional rights of the New York company and the court's declination to accept jurisdiction are discussed. The note focuses on some of the major questions of American civil procedure, exemplified by this recent Connecticut case, and it addresses the major subjects of personal jurisdiction, its burdens on the defendant, the State's and plaintiff's interest in the matter, and the Connecticut Supreme Court's rulings on the various issues. The note also examines the Court's citation of other decisions from varying jurisdictions on similar cases. Finally, the note concludes by viewing the broader policy implications of the denial of jurisdiction in this case.

I. INTRODUCTION

Mickey Reavis, a Connecticut resident, was involved in an auto accident on a Connecticut highway. The driver of the other vehicle involved in the accident, a New York livery driver, was insured by an insurance company registered to do business only in the State of New York. When Mr. Reavis made his claim against the New York insurance company, the company sent an appraiser licensed in the State of Connecticut to assess the damage. The insurance company then sent a letter from New York to Connecticut offering to settle the claim. Mr. Reavis and a representative of the New York insurance company then spoke on the phone about his claim. Mr. Reavis was unhappy with how his claim was handled, and filed a complaint with the Connecticut Department of Insurance.

When the Insurance Commissioner investigated the New York Insurance Company's licensing, she found that neither the insurance company nor its internal claims adjusters were licensed to do business in the State of Connecticut. It also came to light that this insurance company had been settling claims in Connecticut for some time. In order to further her investigation, the Commissioner served the New York insurance

company with a subpoena, with the Connecticut Secretary of State acting as agent per the Connecticut long-arm statute. The New York insurance company argues that the Commissioner does not have personal jurisdiction over the company, as the company does not solicit or transact business in Connecticut.¹ Can the New York Insurance company be held accountable in Connecticut courts?

This set of facts seems concocted to strike fear into the hearts of first-year law students preparing to take a Civil Procedure exam. However, the Connecticut Supreme Court recently decided this very case, determining that while the Commissioner's subpoena satisfied the requirements of the Connecticut long-arm statute,² the insurance company had not established the minimum contacts necessary to satisfy the constitutional due process requirement set out in the United States Supreme Court decision *International Shoe*³.

The trial court had held that the insurance company should have expected to be haled into court due to its "purposeful communications" with Mr. Reavis and the fact that the insurance industry is highly regulated, thus creating the expectation that insurance companies will engage in litigation.⁴ The trial court also cited Connecticut's "strong policy" of protecting Connecticut residents from unfair business practices.⁵

The questions that remain for students of Civil Procedure and observers of the insurance industry are the following: (1) Did the Commissioner's subpoena violate the company's Constitutional rights, and (2) What are the consequences of declining to exercise jurisdiction? Both of these questions will be addressed in this paper.

II. PROCEDURAL HISTORY

After Ms. Cogswell (the Commissioner in the fact pattern above) served a subpoena pursuant to Connecticut statute⁶ on the Connecticut

¹ Cogswell v. Am. Trans. Ins. Co., 923 A.2d 638, 642-44 (Conn. 2007).

² CONN. GEN. STAT. § 38a-273(a) (2007) ("[a]ny act of doing an insurance business, as set forth in subsection (a) of section 38a-271, by any authorized person or insurer" confers personal jurisdiction over the party).

³ Int'l Shoe Co. v. Wash., 326 U.S. 310, 316 (1945).

⁴ Cogswell v. Am. Trans. Ins. Co., No. CV040832164S, 2004 Conn. Super. LEXIS 2167 at *13 (Conn. Super. Aug. 6, 2004).

⁵ *Id.*

⁶ See § 38(a)-16(a) (authorizing the insurance commissioner to conduct investigations and hearings to investigate insurance matters, including the power to issue subpoenas).

Secretary of State as agent for American Transit (the insurance company), American Transit mailed a letter to Ms. Cogswell contesting jurisdiction and requesting a hearing on the issue. Ms. Cogswell replied by letter that she did have the authority to issue such an investigative subpoena and directed American Transit to comply with the subpoena and provide the requested information.⁷

When American Transit refused to comply, Ms. Cogswell filed suit in Connecticut Superior Court to enforce the subpoena. American Transit then filed both a motion to dismiss for lack of personal jurisdiction and a motion to quash the subpoena. As outlined above, the trial court found that American Transit had sufficient minimum contacts with the State of Connecticut and that its actions fulfilled the state long arm statute, and thus denied both of American Transit's motions.⁸ This denial was accompanied by findings that American Transit is licensed with its principal place of business in New York, it has no places of business or property in Connecticut, does not solicit business in Connecticut, does not insure Connecticut residents, and did not execute Mr. Reavis's contract in Connecticut.⁹

In response to Ms. Cogswell's enforcement action, American Transit filed an answer asserting nine special defenses. The defense argued that American Transit did not conduct insurance business in the state of Connecticut as defined by Connecticut law; therefore, Ms. Cogswell had no authority to serve process on the Secretary of State as agent.¹⁰ Ms. Cogswell then filed a motion to strike four of the nine special defenses, and the trial court granted the motion to strike the defense that American Transit did not conduct business in Connecticut on the grounds that the judge who decided the previous motion to dismiss had already decided the question.¹¹ American Transit then filed an appeal to the Appellate Court, which was removed to the Supreme Court.¹²

⁷ *Cogswell v. Am. Trans. Ins. Co.*, 923 A.2d 638, 644 (Conn. 2007).

