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REDISCOVERING THE MCCARRAN-FERGUSON ACT'S COMMERCE CLAUSE LIMITATION

*Raymond A. Guenter**

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INTRODUCTION

The McCarran-Ferguson Act ("Act")[1] was passed in response to the United States Supreme Court's 1944 decision in *United States v. South-Eastern Underwriters Association* ("*SEUA*").[2] The Court held that insurance was interstate commerce[3] overruling a line of cases that held to the contrary dating back to *Paul v. Virginia* ("*Paul*")[4] in 1868. In reliance on *Paul*, the states had developed a system of insurance regulation and taxation, important aspects of which were valid only so long as the constraints of the interstate commerce clause did not apply. The Act attempted to restore to the states the power to regulate and tax insurance as they had prior to *SEUA*. The Act sought to achieve this ambitious objective by means of four statutory provisions, each of one sentence or less, and without bothering to define "insurance" or "regulation."[5] The Act's lack of clarity, and the absence of a federal agency whose interpretations of the Act would be entitled to deference under the *Chevron* doctrine,[6] have led to a welter of disagreements among courts and within the Court.[7] One of these disagreements involves the interpretation of Section 2(a) of the Act (the "preemption exception"), a provision that defines the circumstances under which state insurance laws preempt conflicting federal laws, reversing the normal operation of the supremacy

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1. An Act to Express the Intent of Congress With Reference to the Regulation of the Business of Insurance, ch. 20, 59 Stat. 33 (1945) (codified as amended at 15 U.S.C. §§ 1011-1015 (1984)). The text of the Act is set out in Part II.B *infra*.

2. 322 U.S. 533 (1944). This case was superseded by the McCarran-Ferguson Act. *See* Freier v. New York Life Ins. Co., 679 F.2d 780, 782 (9th Cir. 1982).

3. *See* SEUA, 322 U.S. at 552-53. *See infra* Part I.D for a discussion of the case.

4. 75 U.S. 168 (1868). *See infra* Part I.A for a discussion of the case.

5. 15 U.S.C. §§ 1011, 1012(a), 1012(b) (text preceding the proviso), and § 1014.

6. *See* Chevron U.S.A., Inc. v. National Resources Defense Council, Inc., 467 U.S. 837, 842-45 (1984) (holding that the federal courts will defer to administrative judgments as to the meaning of a statute that are based upon a permissible construction).

7. Among recent Supreme Court split decisions involving interpretation of the Act are *John Hancock Mutual Life Insurance Co. v. Harris Trust*, 510 U.S. 86 (1993) (6-3); *United States Department of the Treasury v. Fabe*, 508 U.S. 491 (1993) (5-4); and *Metropolitan Life v. Ward*, 470 U.S. 869 (1985) (5-4). *See generally* Willy E. Rice, *Federal Courts and the Regulation of the Insurance Industry: An Empirical and Historical Analysis of Courts' Ineffectual Attempts to Harmonize Federal Antitrust, Arbitration, and Insolvency Statutes With The McCarran-Ferguson Act–1941-1993*, 43 CATH. U. L. REV. 399 (1994) (analyzing 275 Supreme Court and federal appellate court cases involving the Act and concluding that the federal courts have failed to develop any consistent legal theory for construing the Act).

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clause. *The question raised is whether the preemption exception applies to conflicts between state insurance laws and federal laws that are based on constitutional authority other than the interstate commerce clause.* This article takes the position that the preemption exception does not apply. It concludes that the Act frees state insurance laws only from the restraints imposed by the interstate commerce clause and that conflicts between state insurance laws and federal laws that exercise non-interstate commerce clause authority should be resolved by applying traditional supremacy clause rules.[8] The courts have generally overlooked the existence of the Act's commerce clause limitation. With few exceptions, they have resolved federal-state conflicts without distinguishing between federal laws that are based on the commerce clause and those that are based on other constitutional grants of authority.[9] The resulting body of case law achieves no consistency of result or reasoning. Statutes covering a broad range of non-commerce clause matters that the Constitution has clearly entrusted to the federal government, including the regulation of foreign commerce, the making of treaties, and the enforcement of civil rights have been challenged, and, in a number of cases, overturned because they conflicted with state insurance laws. When the courts have rejected preemption exception challenges to such federal laws they generally have used rationales equally applicable to commerce clause and non-commerce clause laws.[10] These decisions and their reasoning have in turn been relied on to reject preemption exception challenges to commerce clause laws, undercutting the basic purpose of the Act. In short, the failure to recognize the existence of the commerce clause limitation has led both to the undermining of federal authority in areas never contemplated by the Act or the Constitution, and to the preemption of state insurance laws by the very federal commerce clause statutes that the Act was designed to fend off. These mischiefs will continue to multiply as long as the commerce clause limitation is not recognized. Innumerable commerce clause and non-commerce clause laws apply in some way to the insurance industry and

8. In keeping with the usage generally employed by the courts and commentators, from this point on the Interstate Commerce Clause will be referred to simply as the "commerce clause" unless there is some reason to differentiate it from the foreign commerce clause.

9. *See* discussion *infra* Part III.C.

10. *See id.*

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conflict with some state insurance law.[11] Furthermore, the sheer size and reach of the insurance industry magnify the negative consequences of misconstruing the Act.[12]

The article is divided into three parts. Part I, "The Background of the Act," describes the manner in which the federal government and the state governments exercised authority over insurance during the period between the Supreme Court decisions in *Paul* and *SEUA*. The Act's primary purpose was to re-establish this federal-state allocation of authority. One reason that courts have failed to recognize that the Act's preemption exception doesn't apply to federal non-commerce clause laws is that they are unaware that the federal government exercised extensive authority over insurance pursuant to such laws prior to *SEUA*. Part II, "The McCarran-Ferguson Act," examines the words of the Act in the light of their historical context and legislative history. Failure to pay close attention to these textual and contextual elements is another reason that courts have misconstrued the Act's meaning. Part III reviews the decisions under the Act that have resolved conflicts between federal laws that exercise non-commerce clause authority and state laws that regulate or tax the business of insurance. A clear majority of these cases uphold federal law. However, they utilize a variety of rationales to reach this result and provide no clear guidance for the resolution of future conflicts. The most notable case that sustains state law is the 1993 Supreme Court decision in *United States Department of the Treasury v. Fabe*.[13] Part IV, "Public Policy and the Commerce Clause Limitation," discusses the public policy considerations that support limiting the application of the preemption

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11. Federal laws affecting the insurance industry are described *infra* in Parts I.B.1–I.B.10 and I.B.12. State laws affecting the insurance industry are described *infra* notes 22 and 128 and Part I.C. Some of the conflicts between federal and state laws affecting the insurance industry that have already given rise to litigation are described *infra* Parts III.B and III.C.3.

12. The insurance industry accounts for 2.5% of the gross domestic product. *See* INSURANCE INFORMATION INSTITUTE, FACT BOOK 2000 5.1 (1999). Almost every American family and business purchases insurance products. As of 1997, there were approximately 100 million private auto insurance policies outstanding (calculated by dividing net premiums written by average expenditure for auto insurance per consumer). *See id.* at 2.3-2.4. For a description of commercial property/casualty insurance in force, *see id.* at 2.3, 2.35-2.43. As of 1998, there were approximately 136 million individual life insurance policies outstanding. *See* ACLI FACT BOOK 1999, 8 (1999).

13. 508 U.S. 491 (1993).

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exception to federal commerce clause laws. Failure to recognize the commerce clause limitation undermines non-commerce clause laws that assert federal authority in areas of national concern, undercuts the Act's basic purpose of protecting state insurance laws from preemption by federal commerce clause laws, and results in unnecessary litigation.

I. THE BACKGROUND OF THE ACT

A. The Paul *Case*

Paul[14] was a test case supported by the National Board of Fire Underwriters with the hope that aggressive state insurance laws would be held to violate the federal Constitution and be replaced by a less rigorous federal regulatory scheme.[15] The insurance companies had in mind legislation modeled after the National Bank Act that would offer them the sanctuary of a federal charter.[16] The Virginia statutory scheme that was challenged in *Paul* required out-of-state insurance companies to obtain a license before conducting insurance business in the state. It conditioned the issuance of the license upon the out-of-state insurer depositing bonds issued by the state of Virginia with the state treasurer. It was a violation of the law to act as an agent for an unlicensed out-of-state insurance company. Paul, a resident of Virginia, issued policies on behalf of unlicensed New York insurance companies and was arrested and fined.[17] The Supreme Court upheld his conviction against a challenge based on the commerce clause.[18] The opinion focused on the "contracts of insurance" that Paul issued in Virginia on behalf of the New York insurance companies. The Court determined that these contracts were not commerce because they weren't capable of being offered for trade or barter in a market or of being shipped or forwarded from one state to another like a

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14. Paul v. Virginia, 75 U.S. 168 (1868).

15. *See* Peter R. Nehemkis, Jr., Paul v. Virginia, *The Need For Re-Examination*, 27 GEO. L.J. 518, 525-26 (1939); JOHN G. DAY, ECONOMIC REGULATION OF INSURANCE IN THE UNITED STATES 14-15 (1970).

16. *See* Nehemkis, *supra* note 15, at 523-25; DAY, *supra* note 15, at 13-14.

17. *See* 75 U.S. at 168-69. The article authored by Nehemkis gives a detailed description of the facts surrounding the case, an analysis of counsels' arguments, and the opinion of Justice Field. *See* Nehemkis, *supra* note 15, at 526-33.

18. *See* 75 U.S. at 182-84. The Supreme Court also rejected a challenge to the Virginia law based on the privileges and immunities clause. *See id.* at 177-82.

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commodity.[19] The opinion went on to state that contracts of insurance were not interstate transactions because they were not effective until the agent delivered them in Virginia.[20] The fact that the issuer of the contract was a New York insurance company did not dissuade the Court.[21]

Attempts by various segments of the insurance industry to use the commerce clause to invalidate state laws did not end with the *Paul* decision. Between 1869 and 1927, the Supreme Court rendered ten decisions determining that various types of insurance or insurance-related activities were not interstate commerce, upholding in each case a form of state taxation or regulation that presumably would not have passed constitutional muster if applied to a business that did constitute interstate commerce.[22] In each instance an insurance company or insurance agent

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19. *See id.* at 183.

20. *See id.*

21. *See id.*

22. *See* Ducat v. Chicago, 77 U.S. 410 (1870) (upholding a municipal tax of $2.00 per $100.00 on insurance premiums earned by foreign insurance companies); Liverpool Ins. Co. v. Massachusetts, 77 U.S. 566 (1870) (upholding a state tax on an insurance company incorporated abroad); Philadelphia Fire Ass'n v. New York, 119 U.S. 110 (1886) (upholding a New York retaliatory tax on an out-of-state insurance company); Hooper v. California, 155 U.S. 648 (1895) (upholding statute requiring every out-of-state entity conducting insurance business in the state through an agent to post a bond); Noble v. Mitchell, 164 U.S. 367 (1896) (upholding an Alabama statute that held agents personally liable on policies sold on behalf of unlicensed foreign insurance companies); New York Life Ins. Co. v. Cravens, 178 U.S. 389 (1900) (upholding the validity of a Missouri statute protecting life insurance policies from forfeiture for failure to pay premiums when applied to a policy issued by a New York insurance company in New York to a Missouri resident); Nutting v. Massachusetts, 183 U.S. 553 (1902) (upholding a statute that prohibited the soliciting of insurance business within the state on behalf of unlicensed insurers); New York Life Ins. Co. v. Deer Lodge County, 231 U.S. 495 (1913) (upholding a statute that taxed insurance companies doing business in the state on the difference between premiums received and losses and ordinary expenses related to business done within the state); Northwestern Mut. Life Ins. Co. v. Wisconsin, 247 U.S. 132 (1918) (upholding a statute that taxed the gross income of insurance companies); Bothwell v. Buckbee-Mears, 275 U.S. 274 (1927) (upholding the denial of access to the state's courts to an insurance company that had solicited business in the state without having been qualified to do business); *see also* Colgate v. Harvey, 296 U.S. 404 (1935), *overruled in part by* Madden v. Kentucky, 309 U.S. 83 (1940). The Supreme Court deviated from the Paul doctrine that insurance was not commerce in a case that held that the application of a federal stamp tax to marine insurance policies violated the constitutional prohibition against the taxation of exports. *See* Thames & Mersey Marine Ins. Co. v. United States, 237 U.S. 19 (1915). *See* discussion *infra* Part I.B.1.

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unsuccessfully contended that a state law was invalid because of limitations imposed by the "silence of Congress," i.e., the dormant commerce clause. None of these cases involved an attempt by the federal government to exercise legislative authority over the business of insurance. Despite the apparent constitutional barrier erected by *Paul*, repeated attempts were made to replace state regulation of insurance with a federal regulatory system based on the authority of the commerce clause.[23] Many of these proposals had significant support from segments of the insurance industry, particularly the fire insurance industry.[24]

B. *The Exercise of Federal Non-Commerce Clause Authority Over Insurance During the* Paul-SEUA *Era*

> Prior to our decision in United States v. South-Eastern Underwriters Assn. (citation omitted), we had consistently held that insurance was not commerce (citations omitted). The business of insurance, in consequence, was largely immune from federal regulation. Accordingly, 'the States enjoyed a virtually exclusive domain over the insurance industry.'[25]

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23. For an enumeration of the unsuccessful attempts to pass federal legislation regulating insurance pursuant to the commerce clause, *see* 90 CONG. REC. A4404 (1944). There were also attempts to overturn Paul by constitutional amendment. *See id.*; *see also* DAY, *supra* note 15, at 16.

24. *See* DAY, *supra* note 15, at 16-17; cf. ARTHUR C. MERTZ, THE FIRST TWENTY YEARS – A CASE-LAW COMMENTARY ON REGULATION UNDER THE COMMERCE CLAUSE 5 n. 19 (Nat'l Assn. of Indep. Insurers 1965). It would appear that the degree of industry support for federal versus state regulation depended on its perception of whether federal regulation would be less stringent. *See* DAY, *supra* note 15, at 16-17.

25. United States Dep't of the Treasury v. Fabe, 508 U. S. 491, 499 (1993) (quoting St. Paul Fire & Marine Ins. Co. v. Barry, 438 U.S. 531, 539 (1978)). The same language appears in *Humana, Inc. v. Forsyth*, 525 U.S. 299, 306 (1999). The assertion that "the States enjoyed a virtually exclusive domain over the insurance industry" appears in a number of lower court decisions. *See, e.g.*, Autry v. Northwest Premium Servs., Inc., 144 F.3d 1037, 1039 (7th Cir. 1998); Blue Cross & Blue Shield of Mich. v. Baerwaldt, 726 F.2d 296, 299 (6th Cir. 1984); Bristol Hotel Management Corp. v. Aetna Cas. & Surety Co., 20 F. Supp. 2d 1345, 1348 (S.D. Fla. 1998); Colonial Life & Accident Ins. Co. v. American Family Life Assurance Co. of Columbus, 846 F. Supp. 454, 457 (D.S.C. 1994). *See also* Davis J. Howard, *Uncle Sam Versus the Insurance Commissioners: a Multi-Level Approach to Defining the "Business of Insurance" Under the McCarran-Ferguson Act*, 25 WILLAMETTE L. REV. 1, 19 (1989); Spencer L. Kimball & Barbara P. Heaney, *Emasculation of the McCarran-Ferguson Act: A Study in Judicial Activism*, UTAH L. REV. 1, 7 (1985).

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The *Paul* decision implied that the federal government could not exercise authority over insurance pursuant to the commerce clause. *Paul* didn't suggest any limitations on the exercise of federal authority pursuant to other constitutional powers. In fact, the federal government used those other powers to exert some type of control over every aspect of the insurance business. The above quoted dictum from the Supreme Court's decision in *United States Department of the Treasury v. Fabe* repeats the widely accepted myth that the federal government exercised negligible authority over insurance. To lay that myth to rest so the Act can be correctly interpreted, a detailed description of federal assertions of legislative, judicial and executive authority over the business of insurance has been set forth below. They are grouped by the constitutional grant of authority upon which they are based.

1. Taxation (U.S. CONST. art. I, § 8, cl. 1)

The federal government taxed insurance in much the same way in which it taxed other industries. Insurance company earnings were subject to excise, income and undistributed net earnings taxes.[26] Debt instruments and stock issued by insurance companies were subject to tax.[27] Taxes were assessed on the face amount of life insurance policies[28] and on premiums paid on marine, fire and casualty insurance.[29] Insurance companies were required to withhold from wages to satisfy the income tax liabilities of their employees[30] and to pay the payroll taxes that funded social security benefits.[31] The issuance of insurance policies was subject to a series of

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26. *See* An Act to Reduce Taxation, to Provide Revenue for the Government and for Other Purposes, ch. 349, § 32, 28 Stat. 509, 556 (1894) (income tax); Tariff Act of 1909, ch. 6, §38, 36 Stat. 11, 112-17 (1909) (excise tax); War Revenue Act, ch. 63, § 1206, 40 Stat. 300, 333-34 (1917) (tax on undistributed net earnings).