⁸ *Cogswell*, 2004 Conn. Super. 2167, at *2.

⁹ *Id.* at *2-3.

¹⁰ See CONN. GEN. STAT. § 38(a)-271 (6) (2007) (defining doing insurance business as, inter alia, "directly or indirectly acting as an agent for or otherwise representing or aiding on behalf of another any person or insurer in [the]...investigation or adjustment of claims or losses...or in any other manner representing or assisting a person or insurer in the transaction of insurance with respect to subjects of insurance resident, located, or to be performed in this state").

¹¹ *Cogswell v. Am. Trust [sic] Ins. Co.*, 2005 WL 758051 at *1 (Conn. Super. Feb. 28, 2005).

¹² See CONN. GEN. STAT. § 51-199(c) (2007).

III. PERSONAL JURISDICTION

The inquiry into whether a state court may obtain personal jurisdiction over an out-of-state defendant can be a tortuous undertaking. In each case, two requirements must be fulfilled: first, the court must determine if the state's long-arm statute reaches the conduct of the defendant corporation,¹³ and second, the defendant must have established enough contact with the state to meet the Constitutional due process requirement that it is not unreasonably and unexpectedly "haled into court".¹⁴

In this case, both the trial court and the Supreme Court concluded that American Transit acted in a manner that satisfied the state long arm statute. In general, a long arm statute is "[a]" a statute providing for jurisdiction over a nonresident defendant who has had contacts with the territory where the statute is in effect."¹⁵ In other words, the statute is the means by which the state legislature tells the state courts whom they may pull in as defendants from out of state. The long-arm statute is a way for the legislature to control the number and nature of cases that are litigated in a state's courts, keeping in mind respect for the sovereign rights of other states to regulate the conduct of their own citizens. Another important function of long-arm statutes is predictability for out-of-state actors, who may look to a state's long-arm statute to determine whether their conduct could lead to litigation in the state in question.

The Connecticut long-arm statute states that if the defendant has done insurance business in Connecticut, then it is deemed to have appointed the Secretary of State as its attorney, who in turn may be served all legal process.¹⁶ Once a defendant has a statutorily appointed attorney in a state, it has an official presence in that state and is considered present for the purpose of obtaining personal jurisdiction. "Doing insurance business" is defined as, *inter alia*, adjusting claims or mailing correspondence to a Connecticut resident involved in an insurance claim.¹⁷ This is a far reaching statute, as even the simplest communication will suffice for enactment. The fact that the Connecticut legislature drafted such an all-encompassing statute may lend credence to the trial court judge's assertion

¹³ See generally *Thomason v. Chem. Bank*, 661 A.2d 595 (Conn. 1995), for a treatment of Connecticut law surrounding long-arm statutes.

¹⁴ See *Int'l Shoe v. Wash.*, 326 U.S. 310, 320 (1945).

¹⁵ BLACK'S LAW DICTIONARY 786 (8th ed., 2005).

¹⁶ CONN. GEN. STAT. § 38a-273(a) (2007).

¹⁷ CONN. GEN. STAT. § 38a-271(a) (2007).

that out-of-state based insurance companies should expect to litigate, on occasion, in the state of Connecticut, subsequent to dealings with its residents.

What the trial court and the Supreme Court did not agree on, however, was whether American Transit's conduct established enough contacts in Connecticut to satisfy the second requirement of personal jurisdiction -- the minimum contacts requirement. This is a federally established constitutional baseline requirement that binds state courts, even if their state long-arm statute allows for less contact with a state.¹⁸ The state long-arm statute may require *more* contacts with the state than are constitutionally required, but it may not allow personal jurisdiction on the basis of *fewer* contacts.¹⁹ This requirement is based on the Fourteenth Amendment's guarantee of due process.²⁰

Included in the guarantee of due process is the guarantee that defendants will not be subjected to unexpected and unfair litigation in a jurisdiction with which they have very limited or no contacts.²¹ Due process of law, then, may be interpreted in the context of personal jurisdiction to mean that a defendant may be properly served with notice and obligated to defend a suit in that jurisdiction only if a defendant has committed some positive action in a given jurisdiction. This concept is perhaps best illustrated in the following example: a car dealership sells a car in jurisdiction A. The dealership does not advertise in any other jurisdiction, makes no sales outside of jurisdiction A, and has otherwise no contacts with any other jurisdiction. The family then drives the car to jurisdiction B and is involved in an accident. Subsequently, the family sues the dealership, attempting to force the dealership to defend the suit in jurisdiction B? The United States Supreme Court has held that this tactic would be unfair to the defendant.²² Forcing a defendant to appear and defend a suit in a jurisdiction to which it is totally unrelated is akin to other violations of the due process clause, such as, for example, imposing a penalty on a defendant without affording the defendant a chance to be

¹⁸ *Bensmiller v. E.I. Dupont de Nemours & Co.*, 47 F.3d 79, 82-84 (2d Cir. 1995) (no personal jurisdiction where foreign corporation's sole contact with Connecticut was involvement in a joint venture).

¹⁹ *Aftanase v. Econ. Baler Co.*, 343 F.2d 187, 190 (8th Cir. 1965).

²⁰ *Ins. Corp. of Ireland, Ltd. v. Compagnie des Bauxites de Guinee*, 456 U.S. 694, 712-13 (1982) (Powell, J., concurring).

²¹ *Id.*

²² *Worldwide Volkswagen v. Woodson*, 444 U.S. 286, 295 (1980); *See Bernhard v. Harrah's Club*, 546 P.2d 719 (Cal. 1976).

heard.²³ Both circumstances involve unfair surprise and lack of notice to a defendant. The Constitution acts as a safeguard against such abuses by the judiciary.

There are two types of personal jurisdiction over out-of-state defendants. First, a court may have general jurisdiction. General jurisdiction is defined as the proper assertion of jurisdiction over an out-of-state defendant when the defendant has had “systematic and continuous” contacts with the jurisdiction; so that it is fair to bring the defendant into court on any action.²⁴ The defendant, if subject to general jurisdiction in a forum, has a sufficient presence in a forum so that it will not be surprised to find itself litigating in that forum’s courts, and thus due process will be satisfied. For example, suppose a small businessman based in Jurisdiction A services computers in Jurisdiction B. He has several clients in Jurisdiction B and advertises there. If he makes a slanderous remark about someone in Jurisdiction B, completely separate from his work as a computer serviceman, he may be sued for slander in Jurisdiction B because he has established enough of a presence in Jurisdiction B to be fairly subject to suit in that jurisdiction for any action at all.

The other type of personal jurisdiction that a court may exercise over an out-of-state defendant is specific jurisdiction. Specific jurisdiction is defined as the jurisdiction that a court has when the transaction that is the subject of the suit “arises out of” or is related to the defendant’s contacts with the forum.²⁵ Now suppose that our computer serviceman went only once from his base in Jurisdiction A to service a computer in Jurisdiction B. He could probably not be sued in Jurisdiction B for a slanderous remark made in Jurisdiction A, but he could be sued in Jurisdiction B for, say, negligently ruining the computer belonging to the customer in Jurisdiction B. In that case, the court in Jurisdiction B would be exercising specific jurisdiction because the cause of action, negligently ruining a computer, arises out of the contact that the defendant had with the jurisdiction conducting his business there. The trial court in *Cogswell* pointed to the U.S. Supreme Court finding that one purposeful letter sent to a resident of another state may serve to establish a purposeful contact and justify specific jurisdiction.²⁶ Another aspect of this specific jurisdiction is the concept that the defendant availed himself of the privilege of conducting

²³ *Fuentes v. Shevin*, 407 U.S. 67, 80 (1972).

²⁴ *Helicopteros Nacionales de Colombia, S.A. v. Hall*, 466 U.S. 408, 415 (1984).

²⁵ *See Shaffer v. Heitner*, 433 U.S. 186, 204 (1977).

²⁶ *Cogswell*, 2004 Conn. Super. LEXIS 2167 at *12, *citing McGee v. Int’l Life Ins. Co.*, 355 U.S. 220 (1957).

business in the state, invoking the benefits and protections of the state and thereby creating obligations to follow the state's laws.²⁷

Thus, in order for a Connecticut court to exercise jurisdiction over an out-of-state defendant, both the state's long-arm statute and the requirements of due process must be satisfied.²⁸

IV. THE TRIAL COURT'S CASE FOR PERSONAL JURISDICTION IN *COGSWELL*

The trial court judge in *Cogswell*²⁹ ruled that there was proper personal jurisdiction to pull American Transit into court in Connecticut.³⁰ American Transit argued that Connecticut did not have jurisdiction, because, inter alia, it has its principal place of business in New York, it has no place of business or facilities in Connecticut, and does not own property in Connecticut.³¹ Its only actions in Connecticut, claimed American Transit, were sending a letter to the claimant in Connecticut and making at least one phone call to Connecticut in the course of adjusting the claim.³² The trial court asserted that the clear language of the statute justified the long arm jurisdiction.³³ Additionally, the court opined,³⁴ that American Transit had done enough in Connecticut to satisfy the constitutional due process requirements, arguing, in part, that the regulated nature of the insurance industry created a condition that satisfied the due process requirement.³⁵ The constitutional due process assertion of jurisdiction in this case is one of specific jurisdiction; that is, that the claim arose specifically out of the defendant's actions in the state.³⁶ Specifically, the trial court held that due to the fact that insurance companies are subject to complicated and specific

²⁷ *Burger King Corp. v. Rudewicz*, 471 U.S. 462, 472-76 (1985).

²⁸ *Knipple v. Viking Communications, Ltd.*, 674 A.2d 426, 428-29 (Conn. 1996).

²⁹ In the interest of full disclosure, the trial court judge, Judge Beach (now of the Connecticut Appellate Court) is the father of the author of this article. The views expressed are entirely my own.

³⁰ *Cogswell*, 2004 Conn. Super. LEXIS 2167 at *14.

³¹ *Id.* at *2-3.

³² *Id.* at *3.

³³ *Id.* at *6. ("The clear language of the statute refers to singular acts, and, in light of the highly regulated nature of the insurance industry, is not surprising.")*Id.* at *2 ("The clear language of the statute refers to singular acts, and, in light of the highly regulated nature of the insurance industry, is not surprising.")

³⁴ *Id.*

³⁵ *Id.* at *13.