27. *See* An Act to Reduce Internal Taxes, and for Other Purposes, ch. 255, § 15, 16 Stat. 256, 260-61 (1870).

28. *See* Revenue Act of 1918, ch. 18, § 503, 40 Stat. 1057, 1104 (1919).

29. *See id.*

30. *See* Tariff of 1913, ch. 16, § II.E, 38 Stat. 114, 170 (1913).

31. *See* Internal Revenue Act of 1939, ch. 2, § 1600, 53 Stat. 1, 175, 183-84 (1939). The statute provided an offset against the federal tax liability for payments made into state unemployment insurance funds. *See* Internal Revenue Act of 1939, ch. 2, § 1601, 53 Stat. 1, 175, 183 (1939). A federal district court held that an I.R.S. determination that state unemployment insurance obligations had not been paid prevailed over a ruling to the contrary by the agency that administered the state program. *See* Quality Coal Co. v. United States, 66 F. Supp. 105, 108 (W.D. Ark. 1946).

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stamp taxes.[32] Federal taxation of insurance involved not just the raising of revenue but the implementation of public policy. Fraternal benefit societies that provided death, sickness, accident or other benefits to members received exemptions from excise and income taxes,[33] the growth of the American marine insurance industry was encouraged[34] and the issuance of policies by overseas insurance companies without the countersignature of a U.S. agent was discouraged.[35]

In 1915, the Supreme Court determined in *Thames & Mersey Marine Co. v. United States* that the application of a federal stamp tax to ocean marine insurance policies covering goods being shipped abroad violated the constitutional prohibition against taxes on exports.[36] The Court noted that it was the practice in international trade for the seller to attach a certificate of insurance covering goods in transit to the payment drafts drawn on the purchaser,[37] and that failure to include such evidence of marine insurance coverage was grounds for the purchaser to reject the draft.[38] The Court deduced from the existence of this practice that the marine insurance policy was so directly and closely related to the process of exportation that it was "an integral part of the exportation."[39] Thus, a tax on the marine insurance policy was an impermissible tax on the goods being exported.[40] The opinion noted that Congress had already asserted authority over ocean marine insurance pursuant to the foreign commerce clause based on the same rationale, i.e., that marine insurance was an

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32. *See* An Act to Provide Ways and Means to Meet War Expenditures, and for Other Purposes, ch. 448, § 25, Schedule A, 30 Stat. 448, 460-61 (1898); An Act to Increase the Internal Revenue, and for Other Purposes, ch. 331, § 22, Schedule A, 38 Stat. 745, 762 (1914).

33. *See* An Act to Reduce Taxation, to Provide Revenue for the Government and for Other Purposes, ch. 349, § 32, 28 Stat. 509, 556 (1894); Revenue Act of 1918, ch. 18, § 231 sec. 3, 40 Stat. 1057, 1076 (1919).

34. *See* Revenue Act of 1921, ch. 136, § 1400(a), 42 Stat. 227, 320 (1921) (repealing the one percent federal tax on marine insurance premiums). *See also* discussion of federal policy with respect to the American marine insurance industry *infra* Part I.B.12.

35. *See* Revenue Act of 1924, ch. 234, § 807, Schedule A, § 12, 43 Stat. 253, 336 (1924) (subjecting foreign issued policies that were not countersigned by a U.S. agent to a stamp tax of three cents per dollar of premium charged).

36. 237 U.S. 19 (1915); *see also* U.S. CONST. art. I, § 9, cl. 5.

37. *See Thames*, 237 U.S. at 22-23, 26.

38. *See id.* at 26.

39. *Id.*

40. *See id.* at 27.

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integral part of the commerce it insured.[41] *Thames* implied that the first of the two bases for the *Paul* decision, that insurance was not commerce because it was not a "commodity," did not apply to marine insurance. Furthermore, if marine insurance policies took on the attributes of the goods they insured, the policies themselves would not only be commerce, but foreign commerce or interstate commerce, depending on whether the goods insured were moving between nations or between states. This provided a basis for the exercise of federal authority over marine insurance pursuant to both the foreign commerce and interstate commerce clauses.[42] This implication of the *Thames* decision set off a chain of events that is reflected in one of the Act's provisions.[43]

2. Foreign Commerce (U.S. CONST. art. I, § 8, cl. 3)

Promotion of the American shipping industry has been a congressional objective throughout the country's history.[44] Beginning with the creation of the Bureau of War Risk Insurance ("Bureau") in 1914, Congress has enacted a number of laws designed to support the shipping industry by

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41. *See id.* at 26-27. The Court cited as support for its determination that marine insurance was an integral part of foreign commerce a statement to that effect in the preamble to the War Risk Insurance Act passed in 1914. *See id.* at 26. *See infra* Part I.B.2 for a discussion of the War Risk Insurance Act.

42. The marine insurance business consists of two components–ocean marine insurance, which provides protection for goods shipped across the seas and was the type of insurance at issue in the Thames case, and inland marine insurance. S.S. HUEBNER ET AL., PROPERTY AND LIABILITY INSURANCE 170 (2d ed. 1976). Inland marine insurance began as coverage for waterborne commerce between ports within the same country or along navigable streams or across lakes. Inland marine insurance was later expanded to provide coverage for carriage of goods by overland forms of transportation such as railroads, and trucks. *See id.* at 240-51. Marine insurance policies of the type described in the *Thames* case were also used to cover such shipments of goods. *See id.* at 260-61. Based on the reasoning of the Thames case the marine insurance policies covering such shipment in interstate commerce were themselves interstate commerce. *See* Clarence G. Shenton, *Interstate Commerce During the Silence of Congress*, *in* 3 SELECTED ESSAYS ON CONSTITUTIONAL LAW 840, 868 (American Ass'n of Law Schools 1938) (recognizing that *Thames* represented a departure from the *Paul* doctrine).

43. *See* discussion of Section 29 of the Merchant Marine Act of 1920 *infra* Part I.B.2 and discussion of Section 4 of the Act *infra* Part II.B.4.

44. For a summary of federal efforts to stimulate the American shipping industry from 1789 through the 1950s, *see* GRANT GILMORE & CHARLES L BLACK, JR., THE LAW OF ADMIRALTY § 11.4 (1st ed. 1957).

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assuring the availability of marine insurance.[45] The rationale for the initial legislation was that the private market did not provide American shipping with adequate war risk coverage and as a result, "the foreign commerce of the United States is now greatly impeded."[46] The Bureau was authorized to provide federal war risk insurance for American vessels engaged in the export shipping trade.[47] It had the power to prescribe policy forms, set premium rates, adjust losses and adopt rules and regulations.[48] Any disagreements over claims were to be settled in federal admiralty court.[49] During the period from its inception through 1919, the Bureau issued more than $2 billion in insurance on ships and cargoes.[50] During 1918, it collected more premiums than any private American marine insurance carrier.[51]

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45. *See* War Risk Insurance Act, ch. 293, 38 Stat. 711 (1914).

46. War Risk Insurance Act, ch. 293, Preamble.

47. *See* War Risk Insurance Act, § 2.

48. *See id.* at §§ 3, 4, 6. The United States Shipping Board, established in 1916, was authorized to "examine into the subject of marine insurance . . . and ascertain what steps may be necessary to develop an ample marine insurance system as an aid in the development of an American merchant marine." Shipping Act of 1916, ch. 451, § 12, 39 Stat. 728, 732 (1916). The title of the Shipping Act invokes both the foreign commerce and the war powers. Shipping Act, 1916, ch. 451, 39 Stat. 728 (1916). After the United States entered World War I, the Bureau of War Risk Insurance was authorized to provide life and disability insurance for personnel of American merchant ships that the Secretary of the Treasury could require the owners of American vessels to carry, and to provide war risk insurance for vessels of friendly flags. *See* Act of June 12, 1917, ch. 26, §§ 2-6, 40 Stat. 102, 102-04 (1917); Act of July 1, 1918, ch. 145, § 1, 40 Stat. 897, 897-98 (1918). War risk insurance is a special coverage for cargo aboard ocean-going ships that protects against wartime confiscation by a government and other hazards of war. *See* INSURANCE INFORMATION INSTITUTE, HANDBOOK FOR REPORTERS 109 (1993); HUEBNER ET AL., *supra* note 42, at 212-13. Standard ocean marine insurance covers property damage to the vessel and its cargo and liabilities arising therefrom, but excludes war risk. *See* INSURANCE INFORMATION INSTITUTE, HANDBOOK FOR REPORTERS at 78, 109.

49. *See* War Risk Insurance Act, ch. 293, § 5, 38 Stat. 711, 711-12 (1914).

50. *See Marine Insurance: Hearings Before the Subcomm. of the Comm. on the Merchant Marine and Fisheries of the House of Representatives*, 66th Cong., 1st Sess. 47-48 (1919) (statement of Edward M. Peters, Acting Commissioner of Marine and Seamen's Division).

51. *See* S.S. HUEBNER, REPORT ON STATUS OF MARINE INSURANCE IN THE UNITED STATES (approved by the Committee on the Merchant Marine and Fisheries of the House of Representatives) 66th Cong., 1st Sess. at 91-93 (1920) [hereinafter House Marine Insurance Report]).

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During the period immediately preceding and during World War I, foreign, and in particular British, insurance companies wrote most of the private marine insurance coverage for American ships.[52] This dependence on foreign marine insurance carriers was thought to place American international trade at a competitive disadvantage.[53] One of the reasons that individual American marine insurance companies did not write more business on American vessels was that they did not have the capacity to assume large risks. The British and German marine insurance industries dealt with this problem by the formation of pools or syndicates.[54] However, the specter of the *Thames* case made American marine insurers fearful that such concerted action would violate of the anti-trust laws.[55] To overcome their misgivings, Congress enacted the following provision as Section 29 of the Merchant Marine Act of 1920:

> (b) nothing contained in the anti-trust laws as designated in Section 1 of the [Clayton Act] shall be construed as declaring illegal an association entered into by marine insurance companies for the following purposes: To transact a marine insurance and reinsurance business in the United States and in foreign countries and to reinsurance or otherwise apportion among its membership the risks undertaken by such association or any component members.[56]

While the focus of congressional attention in enacting Section 29 was on the role of ocean marine insurance in international trade, Section 29 is

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52. *See id.* at 24-26.

53. *See id.* at 9-12.

54. *See id.* at 10-11.

55. *See id* at 78; S. REP. NO. 86-1834, at 66 (1960); S. Rep No. 78-1112, at 6 (1944); H.R. REP. NO. 78-873, at 8 (1943).

56. Merchant Marine Act of 1920, ch. 250, § 29, 41 Stat. 988, 1000 (1920) (codified at 46 U.S.C.A. § 885(b)). Following the passage of Section 29, American syndicates were formed to pool risks. *See* 59 CONG. REC. 8600 (1920) (statement of Congressman Edmonds); HUEBNER ET AL., *supra* note 42, at 237-39. The Merchant Marine Act of 1920 invokes both the foreign commerce and war powers. *See* Merchant Marine Act of 1920, ch. 250, Preamble, 41 Stat. at 988. The provisions of the Merchant Marine Act of 1920 that involve the exercise of war powers are discussed in Part I.B.3, *infra*. A 1960 Congressional Report that reviewed the history of Section 29 stated: "Ocean Marine Insurance, both cargo and hull, is basically international commerce and under the United States Constitution is subject to regulation by the Congress of the United States." S. REP. NO. 86-1834, at 61 (1960).

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not by its terms limited to foreign commerce. The passage of Section 29 led to formation of a number of associations that cooperated in the underwriting of inland marine insurance covering interstate commerce on the Great Lakes and along the Mississippi.[57]

On the eve of United States entry into World War II, the federal government went back into the marine insurance business. The United States Maritime Commission was authorized to provide war risk and general marine coverage for American shipping.[58] In 1942, it was authorized to provide such insurance for foreign vessels and crews.[59] In addition, the Maritime Commission used its general contractual authority to underwrite commercial syndicates that provided non-war risk marine coverage.[60] At the time of the passage of the Act, marine insurance one was of the property and casualty insurance industry's larger lines of business.[61]

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57. *See* HUEBNER ET AL., *supra* note 42, at 237-38; S. REP. NO. 86-1834, at 62 (1960). The existence of these associations is a clear indication that Section 29 was understood to apply to interstate as well as foreign commerce. A number of the companies that wrote ocean marine insurance coverage also wrote inland marine insurance and/or non-maritime policies such as motor vehicle insurance, travelers baggage insurance and registered mail insurance. *See House Marine Insurance Report*, *supra* note 51, at 16, 18, 21, 40-41.

58. *See* Act of June 29, 1936, ch. 447 (adding §§ 221-228 to the Merchant Marine Act of 1936), 54 Stat. 689, 689-91 (1940) (codified at 46 U.S.C.A. § 1128).

59. *See* Act of April 11, 1942, ch. 240 (amending §§ 221-228 of the Merchant Marine Act of 1936), sec. 222, 56 Stat. 214, 214-15 (1942) (codified at 46 U.S.C.A. § 1128(a)). Section 221 (a) (1) as amended cites as the rationale for the federal government furnishing marine insurance, supporting the needs of the waterborne commerce of the United States, the war effort and the domestic economy. Congress would thus appear to be invoking the war power and the interstate commerce clause in addition to the foreign commerce clause. Disputes arising out of contracts of insurance issued by the United States were heard in Admiralty. *See* Sec. 225, 56 Stat. 214 at 215-16 (1942). *See also* Field v. United States, 113 F. Supp. 190 (Fed. Cl. 1953). In 1943, the Commission was authorized to pay servicing fees to insurance companies that acted as underwriting agents and to reimburse insurance companies for agents' fees. *See* Act of March 24, 1943, ch 26, § 3(e), 57 Stat. 45, 50 (1943) (codified at 46 U.S.C.A. § 1128(b)).

60. *See* S. REP. NO. 81-1828, at 11-12 (1950).

61. In 1945, marine insurance accounted for $250 million in annual premium income, placing it fourth among the lines of property/casualty insurance. *See* INSURANCE INFORMATION INSTITUTE, 1960 PROPERTY/CASUALTY FACT BOOK 8-19.

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3. The War Powers (U.S. CONST. art. I, § 8, cl. 11; art. II, § 2)

One of President Wilson's first acts following American entry into World War I was to issue a proclamation that the United States branches of German insurance companies could continue to do business but were prohibited from transmitting money outside the United States.[62] He issued a second proclamation that prohibited German marine insurance companies licensed by the states from continuing to conduct such business and prohibited all insurance companies doing business in the United States from reinsuring any risks with German marine insurance companies.[63] The Trading with the Enemy Act passed in October 1917 prohibited all enemy businesses from doing business in the United States unless issued a license by the President.[64] Enemy insurance companies were authorized to make application to the President, who was given the authority to "prohibit any or all foreign insurance companies from doing business in the United States" or in the alternative to "license such companies to do business upon such terms as he may deem proper."[65] On the same day, Congress authorized the Bureau of War Risk Insurance to provide a comprehensive program of life and disability insurance for military personnel.[66] The

62. *See* Proclamation re German Insurance Companies, 40 Stat. 1654, 1654-55 (April 6, 1917). The United States declared war on Germany on April 6, 1917. *See* 40 Stat. 1 (1917).

63. *See* Proclamation re German Insurance Companies, 40 Stat. at 1684, 1684-85 (June 13, 1917). This action was, no doubt, prompted by concern that information about the movements of American merchant shipping would find its way into the hands of the German military.

64. *See* Act of 1917, ch. 106, § 3, 40 Stat. 412-13 (1917) (to define, regulate and punish trading with the enemy) (codified at 50 U.S.C.A. § 3).

65. *Id.* at § 4, 40 Stat. 413 (codified at 50 U.S.C.A. § 4). The presidential proclamations cited in notes 62 and 63 were continued in effect pending the President's disposition of applications for licenses by enemy insurance companies. *See* Trading with the Enemy Act, § 4(a), 40 Stat. 413-14 (1917). The Trading with the Enemy Act was amended in November of 1918 to create the office of Alien Property Custodian. *See* An Act Making Appropriations to Supply Deficiencies in Appropriations for the Fiscal Year Ending June 30, 1919, and the Prior Fiscal Years, On Account of War Expenses, and for Other Purposes, ch. 201, 40 Stat. 1020, 1020-21 (1918). The Alien Property Custodian was held to have the authority to take possession and sell bonds that were the property of alien insurance companies despite the fact that they had been deposited with a trustee for the protection of American policyholders and creditors pursuant to state law. *See* Garvan v. $20,000 Bonds, 265 F. 477, 479-80 (2d Cir. 1920).