³⁶ *Helicopteros Nacionales de Colombia, S.A. v. Hall*, 466 U.S. at 414 (also includes a discussion of personal jurisdiction).*supra* note 24.

regulations in many states, it is not an unfair surprise that an insurance company will have to defend an action in a jurisdiction other than that in which it is based.³⁷

To support its assertion of jurisdiction, the trial court cited the interests that the U.S. Supreme Court considered when deciding its canon of personal jurisdiction cases, which include “the interests of the forum, the defendant, and the litigation.”³⁸ More specifically, the Court laid out factors to be evaluated when determining whether the minimum contacts are “reasonable” for the purposes of determining personal jurisdiction: the burden on the defendant of answering in the forum, the forum’s interest in exerting jurisdiction, the plaintiff’s interest in obtaining relief, the interstate judicial system’s interest in efficient regulation, and states’ shared interest in furthering substantive social policies.³⁹ While the trial court did not specifically cite all five factors, relying instead on the more general three - the defendant, the forum, and the litigation - it is relevant to assess the reasonableness of personal jurisdiction according to the factors laid out in *Burger King* and *World-Wide Volkswagen* that are relevant to this case - the burden on the defendant, the forum’s interest in exercising personal jurisdiction, and the plaintiff’s interest in obtaining relief.

A. THE BURDEN ON THE DEFENDANT

The trial court in this case reasoned that this element of the evaluation of personal jurisdiction was satisfied: “[t]he burden of a New York insurer’s answering in Connecticut is minimal; thousands of Connecticut residents work in New York every day and Hartford is hundreds of miles closer to New York City than is Buffalo.”⁴⁰ In a case which in some ways mirrors this case, the District of Connecticut court reasoned that a New York defendant’s burden of having to litigate in Connecticut was outweighed by the state’s interest in “adjudicating a dispute involving

³⁷ *Cogswell*, 2004 Conn. Super. LEXIS 2167 at *4.

³⁸ *Cogswell*, 2004. Super. LEXIS 2167 at *7, citing *Keeton v. Hustler Magazine, Inc.*, 465 U.S. 770, 775-776.(1984).

³⁹ *Burger King v. Rudewicz*, 471 U.S. 462, 477 (1985); *World-Wide Volkswagen Corp. v. Woodson*, 444 U.S. 286, 292 (1980). See also *Panganiban v. Panganiban*, 54 Conn. App. 634, 639 (1999) (citing *Metropolitan Life Ins. v. Robertson-CECO Corp.*, 84 F.3d 560, 567-568 (2d Cir. 1996)).

⁴⁰ *Cogswell*, 2004 Conn. Super. LEXIS 2167 at *13.

services provided by unlicensed out-of-state accountants to a Connecticut resident.”⁴¹

The First Circuit has a particularly well developed line of case law on this question. The court has held that, unless the burden of litigating in the forum would be “onerous in a special, unusual, or other constitutionally significant way,” this is not a factor that will prevent the proper assertion of personal jurisdiction.⁴² As long as the other elements of the *Burger King* test are satisfied, some inconvenience on the part of the defendant is not sufficient to block the court from exercising personal jurisdiction.⁴³ In fact, the court has held that there was not an undue burden on a defendant who was forced to travel from Hong Kong to Massachusetts: this was outweighed by the fact that much of the relevant evidence was to be found in Massachusetts.⁴⁴

It may certainly be true that the closer the case, the more important this factor becomes. If the court is basing its personal jurisdiction on the minimum contacts of one letter and one phone call, augmented by the fact that the insurance industry is heavily regulated and therefore state interests are greater,⁴⁵ the burden on the defendant becomes weightier.

B. THE INTEREST OF THE FORUM

Generally, every state has an interest in protecting its citizens, and may choose to assert its jurisdiction over a defendant to ensure that the defendant is subject to its regulations when acting within the forum state’s borders.⁴⁶ The interest analysis that courts in most jurisdictions apply to conflicts of law cases is relevant to the analysis that the court in this case had to apply to determine whether minimum contacts were present: the factors as enumerated by the Supreme Court and the Second Circuit for evaluating the reasonableness of personal jurisdiction⁴⁷ track the factors enumerated by the courts for evaluating states’ interests in conflicts of laws

⁴¹ Gerber Trade Finance, Inc. v. Davis, Sita & Co., 128 F. Supp. 2d 86, 93 (D. Conn. 2001).

⁴² Nowak v. Tak How Investments, Ltd., 94 F.3d 708, 718 (1st Cir. 1996).

⁴³ *Id.* (explaining that this factor may “tip the balance” in close cases, but alone is not a particularly significant factor).

⁴⁴ *Id.* at 717.

⁴⁵ See *infra* Part B.

⁴⁶ See Hall v. Nevada, 503 P.2d 1363, 1364 (1972) (holding that the state of Nevada’s interest in staying out of court in California under the doctrine of sovereign immunity is outweighed by California’s policy of compensating its residents in tort cases).

⁴⁷ See *supra* notes 32, 33, and 37.

cases, as illustrated by the Second Restatement.⁴⁸ The U.S. Supreme Court has held that a state's interest in protecting its citizens can outweigh contrary contractual provisions in a conflicts of law situation, showing a strong federal policy towards allowing states to act affirmatively to create a regulatory scheme that will protect its residents from out-of-state business interests in the face of a due process challenge.⁴⁹ The Second Circuit also held in one case that the District Court of Connecticut was justified in refusing to decide a question of state insurance law, explaining, "the fact that the insurance industry is heavily regulated makes it all the more important that we stay our hand in favor of a definitive and uniform interpretation from state courts."⁵⁰ This assertion by a federal court accustomed to interpreting Connecticut law shows that Connecticut has a strong interest in regulating insurance contracts within the state.

In this case, Connecticut has a "strong policy regarding the fair handling of claims and seeks to ensure fair practices"⁵¹, and, in support of this assertion,, the trial court cited Conn. Gen. Stat. § 38a-816(6), which lists unfair claim settlement practices in the context of the Connecticut Unfair Insurance Practices Act.⁵² The legislation shows that Connecticut has an interest in protecting its citizens from unfair or unscrupulous insurance practices. American Transit was "doing insurance business" in

⁴⁸ RESTATEMENT (SECOND) OF CONFLICT OF LAWS § 6 (2) (1969) ("When there is no such directive [a statutory provision], the factors relevant to the choice of the applicable rule of law include (a) the needs of the interstate and international systems, (b) the relevant policies of the forum, (c) the relevant policies of other interested states and the relative interest of those states in the determination of the particular issue, (d) the protection of justified expectations, (e) the basic policies underlying the particular field of law, (f) certainty, predictability, and uniformity of result, and (g) ease in the determination and application of the law to be applied.") Compare the factors cited by the Courts in *Burger King* (see *supra* note 33) for evaluating personal jurisdiction, i.e. the burden on the defendant of answering in the forum, the forum's interest in exerting jurisdiction, the plaintiff's interest in obtaining relief, the interstate judicial system's interest in efficient regulation, and states' shared interest in furthering substantive social policies. The Metropolitan Life factors are designed to balance the state's interest with those of the individual litigants, the state's interests being largely those expounded by the Second Restatement. Thus, decisions evaluating a state's interest in a conflicts of law context are relevant to a determination of a state's interest in a personal jurisdiction context.

⁴⁹ *Watson v. Employer's Liab.Ass'n Corp.*, 348 U.S. 66, 72 (1954); for an excellent analysis of state interests in regulation see *QSP Inc. v. Aetna Cas. & Sur. Co.*, 1998 WL 892997, at *7 n.14 (Conn. Super. Ct. Dec. 8, 1998) (Levin, J.).

⁵⁰ *Smith v. Metro. Prop. & Cas. Co.*, 629 F.2d 757, 761 (2d Cir. 1980).

⁵¹ *Cogswell v. Am. Trans. Ins. Co.*, No. CV040832164S, 2004 Conn. Super. LEXIS 2167 at *13 (Conn. Super. Aug. 6, 2004).

⁵² *Id.*

Connecticut as defined by Connecticut statute.⁵³ Therefore, the second element of the test as expounded by the U.S. Supreme Court in *Burger King* and *World-Wide Volkswagen*, that of the interest of the forum, is clearly satisfied by the facts of the case.

C. THE PLAINTIFF'S INTEREST

The trial court did not address this point expressly, but in this case the factor is closely connected to the concept of state interest as discussed above. Because the plaintiff is the Connecticut Insurance Commissioner, she is carrying out the state's interest in regulating companies that do business within Connecticut, and thus this factor weighs in favor of allowing Connecticut to take personal jurisdiction.

The latter two factors point towards Connecticut having a strong state interest in exercising personal jurisdiction, which, according to *Burger King*, makes such exercise more reasonable.⁵⁴ Having established that it appears reasonable to exercise jurisdiction over this defendant, the Supreme Court's objections must now be examined.

V. THE CONNECTICUT SUPREME COURT'S OBJECTIONS TO THE EXERCISE OF PERSONAL JURISDICTION AND CRITIQUE OF THOSE OBJECTIONS

The Connecticut Supreme Court objected to the exercise of personal jurisdiction on the grounds that American Transit had not "purposely availed" itself of the forum.⁵⁵ Purposeful availment means that the defendant has, of his own volition, made use of the benefits of the state so as to create obligations to the state, including being subject to that state's personal jurisdiction.⁵⁶ This consideration prevents a plaintiff from

⁵³ See Conn. Gen. Stat. § 38(a)-271 (6) (defining doing insurance business as, inter alia, "directly or indirectly acting as an agent for or otherwise representing or aiding on behalf of another any person or insurer in [the]...investigation or adjustment of claims or losses...or in any other manner representing or assisting a person or insurer in the transaction of insurance with respect to subjects of insurance resident, located, or to be performed in this state").

⁵⁴ *Burger King v. Rudzewicz*, 471 U.S. 462, 473-76 (1985) ("A State generally has a 'manifest interest' in providing its residents with a convenient forum for redressing injuries inflicted by out-of-state actors.").

⁵⁵ *Cogswell v. Am. Transit Ins. Co.*, 923 A.2d 638, 654-55 (2007).