66. *See* Act of October 6, 1917, ch. 105, Article IV, 40 Stat. 398, 409-10 (1917). The major reason the government has provided military personnel with life insurance is that

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federal government has provided a program of permanent life and disability insurance for military personnel and veterans ever since.[67] Federal statutes and regulations issued pursuant thereto govern all aspects of these insurance programs[68] and supersede conflicting state law.[69] The Soldiers' and Sailors' Civil Relief Act enacted in 1918 provided that private insurance policies held by military personnel would not lapse, terminate or be forfeited by reason of nonpayment of premiums or policy loans, overriding the contractual provisions to the contrary contained in the policies.[70]

The Merchant Marine Act of 1920 contained a number of provisions designed to stimulate the creation of a strong, privately owned American merchant marine fleet that could serve as a naval or military auxiliary in time of war or national emergency.[71] To this end, the War Shipping Board was authorized to sell to private purchasers ships that the United States had built or seized as alien property during World War I.[72] If the ships were purchased on a deferred-payment basis, the board was authorized to prescribe the type of insurance to be maintained by purchasers, as well as

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commercial policies do not cover war risk. *See* JOHN ALAN APPLEMAN AND JEAN APPLEMAN, INSURANCE LAW AND PRACTICE, § 71 (1981). Except for the fact that its policies covered war risk, the federal life insurance program operated much like a private life insurance company. To obtain coverage, military personnel had to submit an application and pay premiums based upon the American Experience Mortality Table. *See* Act of October 6, 1917, ch. 105, Article IV, 40 Stat. 398, 409-10 (1917).

67. *See* 44 AM. JUR. 2D INSURANCE § 2057 (1982); AMERICAN COUNCIL OF LIFE INSURANCE, 1996 LIFE INSURANCE FACT BOOK at 121-22. (1997). During and immediately after the two world wars, life insurance outstanding in the U.S. under these federal programs equaled or exceeded the total amount of life insurance issued by all U.S. insurance companies. *See* Bureau of the Census, Historical Statistics of the United States, pt. 2, 1051 (1989).

68. *See* 19 GEORGE J. COUCH ET AL., COUCH CYCLOPEDIA OF INSURANCE LAW § 84:1 (2d ed. rev. vol. 1983).

69. *See id.* at § 84.2; United States v. Baker, 36 F.2d 556, 557 (9th Cir. 1929); Cassarello v. United States, 271 F. 486, 488 (M.D. Pa. 1919), *aff'd* 279 F. 396 (3d Cir. 1922).

70. *See* Soldiers' and Sailors' Civil Relief Act, ch. 20, § 405, 40 Stat. 440, 445 (1918) (codified as amended at 50 U.S.C.A. §§ 540, 547). The Civil Relief Act provided for the insurers to receive bonds of the United States as collateral for the eventual payment of the premiums and interest due. *See* Ch. 20, §§ 408-413, 40 Stat. 440, 446-47 (1918).

71. *See generally* Merchant Marine Act of 1920, ch. 250, 41 Stat. 988 (1920) (codified as amended at 46 U.S.C. §§ 861-889).

72. *See id.* §§ 5, 6 at 990-91.

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the identity of the insurance companies, forms of policies and amounts of coverage.[73]

In 1942, Congress created the War Damage Corporation that was authorized to insure all real and personal property located in the United States, its territories and possessions against damage resulting from enemy attack or the actions of the American military in resisting such attacks.[74] Basic fire insurance policies and extended coverage endorsements issued by private insurers typically did not provide protection against such hazards.[75] World War II legislation that established administrative mechanisms to control wages and avert strikes was applied to the insurance industry.[76]

4. Admiralty and Maritime Jurisdiction (U.S. CONST. art. III, § 2, cl. 1)

The Constitution's Admiralty Clause gives the federal courts exclusive jurisdiction over litigation that arises out of events that have a significant relationship to traditional maritime activities and that take place on waters that are navigable for interstate or foreign commerce.[77] The Admiralty Clause also empowers the federal courts to fashion substantive rules that are applicable in state as well as federal court,[78] and authorizes Congress to enact legislation that modifies the rules adopted by the federal courts or

73. *See id.* § 9 at 992.

74. *See* An Act to Provide For the Financing of the War Damage Corporation, to Amend the Reconstruction Finance Corporation Act, as Amended, and for Other Purposes, ch. 198, § 2, 56 Stat. 174, 175-76 (1942).

75. *See* PROCEEDINGS OF THE SEVENTY-FOURTH ANNUAL SESSION OF THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS 60-64 (1943).

76. Salaries in the insurance industry were subject to the same controls applicable to all other industries. *See* Act to Amend the Emergency Price Control Act of 1942; to aid in preventing inflation, and for other purposes, ch. 578, § 5, 56 Stat. 765, 767 (1942), as implemented by Executive Order No. 9520, 1945, U.S.C.C.S. 1217. The amount that employers could pay on account of insurance premiums on the lives of employees was restricted. *See* 32 C.F.R. 4001.1(h)(2) (1944). The War Labor Disputes Act, ch. 144, 57 Stat. 163, was applied to labor disputes in the insurance industry. *See* Paris v. Metropolitan Life Ins. Co., 68 F. Supp. 64, 69 (S.D.N.Y. 1946), *rev'd on other grounds*, 167 F.2d 834 (2d Cir. 1948), *cert. denied* 335 U.S. 827 (1948). This case is discussed *infra* in Part III.B.3.

77. *See* GRANT GILMORE & CHARLES L. BLACK, JR., *supra* note 44, §§ 1-9 - 1-13 (1957); 2 AM. JUR. 2D ADMIRALTY §§ 58-60 (1982).

78. *See* 1 RONALD D. ROTUNDA & JOHN E. NOWAK, TREATISE ON CONSTITUTIONAL LAW SUBSTANCE & PROCEDURE § 3.4 (3d ed. 1999).

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establishes entirely new rules.[79] Rules established by the federal courts and federal admiralty legislation preempt contrary state law.[80] The Supreme Court held that marine insurance contacts were subject to admiralty jurisdiction in 1871.[81] As a result, the law of marine insurance contracts was developed in the federal courts based on federal statutes and case law precedents.[82]

In 1917, the Supreme Court held that the application of state workmen's compensation insurance laws to stevedores violated the Constitution's grant of exclusive authority over maritime matters to the federal government.[83] The Court also struck down as violative of federal maritime power two subsequent federal laws that made state workmen's compensation laws applicable to maritime workers.[84] In 1927, Congress passed the Longshoremen's and Harbor Worker's Compensation Act that established a comprehensive federal workmen's compensation insurance program for workers engaged in maritime trades.[85] Employers were required either to prove that they were financially able to pay compensation or to obtain insurance coverage.[86] No insurance carrier was

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79. *See id.* Congressional authority to enact laws with respect to maritime matters can also be derived from its authority to define and punish piracies and felonies committed on the high seas, and offenses against the law of nations. *See id.*

80. *See id.*

81. *See* Insurance Co. v. Denham, 78 U.S. 1, 31-35 (1871). The decision confirmed a holding by Justice Story in DeLovio v. Boit, 7 Fed. Cas. No. 418 at 441-43 (C.C.D. Mass. 1815) (No. 3776).

82. *See* THOMAS J. SCHOENBAUM, ADMIRALTY AND MARITIME LAW § 18-2 (1987).

83. *See* Southern Pacific Co. v. Jensen, 244 U.S. 205, 217-18 (1917).

84. *See* Knickerbocker Ice Co. v. Stewart, 253 U.S. 149, 164 (1920); Washington v. W.C. Dawson, 264 U.S. 219, 228 (1924). The implication that these two decisions have with respect to the construction of Section 2(a) of the Act is discussed *infra* in Part II.B.2.

85. *See* An Act to Provide Compensation for Disability or Death Resulting from Injury to Employees in Certain Maritime Employments, and for Other Purposes, ch. 509, 44 Stat. 1424 (1927). The constitutionality of the Longshoremen's and Harbor Workers' Compensation Act was upheld in Crowell v. Benson, 285 U.S. 22 (1931). The coverage of the Longshoremen's and Harbor Worker's Compensation Act was extended to workers at military, air and naval bases outside the United States. *See* Act of August 16, 1941, Pub. L. No. 77-208, 55 Stat. 622 (1941). A treaty with Canada giving this law extraterritorial application is discussed *infra* in Part I.B.5.

86. *See* Longshoremen's and Harbor Workers' Compensation Act, ch. 509, § 32(a), 44 Stat. 1424, 1439 (1927). Most of the payments under the federal and state workmen's compensation programs are made by private insurance companies rather than by self-

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eligible to provide the required coverage unless it was approved by the United States Employees Compensation Commission, the federal agency that administered the statute.[87] The commission had the authority to revoke such approval for cause.[88] The statute provided that an employer's knowledge of an injury to an insured employee was deemed notice to the insurance carrier, that jurisdiction over an employer by the commission or any court was deemed to constitute jurisdiction over the carrier, and that the requirements in any order, finding or decision by the commission or by any court were binding upon a carrier to the same extent they were binding upon an employer.[89] All policies had to provide that the insolvency or bankruptcy of the employer would not discharge the carrier from any liability under the policy and that cancellation by the carrier was not effective until thirty days notice had been given to the employer and the commission.[90]

5. The Treaty Power (U.S. CONST. art. II, § 2, cl. 2)

In 1871, the United States entered into a treaty with Great Britain that established a tribunal of arbitration that was empowered to make monetary awards to the United States for damages inflicted on Union shipping during the Civil War by Confederate privateers operating out of ports in the British Empire.[91] Exercising its authority to implement treaties,[92] Congress established the Court of Commissioners of the Alabama Claims to hear and determine the rights of claimants to the funds.[93] Insurance companies that submitted claims were limited to recovering the amount by which the losses they suffered during the Civil War on war risks exceeded the premiums and other gains realized on war risks.[94] Insurers that operated within the Confederacy or who had not borne allegiance to the Union could not present claims.[95] During World War II, the United States

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insuring employers or from government funds. *See* BUREAU OF THE CENSUS, *supra* note 67, at pt. 1, 388, 389.

87. *See* Longshoremen's and Harbor Workers' Compensation Act, § 32 (a)(1).
88. *See id.* § 32 (b) at 1440.
89. *See id.* § 35 at 1441.
90. *See id.* § 36 at 1441-42.
91. *See* Treaty of May 8, 1871, Article VII, 17 Stat. 863 (1871).
92. *See* ROTUNDA & NOWAK, *supra* note 78, at § 6.4.
93. *See* Act of June 23, 1874, ch. 459, 18 Stat. 245 (1874).
94. *See* Act of June 23, 1874, § 12 at 247-48 (1874).
95. *See id.*

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entered into a treaty with Canada establishing the workmen's compensation benefits to be made available to American workers constructing military highways and other military projects on Canadian territory. The treaty provided that American and Canadian workers would be covered by the Longshoremen's and Harbor Workers' Compensation Act and that American insurance companies providing coverage for the workers would be exempt from Canadian taxation on premiums and income but would be registered with and approved by the Canadian Superintendent of Insurance.[96]

6. The Currency Power and the Power to Borrow (U.S. CONST. art. I, § 8, cls. 2 & 5)

The National Bank Act and other federal laws in the banking area are based on the currency power and the power to borrow money.[97] In 1916 the Comptroller of the Currency wrote to the Chairman of the Senate Banking Committee requesting the passage of legislation that would allow national banks in small towns to act as agents for the sale of insurance.[98] He asserted that there was not enough business in the small towns for national banks to operate profitably and that many of them were forced to chose between failure and charging their customers usurious rates of interest.[99] Congress acceded to his request by enacting a law authorizing national banks in towns of 5,000 persons or fewer to sell insurance.[100] This was not a trivial grant of authority. In 1916, approximately fifty-eight percent of the nation's population resided in such towns.[101] Many of the

96. *See* Agreement Respecting Workmen's Compensation and Unemployment Insurance in Connection with Construction Projections in Canada, November 2-4, 1942, U.S.-Can., pars. A(6) and C, 56 Stat. 1770, 1771-74. For a description of the provisions of the Longshoremen's and Harbor Workers' Compensation Act relating to insurance, *see supra* Part I.B.4.

97. *See* Hudspeth v. Mellville, 127 F.2d 373, 375 (10th Cir. 1941).

98. 64 CONG. REC. 1101 (1916) (letter of June 8, 1916, from John Skelton Williams, Comptroller of the Currency to United States Senator Robert L. Owen [hereinafter "Skelton Letter"]).

99. *See* Skelton Letter, *supra* note 98.

100. *See* Federal Reserve Act Amendments, ch. 461, 39 Stat. 752, 753-54 (1916) (codified as amended at 12 U.S.C. § 92 (1994)). The Skelton Letter, *supra* note 98, requested that national banks located in towns having a population of 3,000 or fewer be allowed to sell insurance, but the legislation as enacted set the population cutoff at 5,000.

101. *See* BUREAU OF THE CENSUS, *supra* note 67, pt. I at 11.

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more than 7,500 national banks in existence at the time[102] were located in towns of 5,000 persons or fewer.[103] Equally important in assessing the breadth of this assertion of federal authority over insurance is the language in the statute providing that such activities shall be carried out "under such rules and regulations as shall be prescribed by the Comptroller of the Currency."[104]

Other exercises of the same constitutional powers were the establishment of deposit insurance for commercial banks through the Federal Deposit Insurance Corporation ("FDIC")[105] and for savings and loan associations through the Federal Savings and Loan Insurance Corporation.[106] When the FDIC began operation it covered 14,146 institutions with deposits of $46 billion.[107] The federal deposit insurance programs competed with a state deposit insurance program[108] in the state of Massachusetts.

7. Exercising a Sovereign Prerogative–The Federal Priority Statute

When the United States declared its independence from the British crown, it succeeded to certain powers that are the prerogatives of all sovereign nations.[109] These powers exist independently of those conferred on the federal government by the Constitution. However, they become operative only after Congress has passed legislation declaring its intent that they be exercised.[110] The federal priority statute claims for the federal

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102. *See id.*, pt. II at 1025.

103. *See* Skelton Letter, *supra* note 98.

104. Federal Reserve Act Amendments, ch. 461, 39 Stat. 752, 753 (1916) (codified as amended at 12 U.S.C. § 92 (1994)).

105. *See* Banking Act of 1933, ch. 89, § 8, 48 Stat 162, 168-80 (1933).

106. *See* National Housing Act, ch. 847, tit. IV, 48 Stat. 1246, 1255-61 (1934).

107. *See* FEDERAL DEPOSIT INSURANCE CORPORATION, STATISTICS ON BANKING 1997, A-2, A-3 (1998).

108. *See* An Act Providing for the Establishment of a Fund for the Insurance of Deposits in Certain Savings Banks, 1934 Mass. Acts 43.

109. *See* Late Corp. of the Church of Jesus Christ of Latter-Day Saints v. United States, 136 U.S. 1, 56-57 (1890).

110. *See* United States v. State Bank of N.C., 31 U.S. 29, 35 (1832); Treasure Salvors, Inc. v. Unidentified & Abandoned Sailing Vessel, 569 F.2d 330, 340 (5th Cir. 1978); H. R. Rep. No. 514 (II) (1988), *reprinted in* 1988 U.S.C.C.A.N. 370, 375 (report accompanying the Abandoned Shipwreck Act of 1987); O. John Alpizar, *Sovereign Rights and Sunken Treasure:* Treasure Salvors, Inc. v. Unidentified and Abandoned Sailing Vessel, 7 CAP. U.

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government one of those prerogatives–the "sovereign prerogative to require that the debts owed it be paid before the debts owed other creditors."[111] It provides that unsecured debts due the United States are entitled to a first preference in the event of insolvency not administered under the Bankruptcy Code.[112] This statute has been the focal point of litigation involving conflicting state insurance laws, both before and after the passage of the Act. Therefore, it is essential that the authority upon which it rests be correctly identified.

The federal priority statute has existed in substantially the same form since 1797.[113] The fact that it is a codification of a sovereign prerogative rather than the exercise of a power granted to Congress by the Constitution has been recognized throughout its existence.[114] The priority statute is clearly not an exercise of commerce clause authority. It applies to individual insolvencies including decedents' estate proceedings.[115] Federal

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L. REV. 75, 78-79; (1977-1978); Paxton Blair, *The Priority of the United States in Equity Receiverships*, 39 HARV. L. REV. 1, 2-3 (1925-1926).

111. United States v. Moore, 423 U.S. 77, 80 (1975). Among other federal statutes based on sovereign prerogatives are (i) The Abandoned Shipwreck Act of 1987, 43 U.S.C. §§ 2101-2106 (1995); H.R. REP. NO. 514(II) (1988) (claiming for the states abandoned shipwrecks located in submerged lands or in coralline formations); and (ii) An Act to Punish and Prevent the Practice of Polygamy in the Territories of the United States and Other Places, and disapproving and annulling certain Acts of the Legislative Assembly of the Territory of Utah, ch. CXXVI, § 3, 12 Stat. 501, 501-02 (1862) (escheating to the United States real property located in a territory owned by a religious corporation that exceeds $50,000 in value); *see* Late Corp. of the Church of Jesus Christ of Latter-Day Saints, 136 U.S. at 19, 46-48 (1890).