⁵⁶ *Kulko v. Superior Court*, 436 U.S. 84, 92-93 (1978).

unilaterally claiming a relationship based on the plaintiff's own actions.⁵⁷ In this case, the Supreme Court held that American Transit had not, in fact, satisfied this element of specific personal jurisdiction because all of American Transit's actions were taken in response to the claimant's actions and American Transit had never reached into the state to take advantage of Connecticut's market or other benefit: "before receiving the claim from Reavis, defendant had [not] engaged in any behavior so as to invoke the benefits and privileges of Connecticut law. It did not solicit business, maintain offices, own property, or otherwise seek to conduct its insurance business in Connecticut."⁵⁸

The purpose of the requirement of purposeful availment is to ensure that the defendant will not be haled into court unexpectedly.⁵⁹ I believe that this requirement is based on two theories. First, courts reason that when a defendant acts, he will realize that he is incurring obligations through his action. Therefore, there is no surprise when he is haled into court in the jurisdiction in which he acted.⁶⁰ Second, courts justify this exercise of personal jurisdiction on the idea that once a defendant has taken advantage of the benefits of a jurisdiction (e.g., marketed his products there), he owes the jurisdiction something: the obligation to abide by its laws.⁶¹

These bases are simplistic and can lead to unfortunate results, as in the Connecticut Supreme Court decision in this case. While the defendant insurance company may not have purposely availed itself of business in Connecticut through the traditional means of advertising, there is no doubt but that it secured the business of New York drivers entering Connecticut. The trial court has a valid point in suggesting that, given the close ties between the two states, there is no doubt that these drivers would enter Connecticut.⁶² American Transit would have undoubtedly lost business had it specified that its clients would lose coverage if they enter Connecticut. In this manner, the insurance company availed itself of Connecticut's laws. Under this analysis, American Transit should be subject to Connecticut's personal jurisdiction.

⁵⁷ *Hanson v. Denckla*, 357 U.S. 235, 253 (1958).

⁵⁸ *Cogswell*, 923 A.2d at 655.

⁵⁹ *Burger King*, 471 U.S. at 474-75.

⁶⁰ *Id.*

⁶¹ *Kulko*, 436 U.S. at 92-93.

⁶² *Cogswell v. Am. Trans. Ins. Co.*, No. CV040832164S, 2004 Conn. Super. LEXIS 2167 at *13 (Conn. Super. Aug. 6, 2004).

There is an argument to be made that the simple act of sending a Connecticut-licensed appraiser to examine the damage to Mr. Reavis's vehicle is enough to establish minimum contacts with the state of Connecticut. In *Home Impressions, Inc. v. Director, Division of Taxation*, the Supreme Court of New Jersey held that the actions of independent contractors acting as salespeople was enough to create the minimum contacts between the wholesale seller of mailboxes and the forum state of New Jersey.⁶³ It did not matter that the defendant itself did not directly conduct business in the state, but the simple fact of sending its contractors to do business there was enough to justify extending the New Jersey tax jurisdiction over the corporation. As in *Cogswell*, the tax director had statutory authority to investigate possible abuses of New Jersey tax law.⁶⁴ The mere fact that American Transit sent an appraiser to investigate Mr. Reavis's claim, regardless of the fact that the appraiser was licensed to do business in Connecticut, should be enough to justify jurisdiction of the court over American Transit. It is indicative of an underlying transaction between a Connecticut resident and American Transit, and therefore the insurance commissioner should have the power to investigate the transaction. This activity satisfies the legislature's definition of "doing insurance business" in the state.⁶⁵

The trial court also suggested that the regulated nature of the insurance business decreases the defendant's surprise at having to defend an action in the forum state. As every reader of this journal is aware, the insurance industry is fraught with litigation. There is a reason why insurance companies employ herds of lawyers for their own defense as well as the defense of insureds. There is no reason that American Transit could not have foreseen the possibility of litigation from the state of Connecticut, given the fact that (a) it knew that it insured drivers in metropolitan New York, and given the close business relationship between New York and Connecticut, could guess that these drivers would enter Connecticut, (b) it could certainly predict that some of these drivers would get into accidents, and (c) it knew that the insurance business in Connecticut was closely regulated. Thus, it should certainly come as no surprise that it would be adjusting and settling claims in Connecticut. Any insurance company that knows that it will be settling claims in a state should be aware of the fact that it might have to answer for those deeds in the courts of that state.

⁶³ *Home Impressions, Inc. v. Dir., Div. of Taxation*, 21 N.J. Tax 448, 456 (2004).

⁶⁴ *Id.*

⁶⁵ CONN. GEN. STAT. § 38a-273(a) (2007).

Therefore, any assumption on the part of the court that American Transit would be surprised by having to defend an action in a Connecticut court is naïve. Insurance companies should, and do, know better. The trial court was correct in finding personal jurisdiction appropriate.

VI. OTHER JURISDICTIONS' DECISIONS ON THE ISSUE

The Connecticut Supreme Court cites the decisions of other jurisdictions to support its finding that there was no personal jurisdiction over the defendant.⁶⁶ For example, in *Hunt v. Erie Insurance Group*⁶⁷, the ninth circuit held that a defendant insurance company, licensed and practicing business on the East Coast only, was not required to defend a suit in California when the only contact the company had with California was a failure to pay contested medical costs arising out of an accident in Colorado.⁶⁸ This is a better case for declining to exercise jurisdiction, because the only contact is a failure to act. The element of taking advantage of the forum present in *Cogswell* is, in fact, notably absent. In *Hunt*, the plaintiff was seeking a more satisfactory settlement from the defendant insurance company. In contrast, the Insurance Commissioner was looking to investigate the practices of an insurance company that had adjusted a claim in Connecticut. These fact patterns are clearly different, and the Connecticut Supreme Court misplaced its reliance on this case.