112. *See* Act of March 3, 1797, § 5, 1 Stat. 515 (1845) (codified as amended at 31 U.S.C. § 3713) (1982)).

113. *See* Blair, *supra* note 110, at 1; Frank P. Darr, *Federal Claims in Insurance Insolvencies*, 25 TORT & INS. L.J. 601, 623-24 (1990).

114. *See* United States v. Moore, 423 U.S. 77, 80 (1975); United States v. Romani, 118 S. Ct. 1478, 1483 (1998); United States v. State Bank of N.C., 31 U.S. 29, 35 (1832); Blair, *supra* note 110, at 2-3; O. John Rogge, *The Differences in Priority of the United States in Bankruptcy and Equity Receiverships*, 43 HARV. L. REV. 251, 251 (1929-1930). *But cf.* United States Dep't of the Treasury v. Fabe, 508 U.S. 491, 507 & n. 7 (1993).

115. *See* Department of Agric. v. Remund, 330 U.S. 539 (1947); Viles v. Commissioner of Internal Revenue, 233 F. 376 (6th Cir. 1956); United States v. Boots, 675 F. Supp. 550 (E.D. Mo. 1987); United States v. Snyder, 207 F. Supp. 189 (E.D. Pa. 1962). The priority statute is just as clearly not an exercise of federal authority to enact bankruptcy laws. It had been interpreted as being inapplicable in proceedings under the Bankruptcy Code. *See* 1 COLLIER ON BANKRUPTCY § 5.22(a) (15th ed. 1996). In 1978, it was amended to specifically so provide. *See* Pub. L. No. 95-598, § 322(a), 92 Stat. 2459, 2678 (1978)

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commerce clause authority would not have supported the application of federal control over matters so local in nature at the time the priority statute was enacted, and probably would not do so today.

In 1936, the Supreme Court held unanimously in *United States v. Knott* that the United States was entitled to enforce the priority statute in a state insurance company insolvency proceeding and to prevail over other claimants despite a holding to the contrary by the highest court of the state.[116] The *Knott* decision confirmed that congressional authority over insurance could be based on sovereign prerogatives as well as the non-commerce clause powers granted by the Constitution.

8. Bankruptcy (U.S. CONST. art. I, § 8, cl. 4)

Insurance companies are excluded from the definition of "debtor" under the Bankruptcy Code.[117] However, this reflects congressional policy rather than a lack of constitutional authority. The Bankruptcy Act of 1867 applied to "moneyed, business or commercial corporations," and insurance insolvencies were administered in the federal bankruptcy courts subsequent to the *Paul* decision.[118] A 1910 amendment to the Bankruptcy

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(codified at 31 U.S.C. § 3713(a)(2)). The priority statute does not have the characteristics of a bankruptcy law. It does not it establish a scheme for marshalling and distributing the assets of insolvent debtors and discharging their obligations. Its limited objective is to provide the United States with an adequate flow of revenue by giving it priority over other creditors in insolvencies that occur outside of the purview of the Bankruptcy Act. *See* United States v. Emory, 314 U.S. 423, 426 (1941); United States v. Moore, 423 U.S. at 81-82 (1975); United States v. State Bank of N.C., 31 U.S. at 35. *But cf.* Barnett Bank of Marion County v. Nelson, 517 U.S. 25, 42 (1996) (appears to be referring to the priority statute although it is not specifically identified).

116. *See* United States v. Knott, 298 U.S. 544 (1936); *but cf.* Conway v. Imperial Life Ins. Co., 21 So. 2d 151 (La. 1945). The court in *Conway* agreed that the priority statute was applicable to state administered insolvency proceedings, *see id.* at 152-53, but construed the statute as inapplicable to a perfected lien. *See id.* at 153-55. In 1993, the Supreme Court held in *United States Department of the Treasury v. Fabe* that the Act's preemption exception caused a state insurance insolvency statute to prevail over the priority statute to the extent that the state statute preferred the costs of administering the estate and the claims of policyholders over those of the United States. *See* Fabe, 508 U.S. at 493, 508-10. The Court misperceived the priority statute as a commerce clause-based law. *See* discussion *infra* Part III.B.7.

117. 11 U.S.C. § 109 (b)(2).

118. *See* In re Merchants' Ins. Co., 17 F. Cas. 41 (N.D. Ill. 1871) (No. 9,444); In re Hercules Mut. Life Assur. Soc., 12 F. Cas. 12 (S.D.N.Y. 1872) (No. 6,402); In re Independent Ins. Co., 13 F. Cas. 13 (C.C. Mass. 1872) (No. 7,017).

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Act of 1898 limited its scope to corporations engaged in "manufacturing, trading or mercantile pursuits."[119]

9. The Census (U.S. CONST. art. I, § 1, cl. 3; Fourteenth Amendment)

The legislation providing for the taking of the census of 1880 specifically authorized the Census Bureau to obtained detailed financial information from insurance companies.[120] When the Bureau of Commerce and Labor was established in 1903, it was given authority to "gather, compile, publish and supply useful information concerning corporations doing business within the limits of the United States as shall engage in interstate commerce or in commerce between the United States and any foreign country, including corporations engaged in insurance . . . ."[121]

10. Governing the District of Columbia (U.S. CONST. art. I, § 8, cl. 17)

Congress utilized its authority over the District of Columbia ("District") to establish the same type of regulatory scheme for insurance activities as existed within each of the states. Insurance companies incorporated in the District as well as companies incorporated elsewhere and doing business within the District were subject to federal licensing, reporting and financial soundness requirements.[122] In 1922, Congress passed an act to regulate marine insurance in the District that was part of the overall federal policy of promoting the growth of the American marine

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119. An Act to Establish a Uniform System of Bankruptcy Throughout the United States, ch. 412, § 3, 36 Stat. 838, 839 (1910). In 1873, the Bankruptcy Act was amended to provide that if an insurance company was the subject of prior state insolvency proceedings, a court order made pursuant to state law would be valid despite the institution of proceedings under the Bankruptcy Act. *See* An Act to Amend the Bankruptcy Act, ch. 135, 17 Stat. 436 (1873).

120. *See* An Act to Provide for Taking the Tenth and Subsequent Censuses, ch. 195, § 17, 20 Stat. 473, 479 (1879); BUREAU OF THE CENSUS, *supra* note 67, pt. II at 1050.

121. An Act to Establish the Department of Commerce and Labor, ch. 552, § 6, 32 Stat. 825, 827-28 (1903).

122. *See* An Act to Regulate Insurance in the District of Columbia, ch. 46, 24 Stat. 366 (1887); An Act to Establish a Code of Law for the District of Columbia, ch. 854, 31 Stat. 1189, 1289 (1901) (establishing a department of insurance with full regulatory powers).

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insurance industry.[123] The law was designed to stimulate marine insurance activities within the District by providing for the incorporation of reinsurance companies and companies that would do only international business, subject to few regulatory restrictions.[124] It allowed marine insurance companies to diversify risk by writing other lines of insurance and taxed their profits rather than their premium receipts.[125] The law was designed to serve as a model for the states and to prod them into eliminating provisions in their laws that Congress felt were inhibiting the development of the domestic marine insurance industry.[126] In 1928, Congress extended the workmen's compensation insurance system established by the Longshoremen's and Harbor Workers' Act to most workers employed in the District of Columbia.[127]

11. Due Process and Equal Protection (Fourteenth Amendment)

The *Paul* doctrine had no effect on the Supreme Court's application of due process and equal protection limitations to state insurance legislation. Between 1897 and 1938, the Supreme Court rendered nine decisions striking down state insurance laws.[128] These statutes regulated or taxed

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123. *See* An Act to Regulate Marine Insurance in the District of Columbia, and for Other Purposes, ch. 93, 42 Stat. 401 (1922); Hearings on H.R. 175 Before the Committee on the District of Columbia, 67th Congress, 1st Sess. 4 (statement of Prof. Huebner) [hereinafter "*District Marine Insurance Hearings*"]; House Marine Insurance Report, *supra* note 51, at 75-80.

124. *See* An Act to Regulate Marine Insurance in the District of Columbia, and for Other Purposes, ch. 93, Title II, Title III, Title VIII, 42 Stat. 401, 402-05, 411; *District Marine Insurance Hearings*, *supra* note 123, at 9 (statement of Prof. Huebner).

125. *See* An Act to Regulate Marine Insurance in the District of Columbia, and for Other Purposes, ch. 93, Titles II and V, 42 Stat. 401, 402, 405 (1922).

126. *See District Marine Insurance Hearings*, *supra* note 123, at 10, 13 (statement of Prof. Huebner).

127. *See* An Act to Provide Compensation for Disability or Death from Injury to Employees in Certain Employments in the District of Columbia and for Other Purposes, ch. 612, 45 Stat. 600 (1928). For a description of the provisions of the Longshoremen's and Harbor Workers' Act *see supra* Part I.B.4.

128. *See* Connecticut Gen. Life Ins. Co. v. Johnson, 303 U.S. 77 (1938) (striking down on due process grounds California's imposition of a tax on reinsurance premiums received by a Connecticut life insurance company in Connecticut representing compensation for reinsuring life insurance risks on California residents); Hartford Steam Boiler Inspection & Ins. Co. v. Harrison, 301 U.S. 459 (1937) (striking down on equal protection grounds a Georgia statute that allowed mutual insurance companies to solicit business within the state

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interstate aspects of insurance company activities that had minimal contact with the state, or utilized impermissible classifications.[129] These decisions are in a sense a product of the *Paul* doctrine. If it were not for *Paul*, these cases might well have been disposed of on commerce clause grounds, or the states might not have attempted to exercise this type of control over interstate commerce.

12. The National Policy with Respect to Marine Insurance

Thus far, this discussion of federal exercise of authority over insurance has been segmented by the discrete categories of non-commerce clause

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through salaried employees but prohibited stock companies from doing so); Hanover Fire Ins. Co. v. Harding, 272 U.S. 494 (1934) and Concordia Fire Ins. Co. v. Illinois, 292 U.S. 535 (1934) (striking down on equal protection grounds statutory provisions that taxed the premium receipts of out-of-state insurance companies as personal property but denied them the 40 percent abatement allowed in computing the tax on other forms of personal property, and that taxed fire, marine and inland insurance companies, but not property and casualty companies, on receipts from the same types of policies); Fidelity & Deposit Co. of Maryland v. Tayofa, 270 U.S. 426 (1926) (striking down on due process grounds a statute that provided for the revocation of an insurance company's license if it paid a commission to an out-of-state agent in connection with the sale of insurance on property located within the state); St. Louis Cotton Compress Co. v. Arkansas, 260 U.S. 346 (1922) (striking down as violative of the Fourteenth Amendment a statute that required a corporation doing business in the state to pay a tax based on premium payments made outside the state for coverages on its in-state properties to an insurance company not authorized to do business in the state); New York Life Ins. Co. v. Dodge, 246 U.S. 357 (1918) (striking down on due process grounds the application of a Missouri nonforfeiture statute to a loan on a life insurance policy made in New York to a Missouri policyholder); Provident Savings Life Assurance Society v. Kentucky, 239 U.S. 103 (1915) (striking down on due process grounds a statute requiring insurance companies to continue to file financial reports and pay taxes after they have stopped soliciting new business and collecting premiums within the state); Allgeyer v. Louisiana, 165 U.S. 578 (1897) (striking down on due process grounds a statute that prohibited residents of the state from filling out forms for the purpose of obtaining insurance coverage from nonqualified out-of-state insurance companies). Cf. Compania General De Tabacos De Filipinas v. Collector of Internal Revenue, 275 U.S. 87 (1927). In that case, the Supreme Court struck down a Philippine statute that taxed a company doing business in the Philippines on premiums paid in Spain to an insurance company not authorized to do business in the Philippines. *See id.* at 98. The basis of the decision was the Philippine Organic Act by which Congress imposed on the Philippine legislature the same restriction that the due process and equal protection clauses impose on state legislatures. *See id.* at 91. The authority for the Philippine Organic Act is Article IV, Section 3 of the U.S. Constitution, which gives Congress the power to make rules and regulations respecting territories.

129. *See* cases cited *supra* note 128.

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federal power. However, these separate grants of authority could be combined to achieve a single federal policy objective. This is illustrated by the manner in which a national policy for the marine insurance industry was formulated and implemented. In February 1920, the House Committee on the Merchant Marine and Fisheries approved a report that painted a gloomy picture of the marine insurance industry in the United States and made a set of recommendations to address its problems.[130] The report found that marine insurance was a weapon the nation needed to compete for foreign trade[131] but that two-thirds of the American marine insurance market was in the hands of foreign companies.[132] It placed the blame for the weakness of the American marine insurance industry primarily on the fact that state regulation of the industry was designed to further state rather than national interests.[133] In particular, it was critical of state laws that prevented marine insurance companies from forming combinations for cooperative action, denied marine insurance companies the right to diversify by writing other types of insurance, and taxed marine insurance companies on gross premiums rather than net profits.[134] The report also urged the American marine insurance industry to form cooperative arrangements that would enable it to underwrite larger coverages, spread risks and achieve a stronger competitive position.[135] The committee indicated that if the industry were willing to take this step, it would support the following federal program to strengthen the marine insurance industry: (1) the United States Shipping Board, which had acquired title to hundreds of ships during World War I would place its marine insurance business with American marine insurance companies;[136] (2) enactment of an exemption from the federal antitrust laws for marine insurance industry cooperative underwriting activities;[137] (3) repeal of the one percent federal tax on marine insurance premiums, and;[138] (4) enactment of a liberal marine insurance law for the District of Columbia

130. *See* House Marine Insurance Report, *supra* note 51.
131. *See id.* at 9-12.
132. *See id.* at 1-19, 24-33.
133. *See id.* at 76-77.
134. *See id.*
135. *See id.* at 77.
136. *See id.* at 77-78.
137. *See id.* at 78.
138. *See* Revenue Act of 1918, ch. 18, § 503, 40 Stat. 1057, 1104 (1919).

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that would serve as a model for, and bring pressure on, the states.[139] The committee and the Chairman of the United States Shipping Board addressed a joint letter to the governors and insurance commissioners of each of the states setting forth the specific changes they wished to see made in state law.[140] The letter concluded with a rather blunt threat to the American marine insurance industry and the states:

> The national welfare must be the first consideration. Should the contingency arise that American companies will fail or refuse to cooperate on a comprehensive scale, then your committee is decidedly of the opinion that the Government should remain in the marine insurance business even to the extent of greatly enlarging its operations.[141]

All of the committee's proposals for congressional action were adopted.[142] The United States Shipping Board did direct its marine insurance business to American companies,[143] and the federal government went out of the marine insurance business until the eve of World War II.[144] The states largely acquiesced in the federal government's preeminent role with respect to marine insurance by withdrawing from rate setting and the regulation of unfair competitive practices.[145]

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139. *See* House Marine Insurance Report, *supra* note 51, at 78.

140. *See id.* at 83-84; U.S. Shipping Board Fourth Ann. Rep. 46 (1920).

141. House Marine Insurance Report, *supra* note 51, at 80.

142. *See* The Merchant Marine Act, 1920, ch. 250, § 29, 41 Stat. 988, 1000 (1920) (codified at 46 App. U.S.C.A. § 885) (giving the marine insurance industry an exemption from the federal antitrust laws for cooperative activities). Upon passage of this legislation, the marine insurance industry did form risk syndicates as had been suggested by the Committee. *See* 59 CONG. REC. 8600 (1920); U.S. Shipping Board Fourth Annual Report 43-46 (1920). The Revenue Act of 1921, ch. 136, § 1400 (a), 42 Stat. 320, 320 (1921) repealed the federal tax on insurance premiums. An act to regulate marine insurance in the District of Columbia, and for other purposes, ch. 93, 42 Stat. 401 (1922) was the marine insurance law for the District of Columbia that was intended as a model for state legislation.

143. *See* U.S. Shipping Board Fourth Ann. Rep. 44-46 (1920); U.S. Shipping Board Sixth Ann. Rep. 38-40 (1922).

144. The authority of the Bureau of War Risk Insurance to provide marine insurance pursuant to the War Risk Insurance Act expired in 1921. *See* An Act to Authorize the Establishment of a Bureau of War Risk Insurance in the Treasury Department, ch. 26, § 9, 40 Stat. 102, 105 (1917).

145. A Congressional Report issued in 1960 stated: "Ocean Marine Insurance, both cargo and hull, is basically international commerce and under the United States Constitution

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13. Summary

The *Paul* case did not inhibit in any way the exercise of non-commerce clause powers over insurance. These assertions of federal authority involved all three branches of government and affected every aspect of the business of insurance. They included (1) the taxation of all aspects of the insurance business; (2) the establishment and operation of federal programs that insured American and foreign ships, their cargoes and personnel, the lives of American military personnel, real and personal property located in the United States, and the deposits of commercial banks and savings and loan institutions; (3) the enactment of a provision of the antitrust laws specifically tailored to marine insurance; (4) the revocation of the authority of state-licensed foreign insurance companies to do business within the United States; (5) the establishment of insurance requirements for vessels purchased from the federal government; (6) the nullification of lapse provisions in private life insurance contracts covering military personnel; (7) the application to the insurance industry of administrative controls over wages and compulsory procedures for the resolution of labor disputes; (8) the development by the federal courts of a body of law governing the resolution of disputes arising from marine insurance contracts; (9) the enactment of workman's compensation insurance legislation covering longshoremen and harbor workers and workers employed in the District of Columbia; (10) the negotiation of treaties providing for the extraterritorial application of workman's compensation legislation covering longshoremen and harbor workers and for the allocation of reparations among insurance companies; (11) the enactment of legislation authorizing national banks to sell insurance pursuant to regulations issued by the Comptroller of the Currency; (12) the enforcement of the federal priority statute in insurance company insolvencies; (13) the application of the federal bankruptcy law to insurance companies; (14) the enactment of legislation requiring insurance

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is subject to regulation by the Congress of the United States." S. REP. NO. 86-1834, at 61 (1960). The report goes on to quote a bulletin issued by the American Institute of Marine Insurance Underwriters to its members stating that "in general, state laws do not regulate marine insurance." *Id.* at 62; *see also* JULIUS S. WIKLER, A STATE OUTLOOK, PROCEEDINGS OF THE NEW YORK CITY BAR ASSOCIATION 200, 202-03 (1960). Wikler served as Counsel to the NAIC'S Committee on the Preservation of State Regulation. *See infra* note 160; *see also* An Act in Relation to Corporations, ch. 882, 1939 N.Y. Laws § 187.1 (excluding marine insurance from rate regulation).

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companies to submit financial and other data to federal agencies; (15) the establishment of a comprehensive insurance regulatory system for companies incorporated in, or doing business within, the District of Columbia; and (16) the development and implementation of a national policy with respect to the marine insurance industry.[146] In addition, the Supreme Court vigorously applied due process and equal protection limitations to state insurance law.[147] The foregoing demonstrates the distance between reality and the statement that the business of insurance was "largely immune from federal regulation."[148]

When faced with a conflict between the federal non-commerce clause authority over insurance and state law, the courts upheld federal law.[149] Ironically, the only exercises of federal regulatory authority over the insurance industry that failed to pass constitutional muster were two attempts by Congress to make state workmen's compensation laws applicable to maritime workers in derogation of the federal admiralty power.[150]

C. State Regulation of Insurance During the Paul-SEUA *Era*

The core elements of early state insurance regulation were the licensing of the insurance companies, insurance agents and brokers; the imposition of taxes and fees; and the requirement that insurers submit financial information.[151] Out-of-state and foreign insurance companies were often subjected to more stringent rules than domestic companies.[152]

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146. *See* House Marine Insurance Report, *supra* note 51, at 78.

147. *See* discussion *supra* Part I.B.11.

148. *Supra* note 25 and accompanying text. By 1922, the volume of federal insurance legislation had grown to the point that the Government Printing Office issued a pamphlet discussing it. *See* Laws of Sixty-fifth, Sixty-sixth, and Sixty-seventh congresses relating to insurance (Washington, Government Printing Office 1922).

149. *See* United States v. Knott, 298 U.S. 544 (1936); Southern Pacific Co. v. Jensen, 244 U.S. 205, 217 (1917); United States v. Barker, 36 F.2d 556, 557 (9th Cir. 1929); Garvan v. $20,000 Bonds, 265 F. 477, 479-80 (2d Cir. 1920); Quality Coal Co. v. United States, 66 F. Supp. 105, 107 (W.D. Ark. 1946); Cassarello v. United States, 271 F. 486, 488 (M.D. Pa. 1919), *aff'd* 279 F. 396 (3d Cir. 1922).

150. *See* Washington v. W.C. Dawson, 264 U.S. 219, 228 (1924); Knickerbocker Ice Co. v. Stewart, 253 U.S. 149, 164 (1920). The Thames case struck down the application of a stamp tax on insurance polices, only as applied to marine insurance policies. *See* Thames & Mersey Marine Co. v. United States, 237 U.S. 19, 26-27 (1915).

151. *See* DAY, *supra* note 15, at 5-6, 10-11; Nehemkis, *supra* note 15, at 523-24.

152. *See* DAY, *supra* note 15, at 7.

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As the business of insurance became more complex, the states attempted to keep pace. More powers were conferred on insurance commissioners, particularly with respect to the types of financial information they could request from insurers.[153] To preserve the stability and solvency of insurance companies, regulators were given oversight powers with respect to policy reserve levels, valuation of assets, investment policies, consolidations and changes in capitalization.[154] The increase in sales of insurance to individuals and the obvious disparity in bargaining power and ability to understand the meaning of insurance policies led to controls over policy forms and marketing practices.[155]

The manner in which the fire insurance industry operated made it very difficult for the states to regulate its activities effectively. Competition among fire insurance companies was fierce. The agents who generated the business had no financial stake in the companies and no motivation to avoid bad risks–they earned commissions from bad risks as well as good.[156] As a result, when major fires occurred, many companies did not have the resources to pay claims and declared bankruptcy.[157] The solution adopted by the industry was to set rates collectively for both premiums and agent fees. This started with local or regional rating bureaus and culminated in the establishment of the National Bureau of Fire Underwriters in 1866.[158] While rates set in this way might not be so low as to precipitate insurance company failures, there was no guaranty that they might not be unfairly high. A number of states responded by passing anti-compact laws that prohibited collective ratemaking.[159] The states also recognized that if they were to deal effectively with an industry that was organized on a nationwide basis they would have to act cooperatively. In 1871, a nationwide organization of state insurance commissioners was founded. This evolved into the National Association of Insurance Commissioners

153. *See* DAY, *supra* note 15, at 11-12. A description of administrative oversight in the areas of licensing, policy forms, rates and premiums, payment of claims and business-getting methods is contained in EDWIN WILHITE PATTERSON, THE INSURANCE COMMISSIONER IN THE UNITED STATES, ch. III (1927).

154. *See* DAY, *supra* note 15, at 12; *see also* KENNETH J. MEIER, THE POLITICAL ECONOMY OF REGULATION THE CASE OF INSURANCE 59, 61-62 (1988).

155. *See* DAY, *supra* note 15, at 12-13.

156. *See* MEIER, *supra* note 154, at 51-52.

157. *See id.*

158. *See id.* at 51.

159. *See id.* at 54; DAY, *supra* note 15, at 8-9.

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("NAIC").[160] Ever since, the NAIC has served as the focal point for cooperation among the states in matters of insurance regulation.[161] It has also drafted and obtained the enactment of numerous uniform laws.[162]

The San Francisco earthquake of 1906 and the ensuing fires caused many insurance companies to declare bankruptcy. The remaining companies instituted large rate increases.[163] The Merritt Committee, a committee of the New York legislature, set out to investigate the problem. The insurance companies were able to convince the committee that the real problem was the rate competition fostered by state anti-compact legislation.[164] They contended that such competition resulted in rates that were too low to enable companies to accumulate the necessary reserves to deal with disasters like the San Francisco earthquake.[165] New York, the most important insurance jurisdiction, enacted a law that authorized fire insurance rates to be set by an industry bureau.[166] The rates were filed with the insurance commissioner, and, if not found to be discriminatory, could lawfully be charged.[167] A number of states followed New York's lead with respect to fire insurance, and the concept of collective rate making was also adopted with respect to other forms of property and casualty insurance.[168] This not only reversed the philosophy of the anti-compact laws, but it set state insurance regulation on a collision course with the

160. *See* S. REP. NO. 86-1834, at 4837, 4839 (1960) (State Regulation of Insurance, a statement by Julius S. Wikler and Donald Knowlton [hereinafter "State Regulation of Insurance"]. Wikler and Knowlton were counsel and chairman, respectively, of the NAIC's Committee on Preservation of State Regulation. *See id.* at 4837.

161. *See* State Regulation of Insurance, *supra* note 160, at 48, 48-58; PATTERSON, *supra* note 153, at 461-65.

162. *See* State Regulation of Insurance, *supra* note 160, at 4859, 4863-64; MEIER, *supra* note 154, at 60-61; PATTERSON, *supra* note 153, at 461-64.

163. *See* MEIER, *supra* note 154, at 59.

164. *See id.* at 59-60; DAY, *supra* note 15, at 20.

165. *See* DAY, *supra* note 15, at 18-20.

166. *See* MEIER, *supra* note 154, at 60; DAY, *supra* note 15, at 18-20.

167. *See* MEIER, *supra* note 154, at 60; DAY, *supra* note 15, at 20.

168. *See* MEIER, *supra* note 154, at 60-61; MERTZ, *supra* note 24, at 9. The NAIC supported the concept of collective rate making under the aegis of state law for the fire insurance industry and other lines of property and casualty insurance. *See* DAY, *supra* note 15, at 20. For a description of how collective rate making worked, *see* State Regulation of Insurance, *supra* note 160, at 4869-70.

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federal antitrust laws.[169] Resolving the conflict between the state-sanctioned collective setting of insurance rates and the federal antitrust laws proved to be the most difficult issue Congress faced in coming to agreement on the Act.[170]

As the insurance industry grew during the twentieth century,[171] so did the business of insurance regulation and the power and influence of the NAIC.[172] By the time of the *SEUA* decision, taxation of the insurance industry yielded hundreds of millions of dollars in tax receipts to the states.[173] Interstate operations were responsible for a significant portion of that revenue.[174]

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169. Collective rate making was never universal for all lines of property and casualty insurance, and it was never used to set life insurance rates. *See* MEIER, *supra* note 154, at 60; DAY, *supra* note 15, at 21-22. There was a good deal of variation in the degree of control and/or participation that the states had with respect to the collective rate making-process. *See* DAY, *supra* note 15, at 22-23; State Regulation of Insurance, *supra* note 160, at 4871-73.

170. *See* MERTZ, *supra* note 24, at 5-6; R.K. Powers, *A Year of SEUA*, XXIII CHI.-KENT L. REV. 317, 322-25 (1944-1945).

171. The amount of life insurance in force in the United States grew from $7.6 billion in 1900 to $151.8 billion in 1945. *See* AMERICAN COUNCIL OF LIFE INSURANCE, 1998 LIFE INSURANCE FACT BOOK 21 (1998). Total income of life insurance companies grew from $836 million in 1911 to $7.7 billion in 1945. *See id.* at 69. The assets of stock insurance companies grew from $799 million in 1910 to $6.4 billion in 1945. *See* BUREAU OF THE CENSUS, *supra* note 67, pt. 2 at 1065.

172. For a description of the NAIC's role in fostering cooperation among state regulators and obtaining the passage of model legislation, *see supra* notes 161 and 162 and accompanying text. In 1921, the federal government adopted a system of accounting rules developed by the NAIC for the purpose of calculating federal income taxes payable by insurance companies. *See* MEIER, *supra* note 154, at 127; *cf.* Hanover Ins. Co. v. Commissioner, 598 F.2d 1211, 1213 (1st Cir. 1979). The NAIC also served as the voice of the insurance regulatory establishment, taking public positions on a broad range of issues affecting the insurance industry and insurance regulation. *See infra* note 194; *see also* THE TRAVELERS INSURANCE COMPANY, INDEX OF THE FIRST EIGHTY SESSIONS OF THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS 150-59, 175-91 (topics listed under headings "Executive Committee" and "Committee on Laws and Legislation") (1950).

173. The figure for 1942 was $113 million. *See* 89 CONG. REC. 6548 (1944). The figure for 1943 was $123 million. *See* United States v. South-Eastern Underwriters Ass'n, 322 U.S. 553, 590 (1944). Even under the most sweeping interpretation of *SEUA*, the states would not completely lose the power to tax insurance companies. *See SEUA*, 322 U.S. at 547-49; Nathan R. Berke, *A Legal-Economic Discussion of the "SEUA" and "Polish National Alliance" Cases*, 258 INS. L.J. 394, 394-95 (1944).

174. *See SEUA*, 322 U.S. at 541-42.

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A look back at the way in which federal and state insurance law developed during the *Paul-SEUA* era yields an explanation for the modern myth that the federal government had not exercised meaningful authority over insurance. Every state had an extensive set of insurance laws, grouped in a single volume or title, administered by a single regulatory official or agency.[175] No comprehensive federal statutory scheme regulated the insurance industry on a day-to-day basis. The *Paul* decision suggested that such a system could not exist because the federal government lacked commerce clause authority over insurance. The federal insurance laws were scattered throughout the United States Code, were administered by various federal agencies, and, in some cases, remained in force for a limited period of time. The two dozen Supreme Court cases of the *Paul-SEUA* era that sustained or rejected constitutional challenges to state insurance laws contained a wealth of information about the state regulatory system.[176] Federal insurance laws were, for the most part, not litigated. No comparable body of information about their operation resided in the case law of the period. This combination of factors made it seem safe to assume, without bothering to investigate, that the federal government exercised minimal authority over the business of insurance.

D. The SEUA *Case*

SEUA is one of the Supreme Court's most celebrated reversals of an established precedent.[177] The Court held that the business of insurance was not only commerce,[178] but that it was interstate commerce.[179] This made

175. *See* PATTERSON, *supra* note 153, at ch. II-IV; 29 AM. JUR. §§ 22-43 (1940)

176. *See supra* notes 22 and 128 and cases cited therein. The Court rejected equal protection and due process challenges to state insurance laws in German Alliance Ins. Co. v. Lewis, 233 U.S. 389, 416 (1914) (upholding state law setting fire insurance rates); National Union Fire Ins. Co. v. Wanberg, 260 U.S. 71, 75 (1922) (upholding a state law requiring insurance companies to accept or reject applications for hail insurance within twenty-four hours after an application was taken by a local agent); Firemen's Ins. Co. of Newark, v. Conway, 278 U.S. 580 (1929) (per curiam), *aff'g* 30 F.2d 539 (S.D.N.Y. 1928) (upholding the application of New York law to the investment portfolio of a foreign insurer doing business in New York).

177. *See SEUA*, 322 U.S. 533 (1944) (four-to-three decision), *rev'g* Warlich v. Miller, 51 F. Supp. 71 (W.D. Pa. 1943). The Court's reversal of the venerable *Paul* case upon the vote of only four of the justices brought forth a stream of criticism. *See* Kimball & Heaney, *supra* note 25, at 8 n. 24.

178. *See SEUA*, 322 U.S. at 552-53.

179. *See id.*

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the actions of insurance companies and their employees subject to the Sherman Act.[180] The decision sustained criminal indictments against nearly 200 stock fire insurance companies and twenty-seven individuals.[181] The defendants, members of the South-Eastern Underwriters Association ("Association"), a rating bureau that controlled ninety percent of the fire insurance market in six southeastern states, were charged with using boycotts, coercion and intimidation to force companies and agents to accept the rates established by the Association.[182] State laws that authorized collective ratemaking would not have sanctioned these actions.[183] However, the decision raised the implication that state laws that allowed collective action as part of the rate-setting process might violate the antitrust laws.[184] It also called into question the constitutionality of other important aspects of the state system of taxing and regulating insurance companies that had been upheld against commerce clause challenges[185] and threatened the existence of the state insurance regulatory establishment.[186] The states could, of course, still tax and regulate the insurance business to the same extent they did all other interstate

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180. *See id.* at 559-62.

181. *See id.* at 534-35, 562. The indictments were the result of an investigation instituted by the Justice Department at the behest of the Attorney General of Missouri, who had attempted to prosecute rate practices that affected premiums charged within his state, but found that he could not do so because the activities of the insurers took place outside of the jurisdiction. *See* Hearings on S. 1362, H.R. 3269 and H.R. 3270 Before the Committees on the Judiciary, 78th Cong. 25-26 (statement of Francis Biddle, Attorney General of the United States), 80-110, 168-80, 181-92 (statement of Roy McKittrick, Attorney General of the State of Missouri) (1943). [hereinafter "Judiciary Committee Hearings"].

182. *See SEUA*, 322 U.S. at 534-35; MEIER, *supra* note 154, at 66.

183. *See SEUA*, 322 U.S. at 533, 562.

184. *See* DAY, *supra* note 15, at 24; MERTZ, *supra* note 24, at 4-5. It is possible that some of the collaborative rate-making schemes might have been sustainable pursuant to the state action doctrine enunciated in Parker v. Brown, 317 U.S. 341, 350-52 (1943). *See SEUA*, 322 U.S. at 549-50.

185. Justice Jackson's dissent predicted that the states would lose the ability to effectively regulate the insurance industry. *See SEUA*, 322 U.S. at 590. Each of the state statutory provisions taxing or regulating insurance that were sustained against commerce clause challenge in the cases cited *supra* note 22 would appear to be invalid after the SEUA decision. The insurance industry did take advantage of the SEUA decision to contest the payment of taxes and the validity of state insurance statutes. *See* MEIER, *supra* note 154, at 67; Powers, *supra* note 170, at 319 n. 10.