Next, the Court cited *Batton v. Tennessee Farmers' Mutual Insurance Co.*⁶⁹ In *Batton*, the Arizona Supreme Court held that an insured who was injured in a car accident in Arizona was not entitled to jurisdiction over Tennessee Farmers', since the action by which Tennessee Farmers' was drawn into Arizona was purely unilateral.⁷⁰ Tennessee Farmers' had no offices or insureds in Arizona, and did not solicit business there; its only contact with Arizona was to communicate with the plaintiff regarding his claim for benefits under his insurance policy, which provided coverage in all 50 states.⁷¹

The problem that the court had with extending jurisdiction to the plaintiff in Arizona was that it found that the defendant insurance company

⁶⁶ *Cogswell v. Am. Trans. Ins. Co.*, 923 A.2d at 655-56 (Conn. 2007).

⁶⁷ 728 F.2d 1244 (9th Cir. 1984).

⁶⁸ *Id.* at 1247.

⁶⁹ 153 Ariz. 268 (1987).

⁷⁰ *Id.* at 273.

⁷¹ *Id.* at 269-70.

had not “purposely availed” itself of the Arizona forum.⁷² There are two reasons why this is not applicable to the *Cogswell* case: (1) the reasoning itself is flawed, and (2) the facts of *Batton* are distinguishable from the facts of *Cogswell*.

To address the first problem, if it is true that the defendant insurance company did not purposely avail itself of the Arizona forum, then what is the point of selling a policy that allows coverage in all 50 states? A buyer purchases a policy stating that he is “covered” in all 50 states. The court pointed out that the agreement in this case was to defend and indemnify and that this agreement did not imply that the insured is allowed to bring suit in any state he wishes.⁷³ However, this seems contrary to basic principles of consumer protection and jurisdiction. The court itself stated that one reason for the existence of specific jurisdiction is so that an injured plaintiff need not travel to a foreign jurisdiction to redress wrongs.⁷⁴ Why should an insured, who has been sold a policy that purports to cover him in all 50 states, have to travel to a foreign jurisdiction to get compensation? It is clear that the insurance company benefited from the fact that it sells its policies as providing coverage in every state. If so, shouldn’t this measured action constitute purposeful availment? It seems unfair to ask an injured plaintiff to travel back to the jurisdiction in which the policy was bought and the defendant resides to claim coverage for an accident that was supposedly covered by a policy that covered accidents in all 50 states.

Secondly, the facts of *Batton* and the facts of *Cogswell* are distinguishable. In *Batton*, the plaintiff was seeking to get medical benefits that had been denied by his insurance company after his accident in Arizona.⁷⁵ In *Cogswell*, the Insurance Commissioner was simply seeking more information about the handling of a claim in Connecticut.⁷⁶ There is no question but that the inconvenience of the litigation to the defendant affects the propriety of the exercise of jurisdiction.⁷⁷ Even if a court is justified in denying jurisdiction over a defendant who has sold a policy covering all 50 states to a plaintiff seeking to litigate for recovery of

⁷² *Id.* at 273, for a discussion of this concept see *Hanson v. Denckla*, 357 U.S. 235, 253 (1958).

⁷³ *Id.* at 272-73.

⁷⁴ *Batton v. Tenn. Farmers’ Mut. Ins. Co.*, 153 Ariz. 268, 274 (1987).

⁷⁵ *Id.* at 269.

⁷⁶ *Cogswell v. Am. Trans. Ins. Co.*, 923 A.2d 638, 643 (Conn. 2007).

⁷⁷ *See, e.g.*, 63B Am. Jur. 2d *Products Liability* § 1677 (2008) (“[I]n determining whether an exercise of in personam jurisdiction over a non-resident defendant comports with due process requirements, the court must consider the defendant’s...relative inconvenience.”).

medical expenses in a foreign jurisdiction, it is less reasonable to deny a state's insurance commissioner a subpoena to gather more information. In *Cogswell*, American Transit was merely requested to provide information, which does not involve much inconvenience at all. Modern methods of communication and travel have affected the exercise of personal jurisdiction as well,⁷⁸ and it is difficult to believe that the defendant would have been very inconvenienced by sending a few documents to Ms. Cogswell.

Because the reasoning of the *Batton* court is flawed, and even if a court were to accept its holding the facts of *Cogswell* are distinguishable. *Batton* does not provide support for the Connecticut Supreme Court's denial of jurisdiction in *Cogswell*.

VII. SUPPORT FOR FINDING JURISDICTION OVER AMERICAN TRANSIT

There is a significant body of legislation and case law supporting a finding of personal jurisdiction over American Transit from both Connecticut and other jurisdictions. As the trial court pointed out, there is a strong policy in Connecticut of regulating the insurance business and protecting consumers of insurance products.⁷⁹ For example, in *Nationwide Mutual Insurance Company v. Pasion*, the Connecticut Supreme Court examined the legislative history of § 38-175c (a) (2) to find that the legislature had determined that this protection of the consumer in the insurance business was a high priority for the legislature.⁸⁰ Connecticut also has enacted the Connecticut Unfair Insurance Practices Act (CUIPA) for the very purpose of regulating insurance businesses within the state.⁸¹ These pieces of legislation indicate a strong policy in the state that should be respected by the state's courts.

Further, there is persuasive case law from other jurisdictions to support a finding of jurisdiction over American Transit. In a case similar to *Cogswell*, *Florida Department of Insurance and Treasurer v. Bankers Insurance Company*, the Florida Court of Appeals reasoned that an

⁷⁸ See *State ex rel. Hydraulic Servocontrols Corp. v. Dale*, 657 P.2d 211, 214 (Or. 1982).