186. *See* Kimball & Heaney, *supra* note 25, at 9.

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commerce, i.e., in a manner that did not impose an undue burden or discriminate.[187]

On the same day it decided *SEUA,* the Supreme Court decided another case involving the application of a commerce clause based statute to the insurance industry, *Polish National Alliance of the United States of North America v. National Labor Relations Board* ("NLRB").[188] Although overshadowed by *SEUA*, *Polish National Alliance* had its own impact on the Act. The Court upheld the NLRB's determination that unfair labor practices on the part of an insurance company would affect commerce and thus fell within the scope of the National Labor Relations Act ("NLRA").[189] The constitutional basis for the NLRA was, of course, the interstate commerce clause.[190] This meant that organized labor had an important stake in any legislation that attempted to curtail federal commerce clause authority over the insurance industry.[191]

The *SEUA* decision triggered the passage of the Act. The content of the Act was shaped by the manner in which the state and federal governments had adjusted to the *Paul* case and the manner in which the Supreme Court treated those adjustments. State insurance laws had expanded into areas that normally would have been proscribed by the dormant commerce clause or preempted by the provisions of the federal antitrust laws.[192] The federal government exercised its non-commerce clause authority through dozens of laws that targeted specific segments or aspects of the insurance industry.[193] These laws were implemented largely without challenge. Their existence was not perceived as a threat to the state regulatory system or to the important power to tax the interstate operations

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187. *See SEUA*, 322 U.S. at 547-49; *see also* Berke, *supra* note 173, at 395-96; Hugh Evander Willis, *United States v. South-Eastern Underwriters Association*, 258 INS. L.J. 390, 391-92 (1944).

188. 322 U.S. 643 (1944).

189. *See id.* at 648.

190. *See id.* at 649.

191. *See* Judiciary Committee Hearings, *supra* note 181, at 534-43 (statement of Herbert S. Thatcher, Associate General Counsel, American Federation of Labor). *See also* discussion of Section 4 of the Act *infra* Part II.B.4.

192. If *Paul* had determined that insurance was interstate commerce, the state insurance statutes upheld in the cases described *supra* note 22 would have run afoul of the dormant commerce clause and the insurance industry would have been subject to the federal anti-trust laws. *See SEUA*, 322 U.S. at 553-62.

193. *See supra* Parts I.B.1 - I.B.10.

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of insurance companies. The NAIC supported many of the federal non-commerce clause initiatives, and state regulatory authorities and the insurance industry participated in the implementation of a number of them.[194] It is not surprising, then, that when the NAIC drafted the Act, it focused on removing the commerce clause restrictions on state regulation that had been triggered by the *SEUA* decision, but it saw no need to address the exercise of federal of non-commerce clause authority.

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194. The NAIC endorsed the original decision of the federal government to provide life insurance to military personnel and the subsequent decision to convert the policies to permanent coverage. It urged military personnel to take advantage of the opportunity to keep the coverage in force. *See* Proceedings of the Fiftieth Session of the National Convention of Insurance Commissioners 23 (1919). An NAIC Committee worked with the federal government to formulate a policy on the operations of German insurance companies during World War I, and individual insurance commissioners issued regulations aimed at implementing the presidential proclamation prohibiting them from transferring funds out of the country. *See* Proceedings of the Forty-Eighth Session of the National Convention of Insurance Commissioners 70-77 (1917). The NAIC offered congratulations to the federal government on the establishment of the War Damage Insurance Corporation and cooperated with the War Damage Insurance Corporation to make certain that standard private life insurance forms meshed with the war damage policies. *See* Proceedings of the Seventy-Third Annual Session of the National Association of Insurance Commissioners 119 (1942); Proceedings of the Seventy-Fourth Session of the National Association of Insurance Commissioners 60-65 (1943). Insurance companies and their agents were involved in the issuance of war damage policies, and the companies took an equity position in the operations of the War Damage Corporation. *See* 93 CONG. REC. A3440 (1947). American marine insurance companies and syndicates acted as selling, adjusting and settling agents for the war risk insurance issued by the federal government during World War II. *See* S. REP. NO. 81-1828, at 9 (1950). The NAIC had even endorsed the preferred status of the federal government in insolvency proceedings of insurance companies. *See* Proceedings of the Forty-Ninth Session of the National Convention of Insurance Commissioners 14 (1918); Proceedings of the Forty-Seventh Session of the National Convention of Insurance Commissioners 265-78 (1916). The NAIC endorsed many of the recommendations made by the House Committee on Merchant Marine and Fisheries and the U.S. Shipping Board for changes in state laws governing marine insurance. *See* U.S. Shipping Board Fifth Ann. Rep. 61-62 (1921). Julius Wikler, who was at the time counsel to the NAIC's Committee on the Preservation of State Regulation, expressed the opinion, in 1960, that the federal assertion of authority over marine insurance (described in Part I.B.12, *supra*) was appropriate because it involved international matters that the states could not have effectively regulated. *See* Wikler, *supra* note 145, at 202-03; State Regulation of Insurance, *supra* note 160, at 4837.

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II. THE MCCARRAN-FERGUSON ACT

A. How the Act Became Law

Legislation dealing with the issues raised by the *SEUA* litigation was considered in three sessions of Congress before the Act became law.[195] All bills were referred to the judiciary committees of the two houses for consideration.[196] Senators McCarran and Ferguson, the co-sponsors of S. 340, the bill that became the Act, were members of the Senate Judiciary Committee and of a five-member subcommittee created to consider bills relating to the *SEUA* case.[197] McCarran became chairman of the Senate Judiciary Committee in February 1944.[198]

Three forces shaped the legislation that finally emerged as the Act–the stock fire insurance industry, the Justice Department as the agency responsible for the antitrust policy of the Roosevelt administration, and the NAIC. The fire insurance industry, faced with the criminal indictments growing out of the *SEUA* case and federal scrutiny of all collective ratemaking, wanted an insurance industry exemption from the Sherman and Clayton Acts. On the other hand, the fire insurance companies had tried to use the commerce clause to escape state taxation and regulation and had supported attempts to replace state regulation with a federal scheme.[199] They had no interest in legislation that would shield state regulation and taxation of insurance from the restrictions of the commerce clause.[200] The Roosevelt administration was willing to allow collective

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195. *See* An Act to Express the Intent of the Congress With Reference to the Regulation of the Business of Insurance, ch. 20, 59 Stat. 33 (1945).

196. *See* H.R. REP. NO. 79-143, at 1 (1945); H.R. REP. NO. 79-68, at 1 (1945); S. REP. NO. 79-20, at 1 (1945); S. REP. NO. 78-1112, at 1 (1944); H.R. REP. NO. 78-873, at 1 (1943).

197. *See* Judiciary Committee Hearings, *supra* note 181, at II. Senators McCarran and Ferguson were two of the three Senate managers appointed to the Conference Committee that reported out the final version of S. 340 on February 22, 1945. *See* H.R. REP. NO. 79-213, at 1 (1945).

198. *See* 90 CONG. REC. 1239 (1944).

199. Fire insurance companies were instrumental in the litigation that led to the Paul decision. *See* Nehemkis, *supra* note 15, at 525-27. Two of the subsequent cases that tested the *Paul* doctrine involved a fire insurance company and an agent for a fire insurance company. *See, e.g.*, Noble v. Mitchell, 164 U.S. 367 (1896); Philadelphia Fire Ass'n v. New York, 119 U.S. 110 (1886).

200. *See* Proceedings of the Seventy-Sixth Annual Session of the National Association of Insurance Commissioners 166 (1945) [hereinafter "NAIC 1945 Proceedings"].

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rate making under the supervision of state law, but was unwilling to give up the ability to use the federal anti-trust laws to prosecute boycotts, coercion or intimidation or collective activities that were not carried out under the direction of state law.[201] The administration had no objection to the continuation of the pre-*SEUA* scheme of regulation and taxation of insurance by the states with respect to all other matters.[202]

The NAIC's primary interest was to restore to the states the right to regulate the day-to-day activities of the insurance industry and to tax its interstate operations as they had prior to the *SEUA* case, i.e. without the restrictions that flowed from the commerce clause.[203] The NAIC was mindful of the inability of the states to deal with nationwide organizations of insurers that engaged in boycotts, coercion or intimidation. Therefore, it favored the application of the Sherman and Clayton Acts to such practices.[204] However, the NAIC wanted to free collective rate making and related cooperative activities carried out under the aegis of state law from the constraints of the antitrust laws.[205] Finally, it opposed any application of the Federal Trade Commission Act and the Robinson-Patman Act to the business of insurance on the grounds that the states had in place machinery that could effectively deal with unfair methods of competition and price discrimination.[206] Despite early legislative victories by the stock fire

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201. *See* 90 CONG. REC. A3360-3361 (1944) (statement of Attorney General Biddle); 91 CONG. REC. 482 (1945) (letter from President Roosevelt to Senator Radcliffe dated January 2, 1945).

202. *See* 90 CONG. REC. A3360-3361 (1944) (statement of Attorney General Biddle); 91 CONG. REC. 482 (1945) (letters from President Roosevelt to Senator Radcliffe dated June 10, 1944, and January 2, 1945).

203. *See* 90 CONG. REC. A3976, A4406 (1944); *see also* MEIER, *supra* note 154 at 68.

204. *See* 90 CONG. REC. A4406 (1944) (Joint Statement of Newell R. Johnson, president of the NAIC et al.); *see id.* (text of Section 4 of legislation proposed by the NAIC setting forth the specific circumstances under which the Sherman and Clayton Acts would be applicable to the insurance industry); 90 CONG. REC. A 4407 (1944) (memorandum explaining text of Section 4); 90 CONG. REC. 8482 (1944) (letter from the Michigan Commissioner of Insurance to Senator Vandenberg comparing the Walters-Hancock bill with the legislation proposed by the NAIC).

205. *See* 90 CONG. REC. A4405 (1944) (Report of the NAIC Subcommittee on Federal Legislation); 90 CONG. REC. A4406 (1944) (Joint Statement of Newell R. Johnson, president of the NAIC et al.); *see id.* (text of Section 4 of legislation proposed by NAIC); 90 CONG. REC. A 4407(1944) (memorandum explaining text of Section 4).

206. *See* 90 CONG. REC. A4405 (1944) (Report of the NAIC Subcommittee on Federal Legislation); 90 CONG. REC. A4406 (1944) (Joint Statement of Newell R. Johnson,

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insurance companies, the provisions of the Act, other than those that relate to the applicability of the federal antitrust laws to insurance, are almost identical to legislation proposed by the NAIC.[207] The provisions with respect to the applicability of the federal antitrust laws represent an accommodation reached among the three forces.[208] There was never any consideration of utilizing the federal government's newfound authority over insurance to enact a general regulatory scheme governing the industry's day-to-day activities.

The formal legislative history of the Act began more than eight months before the Supreme Court's decision in the *SEUA* case with the introduction of the Walters-Hancock bill in the House on September 20, 1943 and the introduction of a companion measure, the Bailey-Van Nuys bill, in the Senate on September 21, 1943.[209] The appearance of these two bills sponsored by the stock fire insurance companies[210] was triggered by the Justice Department's appeal from the District Court's decision dismissing the criminal indictments in the *SEUA* case.[211] The proposed legislation was extremely brief and addressed only the applicability of the Sherman and Clayton Acts to the business of insurance and the ability of the states to sanction collective ratemaking:

> That nothing contained in the Act of July 2, 1890, as amended, known as the Sherman Act, or the Act of October 15, 1914, as amended known as the Clayton Act, shall be construed to apply to the business of insurance or to acts in the conduct of that business or in any wise to impair the regulation of that business by the several states.[212]

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president of the NAIC et al.); *see id.* (text of Section 3 of legislation proposed by NAIC); 90 CONG. REC. A 4407 (1944) (memorandum explaining text of Section 3).

207. *See* Kimball & Heaney, *supra* note 25, at 9; *cf.* American Deposit Corp. v. Schacht, 84 F.3d 834, 842 (7th Cir. 1996), *cert. denied*, 519 U. S. 870 (1996).

208. *See* NAIC 1945 Proceedings, *supra* note 200, at 140, 158-59, 162-63; 91 CONG. REC. 1088-89 (1945).

209. *See* 89 CONG. REC. 7686, 7689 (1943).

210. *See* 89 CONG. REC. A5272 (1943) (statement of Representative White); MERTZ, *supra* note 24, at 5.

211. *See* MERTZ, *supra* note 24, at 5.

212. S. REP. NO. 78-1112, at 2 (1944). A series of preambles that were part of the Walters-Hancock bill as originally introduced were stricken by the House Judiciary Committee. *See* H.R. REP. NO. 78-873, at 1 (1943).

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It completely ignored the effect of *SEUA* on other aspects of state regulation of insurance and on state taxation of insurance.[213] The Justice Department registered its opposition to the Walter-Hancock bill.[214] The NAIC would not support it.[215] Nevertheless, it passed in the House by a vote of 283 to 54 on June 22, 1944, seventeen days after the *SEUA* decision.[216] In an attempt to slow down the momentum behind the bill, a statement by the attorney general was published in the Congressional Record the next day indicating that the Justice Department would not try the *SEUA* case or take other action against insurance companies until Congress and the states had an opportunity to amend existing statutes.[217] The Walters-Hancock bill remained stalled in the Senate Judiciary Committee until September 20, 1944 when it was reported out favorably.[218] It passed the Senate as the result of a procedural error on September 21, 1944, but was immediately recalled and received no further consideration.[219]

In September 1944, the focus of congressional attention shifted to the NAIC's legislative initiative. The NAIC wrote to the Senate Judiciary Committee requesting that no definitive action be taken on insurance legislation until it had an opportunity to formulate and present a specific proposal that would allow the states to continue their traditional regulation of the insurance business.[220] The letter was accompanied by a document that set forth a history of state insurance regulation and of the unsuccessful

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213. The Walters-Hancock bill would have given the fire insurance industry the best of all possible worlds. The federal antitrust laws would not interfere with collective rate-making under the auspices of state law and would not apply to boycotts, threats and intimidation that in many instances were beyond the ability of state law enforcement agencies to deal with. On the other hand, state regulation and taxation would remain subject to challenge pursuant to the commerce clause. The earlier goal of a federal charter had become less desirable as the federal government had become a more effective regulator. *See* DAY, *supra* note 15, at 16-17.

214. *See* Judiciary Committee Hearings, *supra* note 181, at 23; H.R. REP. NO. 78-873, at 6-8 (1943).

215. *See* MERTZ, *supra* note 24, at 5.

216. *See* 90 CONG. REC. 6565 (1944).

217. *See* 90 CONG. REC. A3360 (1944).

218. *See* S. REP. NO. 78-1112, at 1 (1944) (statement of Attorney General Biddle).

219. *See* 90 CONG. REC. 8054 (1944).

220. *See* S. REP. NO. 78-1112, pt. 1, at 7 (1944) (minority views). The minority views supported the NAIC's request for time to formulate a legislative proposal before Congress took final action. *See id.* at 5-6.

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attempts to enact a commerce clause based federal regulatory scheme, a description of the impact of the *SEUA* decision on state regulation and taxation of insurance, and an outline of the matters that the NAIC wished to see covered by legislation.[221] A broad spectrum of state insurance regulators and insurance industry groups had participated in the formulation of this position.[222] Two months later the NAIC produced a document containing the text of proposed legislation (the "NAIC Legislative Proposal")[223] together with a memorandum of explanation (the "NAIC Legislative Memorandum").[224] The full text of this document was sent to each member of the Congress[225] and printed in the Congressional Record on November 16, 1944.[226] In December 1944, two bills containing the NAIC Legislative Proposal with minor changes were introduced, but Congress adjourned without taking action.[227]

S. 340, the legislation that became the Act, was introduced by Senators McCarran and Ferguson on January 18, 1945,[228] passed the House on February 23, 1945,[229] passed the Senate on February 27, 1945,[230] and was signed into law on March 9, 1945. Congress was fully aware that S. 340 was, in fact, the NAIC's Legislative Proposal.[231] There were spirited floor debates and a number of amendments were made to the legislation, but these related almost exclusively to the application of the anti-trust laws to

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221. S. REP. NO. 78-1112, pt. 2, at 6 (1944) (minority views) quotes from this document. It was printed in the Congressional Record in September 1944 (90 CONG. REC. A3975-77 (1944)) and again in November of 1944 (90 CONG. REC. A 4403-06 (1944)).

222. *See* 90 CONG. REC. A3976 (1944); Powers, *supra* note 170, at 322-23.

223. *See* 90 CONG. REC. A4406 (1944).

224. *See* 90 CONG. REC. A4406-08 (1944).

225. *See* NAIC 1945 Proceedings, *supra* note 200, at 10-11.

226. *See* 90 CONG. REC. A4403-08 (1944) (appended to the remarks of Senator Hatch).

227. *See* 90 CONG. REC. 9628 (1944) (reference to bills introduced by Senators McCarran and Ferguson and by Senators O'Mahoney and Hatch as substitutes for H.R. 3270, the Walters-Hancock bill).

228. *See* 91 CONG. REC. 330 (1945).

229. *See* 91 CONG. REC. 1396 (1945).

230. *See* 91 CONG. REC. 1488-89 (1945).

231. Senator O'Mahoney stated: "It is no secret that Senate bill 12, introduced by the Senator from New Mexico [Mr. Hatch] and myself, and Senate bill 340, the bill which was reported by the committee, are modifications of a measure which was originally drafted by the legislative committee of the National Association of Insurance Commissioners." 91 CONG. REC. 483 (1945). There were other acknowledgments of the NAIC's authorship. *See* 91 CONG. REC. 1087 (1945) (Congressman Hancock); 91 CONG. REC. 1488 (1945) (Senator Barkley).

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the business of insurance and the extent to which state regulation could shield the insurance industry from their applicability.[232] The Act's overall structure, its declaration of policy, the provision describing the authority of the states to regulate the insurance business, and the preemption exception are, with minor exceptions, identical to the NAIC Legislative Proposal. The NAIC had, with the knowledge and acquiescence of Congress, performed the function of a legislative drafting service. What started out eighteen months before as a piece of industry legislation ended up as a regulators' bill. The NAIC was able to exert this kind of influence because:

1. It had an enormous amount of expertise in dealing with the legislative process. A large part of its activities consisted of securing the passage of uniform insurance legislation after consultation with the industry and achieving a consensus among the regulators.[233] Once the NAIC Legislative Proposal was put before Congress, the insurance industry, with few exceptions, united in support.[234]

2. The objective of the Congress in responding to *SEUA* was to produce legislation that would restore to the states the ability to tax and regulate the insurance industry as they had prior to *SEUA*. The NAIC represented the collective experience of the states in taxing and regulating insurance. There was no federal agency with comparable expertise that Congress could turn to.

B. Examining the Act's Meaning

Perhaps the only matter about which decisions interpreting the Act and commentators are unanimous is that the Act was an attempt to undo the result of *SEUA*,[235] a case that turned on the question of whether insurance fell within the ambit of the commerce clause. The Act was viewed as an

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232. *See* 91 CONG. REC. 478-88, 1085-93, 1477-88 (1945).

233. *See supra* notes 161, 162 and 172 and accompanying text.

234. *See* H. R. REP. NO. 79-143, at 4 (1945); NAIC 1945 Proceedings, *supra* note 200, at 15-17, 165.

235. *See* Barnett Bank of Marion County v. Nelson, 517 U.S. 25, 40 (1996); Department of the Treasury v. Fabe, 508 U.S. 491, 499 (1993); Metropolitan Life Ins. Co. v. Ward, 470 U.S. 869, 880, n.8 (1985); Western & S. Life Ins. Co. v. State Board of Equalization, 451 U.S. 648, 653-54 (1981); Maryland Cas. Co. v. Cushing, 347 U.S. 409, 413 (1954) (stating that the Act's "exclusive purpose" was to counteract *SEUA*); Kimball & Heaney, *supra* note 25, at 9-10.

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exercise of congressional commerce clause power.[236] The debates,[237] hearings[238] and committee reports[239] are filled with references to commerce clause theory and commerce clause cases. None of the federal laws that exercised non-commerce clause authority over insurance were discussed. The acknowledged objective of the Act is simple–to restore to the states their pre-*SEUA* authority over insurance. However, the context in which the Act operates, the Supreme Court's interpretation of the constitutional allocation of authority over interstate commerce between the states and the federal government, is anything but simple. Congress could not overrule the Supreme Court's determination that insurance was interstate commerce. That determination carried with it the restrictions on state authority that flow from the dormant commerce clause, the constitutional law canon that interprets silence on the part of Congress in matters relating to interstate commerce as a prohibition against state legislation that unduly burdens, or discriminates against, interstate commerce.[240] The *SEUA* decision also meant that federal statutes that regulated interstate commerce now applied to insurance, and, in the event of a conflict with state law, had

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236. The NAIC's initial communication to Congress in September 1944 recommended "[t]he enactment by Congress of affirmative legislation under the commerce clause of the Constitution by which it formulates its own policy and establishes its own rules to the effect that the regulation and taxation of the insurance business shall continue in the several states." 90 CONG. REC. A4405 (1944).

237. *See* 89 CONG. REC. 10148-50 (1943) (statement of Congressman Russell); 90 CONG. REC. 6551-56, A 3020 (1944) (statement of Congressman Walter); 91 CONG. REC. 479-80, 1085-86, 1087, 1089-90 (1945) (statements of Senator O'Mahoney, Congressman Walter, Congressman Hancock and Congressman Gwynne).

238. *See* Judiciary Committee Hearings, *supra* note 181, at 2-8 (statement of Josiah W. Bailey, United States Senator from North Carolina); *see id.* at 31-65 (statement of Francis Biddle, Attorney General of the United States).

239. *See* H.R. REP. NO. 79-143, at 2-3 (1945); H.R. REP. NO. 79-68, at 1-2 (1945); S. REP. NO. 79-20, at 1-2 (1945); S. REP. NO. 78-1112 at 2-6 (1944); H.R. REP. NO. 78-873, at 1-8 (1943).

240. In their treatise, Rotunda and Nowak expressed the rule as follows: "When the Court seeks to decide the extent of permissible state regulation in light of a 'dormant' commerce clause power, it is in effect attempting to interpret the meaning of Congressional silence . . . ." 2 RONALD D. ROTUNDA & JOHN E. NOWAK, TREATISE ON CONSTITUTIONAL LAW SUBSTANCE & PROCEDURE § 11.1, at 131 (3d ed. 1999). *See generally* Henry Wolfe Bikle, *The Silence of Congress*, 41 HARV. L. REV. 200 (1927-1928); Laurence H. Tribe, *Toward a Syntax of the Unsaid: Construing the Sounds of Silence*, 57 IND. L.J. 515, 521-22 (1981-1982); *see also* Oregon-Washington R.R. & Navigation Co. v. Washington, 270 U.S. 87, 101 (1926).

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the support of the supremacy clause. In order to restore pre-*SEUA* state authority over insurance and to secure congressional support for that objective, the Act had to achieve three results:

1. Eliminate the restraint on state insurance legislation that the dormant commerce clause inferred from the silence of Congress. The Act had to find a way to overcome the effect of congressional silence without saying anything specific about the conduct of the business of insurance, i.e. without adopting a national insurance code.[241]

2. Enable state laws regulating and taxing insurance to prevail over the generally applicable commerce clause laws that now included insurance within their scope.

3. Provide that existing and future federal laws representing a conscious exercise of congressional commerce clause authority over insurance (including certain provisions of the anti-trust laws) would prevail over state insurance law.

The Act contains obscure language and cryptic references to constitutional law principles. For example, the expressed purpose of the Act is to provide for the "continued taxation and regulation by the several States of the business of insurance," but no attempt is made to define "regulation" or "the business of insurance."[242] An accurate interpretation of the Act requires a close reading of the individual provisions within the framework of the Act as a whole. It also requires resort to the history surrounding the Act, and, in particular, to the history of federal and state exercise of authority over insurance.

The complete text of the Act, as originally enacted, is set forth below in bold type. Sections 1, 2(a), 2(b) and 4 bear on the issue of the commerce clause limitation. Differences, if any, between these Sections and the corresponding provisions of the NAIC Legislative Proposal are indicated in brackets.[243] The explanatory comments from the NAIC Legislative Memorandum that relate to these provisions are set forth in italics. The

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241. *See* ROTUNDA & NOWAK, *supra* note 240, §§ 11.6 - 11.7.

242. 15 U.S.C. § 1011 (1994). Congress may have thought definitions were unnecessary because it was enacting into law something that had been defined by seventy-five years of practice, i.e., the authority of the states to regulate and tax insurance without the constraints imposed by the commerce clause.

243. For the NAIC's own comparison between the Act with the NAIC Legislative Proposal, *see* NAIC 1945 Proceedings, *supra* note 200, at 143, at 157-59. In their piece, Kimball & Heaney indicate that the NAIC Proposal "with only modest changes" became the Act. *See* Kimball & Heaney, *supra* note 25, at 9.

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NAIC Legislative Memorandum discusses the purpose of each of the key provisions of the Act. It also fleshes out their meaning by identifying for the reader the relevant constitutional law theories, Supreme Court decisions and legislative precedents.

1. Section 1: The Declaration of Policy

1. Congress declares that the continued regulation and taxation by the several states of the business of insurance is in the public interest, and that silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several states.

[The language of Section 1 and the NAIC Legislative Proposal are identical.]

The National Association of Insurance Commissioners sincerely believes that the States can adequately regulate the insurance business, and because of legal considerations and the close proximity of State supervisory officials to the people affected, are in a better position to regulate that business than the Federal Government. In that regard it had regulatory machinery available, including regulatory statutes and trained personnel. It is our understanding that Congress shares this belief. It is therefore regarded as essential that Congress should declare its policy and its will. This first paragraph intends that result.

There are a number of decisions of the United States Supreme Court to the effect that congressional silence or inaction in the field of interstate commerce is "equivalent to a declaration that the interstate commerce shall be free and untrammeled." (Welton v. Missouri (91 U.S. 274 (1875)). See also *Hail v. DeCuir (95 U.S. 485 (1877)); County of Mobile v. Kimbill (102 U.S. 601 (1881)); Escanaba Company v. Chicago 107 U.S. 678 (1882)); Covington Bridge Co. v. Kentucky (154 U.S. 204 (1892); West v. Kansas Natural Gas Co. (221 U.S. 229 (1911)); Missouri V. Kansas Natural Gas Co. (205 U.S. 298 (1924)).* See also *an article by Bikle, The Silence of Congress (41 Harv. L. Rev. 200).*

But there are some recent cases which would conceivably support a contrary conclusion. (Minnesota Rate Cases (230 U.S. 352 (1912)); Parker v. Brown (317 U.S. 341 (1943)); United States v. South-Eastern Underwriters Association et al. (64 U. S. Supreme Court 1162).).

Since the immediate problem involves a business with an annual premium income in the billions, with outstanding contracts affecting

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millions of our people in every phase of American business and social life, it was felt that any possible conflict in these decisions should be considered in the declaration of congressional policy and will, even though they may seem to be somewhat contradictory.

The Act's legislative history confirms that the scheme of "continued regulation and taxation of insurance by the several States" that Congress declares to be in the public interest is the scheme that existed before *SEUA* transformed insurance into interstate commerce. That scheme coexisted with, and was subordinate to, the exercise of federal non-commerce clause authority over insurance. The following language appears in both House Reports on S. 340:

> It is not the intention of Congress in the enactment of this legislation to clothe the States with any power to regulate or tax the business of insurance beyond that which they had been held to possess prior to the decision in the Southeastern Underwriters Association case. Briefly, your Committee is of the opinion that we should provide for the continued regulation and taxation of insurance by the States, subject always, however, to the limitations set out in the controlling decisions of the Supreme Court, as, for instance, in Allgeyer v. Louisiana (165 U.S. 578), St. Louis Cotton Compress Co. v Arkansas (260 U.S. 346) and Connecticut General Insurance Co. v. Johnson (303 U.S. 77) (which hold, inter alia, that a State does not have the power to tax contracts of insurance or reinsurance entered into outside of its jurisdiction by individuals or corporations resident or domiciled therein covering risks within the State or to regulate such transactions in any way).[244]

This statement in the House Reports that the continued system of state regulation and taxation is to be subject to the controlling decisions of the Supreme Court underscores congressional intent not to interfere with the

244. H.R. REP. NO. 79-143, at 3 (1945); H. R. REP. NO. 79-68, at 2 (1945). The second report discusses H.R. 1973, a companion bill to S. 340, that had been introduced in the House. The Supreme Court relied on this portion of the Act's legislative history in determining that Congress intended that the Court's pre-*SEUA* decisions would continue to control the authority of the states to tax out-of-state insurance companies. *See* State Board of Ins. v. Todd Shipyards Corp., 370 U.S. 451, 455-56 (1962).

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supremacy of federal non-commerce clause authority. The specific decisions cited involve the application of the equal protection clause to state insurance legislation. However, the controlling decisions of the Supreme Court at the time the Act was passed also included *United States v. Knott*[245] and *Southern Pacific Company v. Jensen*,[246] both of which struck down state insurance laws that conflicted with federal non-commerce clause law. Senator McCarran, the cosponsor of the legislation, read the above-quoted statement into the record on the day before the Senate voted on the final version of S. 340,[247] and then summarized it as follows: "In other words, we give to the states no more powers than those they previously had, and we take none from them."[248] McCarran's statement is another clear indication that the Act was not intended to curtail in any way the extensive exercise of federal non-commerce clause authority that had taken place prior to *SEUA*.

The second clause of the Act's declaration of policy addresses a key commerce clause issue. It states that "silence on the part of Congress" shall not inhibit state regulation and taxation of insurance.[249] The NAIC Legislative Memorandum confirms the purpose of this language. It cites a line of Supreme Court decisions striking down state laws affecting interstate commerce in the presence of congressional silence. It also cites a 1927 Harvard Law Review article that concludes that Congress may, by taking affirmative action, nullify the preemptive effect of its silence on state regulation of interstate commerce.[250]

The two clauses of the declaration of policy deal exclusively with the impact of the commerce clause on state insurance regulation. The NAIC Legislative Memorandum comments that subsequent provisions of the Act (Sections 1, 2(a), 2(b) and (4)) are intended to implement the Declaration

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245. 298 U.S. 544 (1936). *See* discussion *supra* Part I.B.7.

246. 244 U.S. 205 (1917). *See* discussion *supra* Part I.B.4.

247. *See* 91 CONG. REC. 1442 (1945).

248. *Id.*

249. Constitutional law commentary of the period frequently used the phrase "the silence of Congress" or some variation thereof (as distinguished from "the dormant commerce clause") when describing the effect of congressional inaction on the ability of the states to regulate interstate commerce. *See* Bikle, *supra* note 240; Shenton, *supra* note 42; Thomas Reed Powell, *The Still Voice of the Commerce Clause*, *in* 3 SELECTED ESSAYS ON CONSTITUTIONAL LAW 931 (American Association of Law Schools 1938); JOHN B. SHOLLEY, THE NEGATIVE IMPLICATIONS OF THE COMMERCE CLAUSE, *in id.* at 933, 960-65.

250. *See* Bikle, *supra* note 240, at 219-24.

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of Policy. This would argue that, absent language to the contrary, the scope of these subsequent provisions should be construed as being similarly limited.

2. Section 2(a): Disarming the Dormant Commerce Clause

2(a): The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.

[The language of Section 2(a) is substantively identical to the NAIC Legislative Proposal. Section 2(a) substitutes "several" for "respective" and "taxation of such business" for " imposes taxes or fees thereon"]

Sub*section 2(a): this subsection implements the earlier declaration of congressional policy and will by providing that "the business of insurance and every person engaged therein, shall be subject to the laws of the respective States which relate to the regulation of such business and which impose fees or taxes thereon." There is ample congressional and judicial precedent for this phase of the legislation. (Pilotage Law 1789) 46 U. S. C. A. 211): Cooley v. Board of Wardens (12 How. 299 (1851)); Wilson Act (1893) 27 U. S. C. A. 121); In re Rahrer (140 U.S. 515 (1891)); Lacey Act (1900) (18 U. S. C. A. 395); Silz v. Hesterberg (211 U.S. 311(1908)); Webb-Kenyon Act (1913) (27 U. S. C. A. 122); Clark Distilling Co. v. Western Maryland Railway Co. (242 U.S. 311 (1917)); Hawes-Cooper Act (1929) (49 U. S. C. A. 60); Whitefield v. Ohio (297 U.S. 431 (1936)).*

It is impossible to assign a rational meaning to Section 2(a) by reading its language in a vacuum. The business of insurance, like every other business, is subject to the laws of the states. A congressional declaration to that effect is, on its face, completely gratuitous. To find a plausible purpose for this provision, it is necessary to examine its statutory antecedents. The NAIC Legislative Memorandum cites as legislative precedents for Section 2(a) five federal statutes, each of which had the sole purpose of expanding state authority into an area that would otherwise be protected by the silence of Congress.[251] The language that Section 2(a)

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251. The Pilotage Law allowed the states to regulate the use of pilots on navigable streams (Act of August 7, 1789, ch. IX, § 4, 1 Stat. 54, (1789)). The Wilson Act allowed the states to exercise their police powers over intoxicating liquors transported into a state to the same extent as if such liquor had been produced in such state (ch. 728, 26 Stat. 313 (1890)). The Lacey Act allowed the states to exercise their police powers over the carcasses of animals or birds shipped into the state (ch 553, § 5, 31 Stat. 187, 188 (1900)). The Webb-

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uses, "[t]he business of insurance . . . shall be subject to the laws of the several States," closely tracks wording used in these statutes.[252]

At the time the Act became law, congressional power to alter the constitutional distribution of authority between the federal government and the states was thought to be limited. The contemporary understanding of that limitation provides insight into the meaning of Section 2(a). The Wilson Act and the Webb-Kenyon Act, two of the legislative models for the Act, authorized the states to enact statutes of a type that had been previously struck down by the Supreme Court as impermissible burdens on interstate commerce.[253] The Supreme Court upheld these congressional expansions of state authority over interstate commerce,[254] but did so with some difficulty, asserting in each instance that Congress was not delegating its authority to the states, but was redefining interstate commerce or adopting state law.[255] However, after holding in the *Jensen* case[256] that the application of state workmen's compensation laws to stevedores violated the Constitution's grant of admiralty authority to the federal courts, the Court rejected as unconstitutional two attempts by Congress to reduce federal admiralty power by allowing maritime workers to exercise their rights under state workmen's compensation laws.[257] The Court explained in *Knickerbocker Ice Co. v. Stewart* why it was permissible for Congress to delegate commerce clause authority, but not the admiralty power:

Kenyon Act prohibited the shipment of intoxicating liquor into a state in violation of its laws (ch. 90, 37 Stat. 699-700 (1913)). The Hawes-Cooper Act authorized each state to exercise the same power over prison-made goods shipped into that state as it could exercise if such goods originated in that state (ch. 79, 45 Stat. 1084 (1929)).