⁷⁹ *Cogswell v. Am. Trans. Ins. Co.*, No. CV040832164S, 2004 Conn. Super. LEXIS 2167 at *13 (Conn. Super. Aug. 6, 2004).

⁸⁰ *Nationwide Mut. Ins. Co. v. Pasion*, 594 A.2d 468, 471-72 (Conn. 1991).

⁸¹ Conn. Gen. Stat. § 38a-815 (2007).

administrative agency may take steps that may or may not be proper for the judiciary to take.

The...power involved here is the power to get information from those who can best give it....Because judicial power is reluctant if not unable to summon evidence until it is shown to be relevant to issues in litigation, it does not follow that an administrative agency charged with seeing that the laws are enforced may not have and exercise powers of original inquiry....When investigative and accusatory duties are delegated by statute to an administrative body, it, too, may take steps to inform itself as to whether there is probable violation of the law.⁸²

The Supreme Court of New Jersey has held that the New Jersey Bureau of Securities was justified in issuing an investigative subpoena to an out-of-state defendant in a securities action who engaged in purposeful conduct in New Jersey. The court specifically reasoned that “to allow [the defendant] to reside in New York, do business in New Jersey more than minimally, and affect a well-regulated industry in New Jersey, without fear of investigation or subpoena, is offensive to traditional notions of fair play and substantial justice.”⁸³ The court did hold that the defendant must have purposefully availed himself of the advantages of doing business in the forum,⁸⁴ but as explained above, in this case, American Transit did in fact take advantage of doing business in Connecticut.⁸⁵

Other jurisdictions have not hesitated to find jurisdiction over out-of-state defendants in similar circumstances, particularly where the policy interests of the state in regulating industries such as securities and insurance are concerned. There is no reason why, in light of the important interests at stake, the Connecticut Supreme Court should not have followed suit.

VIII. POLICY IMPLICATIONS OF DENYING JURISDICTION

One fact surrounding the *Cogswell* litigation that has not received mention in this Note so far is the fact that Ms. Cogswell received notice that American Transit had adjusted more claims than simply that of Mickey Reavis.⁸⁶ Ms. Cogswell alleged that she had discovered that twenty-one claims had been handled by appraisers licensed by the state of Connecticut

⁸² Florida Dept. of Ins. v. Bankers Ins. Co., 694 So. 2d 70, 71-72 (Fl. App. 1997).

⁸³ Silverman v. Berkson, 661 A.2d 1266, 1267 (N.J. 1995).

⁸⁴ *Id.* at 1276.

⁸⁵ See Part V, *supra*.

⁸⁶ *Cogswell v. Am. Trans. Ins. Co.*, 923 A.2d 638, 642-43, 653 (Conn. 2007).

but adjusted by adjusters not licensed by the state of Connecticut, which practice may violate Connecticut law.⁸⁷ Therefore, her investigation is even more significant than the investigation of a single claim; if an insurance company has been regularly conducting insurance business in Connecticut without proper licensing, the insurance commissioner has a right to know and to investigate. Ms. Cogswell was simply seeking enforcement of an investigative subpoena to determine what actions might be taken against the out-of-state defendants in pursuance of Connecticut law. By denying jurisdiction over the matter, the Connecticut Supreme Court has hobbled the commissioner and allowed an insurance company who may be dealing regularly with Connecticut residents to escape without scrutiny of its compliance with Connecticut law.

There is a larger policy concern to be contended with in this case, which is the cooperation between states. It is manifestly unfair to leave Mr. Reavis without recourse in this matter. He is reliant on the officials of the state of Connecticut, who have been appointed or elected to protect his interests. He is not a citizen of New York, and is therefore not entitled to rely on the New York regulatory system to protect his rights. While there may be some courts that hold that this exercise of jurisdiction is a violation of due process, is it not a violation of Mr. Reavis's due process to be left without the ability to complain of his treatment? To whom is he to turn to express his displeasure, and possibly unlawful treatment, if not to the insurance commissioner of the state in which he resides, the state in which the accident occurred, and the state in which his claim was appraised and adjusted? As the New Jersey Supreme Court reasoned in *Silverman*, "a form of horizontal federalism, one in which states cooperate in the discharge of their governmental duties, is both timely and reasonable."⁸⁸

As the trial court pointed out, Connecticut has a strong policy in favor of regulating insurance companies and protecting consumers' rights.⁸⁹ The strength of the policy in favor of allowing the insurance commissioner to investigate compliance with Connecticut law and the relatively insignificant inconvenience of providing such information points in favor of granting jurisdiction.

⁸⁷ *Id.* at 526-27, n. 13 (discussing the application of CONN. GEN. STAT. § 38a-271(a)).

⁸⁸ *Silverman v. Berkson*, 661 A.2d 1266, 1275 (N.J. (1995)).

⁸⁹ *Cogswell*, 2004 Conn. Super. LEXIS 2167 at *13.

Correction: Volume 14.2 incorrectly listed the authors for “The Practical Ramifications of Dual Sovereignty in Prosecuting Declaratory Judgment Actions Against State and Federal Governments” article. The authors are Daniel Maldonado, Steven Plitt, and Joshua D. Rogers.

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