252. *See* The Hawes-Cooper Act, ch. 79, 45 Stat. 1084 (1929); The Lacey Act, ch. 553, § 5, 31 Stat. 187, 188 (1900); The Wilson Act, ch. 728, 26 Stat. 313 (1890).

253. *See* Leisy v. Hardin, 135 U.S. 100, 124-25 (1890); Bowman v. Chicago and Northwestern Ry. Co., 125 U.S. 465, 493 (1888).

254. *See* Whitfield v. Ohio, 297 U.S. 431, 439 (1936); Clark Distilling Co. v. Western Md. Ry. Co., 242 U.S. 311, 329-30 (1917); In re Rahrer, 43 U.S. 556, 564-65 (1890); Cooley v. Board of Wardens, 53 U.S. (12 How.) 299, 320-21 (1851).

255. *See* ROTUNDA & NOWAK, *supra* note 240, at § 12.6(b); William Cohen, *Congressional Power to Validate Unconstitutional State Laws: A Forgotten Solution to an Old Enigma*, 35 STAN. L. REV. 387, 393-98 (1983).

256. *See* Southern Pac. Co. v. Jensen, 244 U.S. 205, 217-18 (1917).

257. *See* Washington v. W.C. Dawson & Co., 264 U.S. 219, 222-23 (1924); Knickerbocker Ice Co. v. Stewart, 253 U.S 149, 164 (1920).

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> Here we are concerned with a wholly different constitutional provision [the admiralty clause]–one which, for the purpose of securing harmony and uniformity, prescribes a set of rules, empowers Congress to legislate to that end, and prohibits material interference by the States. Obviously, if every State may freely declare the rights and liabilities incident to maritime employment, there will at once arise the confusion and uncertainty which framers of the Constitution both foresaw and undertook to prevent.[258]

As late as 1944, the Supreme Court continued to cite *Jensen* and *Knickerbocker* as controlling precedents in cases dealing with the interaction of federal maritime law and state law.[259] While the language quoted above no longer represents the Supreme Court's position on congressional grants of federal authority to the states,[260] at the time the Act passed it constituted a formidable constitutional barrier to the blanket delegation of federal power over insurance to the states.[261] The NAIC Legislative Memorandum demonstrates a keen awareness of constitutional law issues. It seems unlikely that these draftsmen would gamble on the Act's being struck down by the Supreme Court in order to extend the power of the states into areas not relevant to their basic concern, the restoration of pre-*SEUA* regulation and taxation of insurance. A more credible conclusion is that they and the Congress[262] intended that Section

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258. *Knickerbocker Ice Co.*, 253 U.S. at 166.

259. *See* Norton v. Warner, 321 U.S. 565, 570 (1944); Davis v. Department of Labor & Indus. of Wash., 317 U.S. 249, 252-53, 255 (1942) (specifically declining to overrule *Jensen*); Parker v. Motor Boat Sales, Inc., 314 U.S. 244, 247-48 (1941) (indicating it would not reconsider the constitutional principles announced in the *Jensen* and *Knickerbocker* cases).

260. *See* ROTUNDA & NOWAK, *supra* note 240, § 12.6 (b) at 240-41.

261. The Bikle article, which the NAIC Legislative Memorandum cites in its comment on the Act's declaration of policy, notes that it is beyond the power of Congress to allow state workmen's compensation laws to apply to maritime workers. *See* Bikle, *supra* note 240, at 204 n.7; *see also* Felix Frankfurter & J. M. Landis, *The Compact Clause of the Consititution—A Study in Interstate Adjustments*, *reprinted in* 3 SELECTED ESSAYS ON CONSTITUTIONAL LAW 1606, 1684-49 (American Association of Law Schools 1938) (noting that Congress can make changes in the federal-state allocation of power over interstate commerce, but that it cannot do so with respect to the Admiralty Clause).

262. In discussing H.R. 1973 (the companion bill to S. 340 introduced in the House), Representative Gwynne noted that the legislation "starts out with the statement that

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2(a) perform the limited, but constitutionally permissible, function of freeing state insurance legislation from the restrictions of the dormant commerce clause.

3. The First Clause of Section 2(b): The Preemption Exception

Section 2(b) provides as follows: No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance . . . .

[The language of the preemption exception in Section 2(b) of the Act is identical to that used in the NAIC Legislative Proposal and in S. 340 as originally introduced, except that Section 2(b) substitutes the phrase "unless such Act specifically relates to the business of insurance" for the phrase "unless such act specifically so provides".]

Subsection (b): This subsection further implements the earlier expression of congressional policy and will, and is designed to eliminate or at least minimize conflict between State laws and existing or future acts of Congress, and perhaps more important, furnish a guide to the courts in any litigation which may ensue as to just what the Congress intended.

One of the pillars, if not the keystone of State regulation, is the licensing power. The United States Supreme Court in interpreting the commerce clause of the Constitution has held many times that no State can insist that an individual or other person obtain a license as a condition precedent to conducting interstate business. (Dahnke-Walker Co. v. Bondurant, 257 U.S. 282 (1921); Crutcher v. Kentucky, 141 U.S. 47, 57 (1891); Western Telegraph Co. v. Kansas, 218 U.S. 1, 27 (1910); Sioux Remedy Co. v. Cope, 215 U.S. 197 (1914); Bingaman v. Golden Eagle Western Lines, Inc. 297 U.S. 30 (1936)).

Prior to the decision in the Southeastern Underwriters Association case, supra, and when insurance was held not to be commerce, the cases cited immediately above were inapplicable to the insurance business. If the

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insurance shall be subject to State control. The Congress, of course, cannot delegate to the states the power to regulate insurance. What we are trying to do is to make it clear to the States and the insurance companies that we are as far as possible removing ourselves from the field." 91 CONG. REC. 1090 (1945).

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rationale of these decisions is applied to the insurance business, effective regulation of that business by the States will be markedly impaired.

It is hoped at least that a declaration of congressional policy and will combined with the fact that the licensing system has been in use in the field of State insurance regulation since its inception several decades ago will result in a determination by the United States Supreme Court, if the subject is ever reviewed, that the rule followed in the cases cited will not be applied to the insurance business and that licensing be continued. We do not believe that it is undue optimism to expect the Supreme Court to sustain State licensing under such a congressional enactment, should such an enactment be challenged; indeed such a holding may be foreshadowed by the following statement of the Court in the South-Eastern Underwriters Association case:

"And the fact that particular phases of an interstate business or activity have long been regulated or taxed by States has been recognized as a strong reason why, in the absence of conflicting congressional action, the State regulatory and tax laws should be declared valid."

The first clause of Section 2(b) denies the preemptive power of the supremacy clause to any "Act of Congress" that conflicts with state insurance laws. The courts are directed to construe such federal laws so that they do not "invalidate, impair or supersede" the state insurance regulatory statutes.[263] The legislative history of the preemption exception leads to the conclusion that Congress intended it to apply only to commerce clause laws. In discussing the meaning of Section 2(b), Senator Ferguson stated:

> I think an explanation of paragraph (b) of section 2 should be made at this time. The purpose of that provision is very clear, that Congress did not want at the present time to take upon itself the responsibility of interfering with the taxation of insurance or the regulation of insurance by the States.
>
> . . .
>
> If there is on the books of the United States a legislative act which relates to interstate commerce, if the act does not specifically relate to insurance, it would not apply at

263. 15 U.S.C. §1012(b).

> the present time. Having passed the bill now before the Senate, if Congress should tomorrow pass a law relating to interstate commerce, and should not specifically apply the law to the business of insurance, it would not be an implied repeal of this bill, and this bill would not be affected, because the Congress had not, under subdivision (b), said that the new law specifically applied to insurance.[264]

During debate in the House on February 14, 1945, Congressman Gwynne stated: "The second thing this bill states is that no Act of Congress governing interstate commerce shall apply to insurance unless the Act specifically so states."[265] On the day the Act passed the Senate, Senator Ferguson stated:

> What we have in mind is that the insurance business, being interstate commerce, if we merely enact a law relating to interstate commerce . . . it would not apply to insurance. We wanted to be sure that the Congress, in its wisdom, would act specifically with reference to insurance in enacting the law.[266]

In explaining the purpose of Section 2(b), the NAIC Legislative Memorandum notes that it is necessary to protect state licensing laws, the keystone of state insurance regulation, from preemption because "[t]he United States Supreme Court, in interpreting the commerce clause of the Constitution, has held many times that no State can insist that an

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264. 91 CONG. REC. 481 (1945). During the same colloquy, Senator Ferguson made two other statements concerning the meaning of section 2(b). "It [section 2(b)] provides that no Federal legislation relating to interstate commerce shall by implication repeal any existing State law unless such act of Congress specifically so provides." 91 CONG. REC. 483 (1945). "In other words, the case before the Supreme Court [*SEUA*] was a case applying the Sherman Act and the Clayton Act. We wanted to have the Clayton Act and the Sherman Act apply to insurance, but we did not want to go back into all the laws which had been enacted respecting interstate commerce and apply them to the business of insurance." 91 CONG. REC. 486 (1945). Senator Revercomb, also a member of the Senate Judiciary Committee, made a statement to the same effect during the same debate. *See* 91 CONG. REC. 485 (1945).

265. 91 CONG. REC. 1090 (1945).

266. 91 CONG. REC. 1487 (1945).

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individual or other person obtain a license as a condition precedent to interstate business."[267]

The historical context of the Act provides additional reasons for concluding that the preemption exception does not apply to non-commerce clause laws. The universally acknowledged purpose of the Act, the restoration the states' authority to tax and regulate insurance as they had before *SEUA*,[268] is fully accomplished if the preemption exception is limited to commerce clause laws. On the other hand, failure to so confine the scope of the preemption exception produces a result that is less than credible. The entire corpus of federal non-commerce clause law described in Part II.B would become subordinate to every conflicting provision in each state insurance code. This subordination would include federal insurance programs, which, at the time the Act was passed, accounted for a significant percentage of the nation's outstanding insurance coverage. The aggregate amount of government life insurance in force on the lives of military personnel was $124 billion, a figure almost as great as the aggregate amount of life insurance on the books of all of the nation's life insurance companies.[269] The War Damage Corporation had 5,000,000 policies outstanding providing $140 billion of protection against war-related damage to real and personal property.[270] During the course of the war, the War Shipping Administration provided $31 billion in war, risk and other marine coverages.[271] The federal workmen's compensation insurance systems administered by the Federal Employees Compensation Commission ("Commission") provided hundreds of thousands of workers

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267. 90 CONG. REC. A4407 (1944).

268. *See supra* note 235.

269. *See* 1945 ADMIN. OF VET. AFF. ANN. REP. 26. The aggregate amount of non-governmental life insurance outstanding as of December 31, 1945, was $152 billion. *See* AMERICAN COUNCIL OF LIFE INSURANCE, 1998 FACT BOOK 21 (Table 1.11). The Veterans Administration had also approved nearly 90,000 applications from military personnel to override the lapse provision in private life insurance coverage pursuant to the provisions of the Soldiers' and Sailors' Civil Relief Act. *See* 1945 ADMIN. OF VET. AFF. ANN. REP. 27.

270. *See* 93 CONG. REC. A3440 (1947). The War Damage Corporation operated through 1450 policy-issuing offices throughout the country utilizing the facilities and personnel of insurance companies, agents and brokers. *See id.*

271. *See* Letters from Edmond T. Sommer, Freedom of Information Act Officer, *U.S. Department of Transportation Maritime Administration*, to the author (Dec. 21, 1999 and Jan. 21, 2000) (on file with The Connecticut Insurance Law Journal); cf. S. REP. NO. 81-1828, at 5, 9, 11-12 (1950).

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with coverage for work-related injury or death,[272] accounting for about four percent of all workmen's compensation benefits paid nationally.[273] The Commission regulated the activities of the 300 insurance carriers that provided coverage for these systems on a day-by-day basis.[274] If the preemption exception were not limited to commerce clause laws, then these federal insurance programs would be subject to every law regulating or taxing insurance that was in force in each of the forty-eight states, including those prescribing policy forms and setting rates. In the absence of a commerce clause limitation, the preemption exception would also have applied to two key pieces of war power legislation designed to stabilize the economy, the Emergency Price Control Act and the War Labor Disputes Act, both of which had been applied to the insurance industry by administrative action.[275] It is hard to believe that a federal statute passed in the midst of World War II was intended to have such an effect.[276] It is even harder to believe that such a radical change in the

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272. *See* 29 U.S. EMP. COMP. COMM'N ANN. REP. 36-38, 43-45 (1945). The Federal Employees Compensation Commission administered the workmen's compensation insurance systems covering maritime workers and most employees engaged in private employment in the District of Columbia. *See* The Longshoremen's and Harbor Workers' Compensation Act, ch. 509, 44 Stat. 1424 (1927); Act of May 17, 1928, ch. 612, 45 Stat. 600 (1928) (adding the District of Columbia to the Act). The Commission also administered a number of other programs that provided compensation by the federal government for injuries or death of various classes of workers, but these generally involved direct payments of federal funds rather than an insurance system. *See* 29 U.S. EMP. COMP. COMM'N ANN. REP. 1-5 (1945).

273. *See* 29 U.S. EMP. COMP. COMM'N ANN. REP. 39-40, 45-46 (1945); BUREAU OF THE CENSUS, *supra* note 67, at 355.

274. *See* 29 U.S. EMP. COMP. COMM'N ANN. REP. 27-29 (1945).

275. Wages paid by all employers were frozen. *See* An Act to Amend the Emergency Price Control Act of 1942, ch. 578, § 5, 56 Stat. 765, 767 (1942) (as implemented by Executive Order No. 9250, 1942 U.S.C.C.S. 1259). The amount that employers could pay on account of insurance premiums on the lives of employees was restricted. *See* 32 C.F.R. 4001.1(h)(2) (1944); *see also* U.S. CODE CONG. SERVICE 1942, 1857. The War Labor Disputes Act of 1943 was applied to labor disputes in the insurance industry. An order issued pursuant to that act was held to preempt a contrary provision of New York insurance law. *See* War Labor Disputes Act, ch. 144, 57 Stat. 163 (1943); Paris v. Metropolitan Life Ins. Co., 68 F. Supp. 64, 69 (S.D.N.Y. 1946), *rev'd on other grounds*, 167 F.2d 834 (2d Cir. 1948), *cert. denied* 335 U.S. 827 (1948), discussed *infra* Part III.B.3.

276. The language defining the scope of the Emergency Price Control Act and the War Labor Disputes Act is generic. There is no mention of "insurance." Therefore, the "specifically relates to insurance" clause of the preemption exception would not be applicable. The same is true with respect to other non-commerce clause statutes such as the

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balance of authority between federal and state government would be made without any specific indication in the legislation itself, any floor discussion or debate, or any explanation in committee reports.

4. The Section 2(b) Proviso and the Remaining Provisions of the Act: Commerce Clause Laws That Apply to Insurance Despite the Act

Section 2(b): *[P]rovided,* That after January 1, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, as amended, shall be applicable to the business of insurance to the extent that such business is not regulated by State law.

Section 3(a): Until January 1, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, and the Act of June 19, 1936, known as the Robinson-Patman Anti-Discrimination Act, shall not apply to the business of insurance or to acts in the conduct thereof.

(b) Nothing contained in this chapter shall render the said Sherman Act inapplicable to any agreement to boycott, coerce, or intimidate, or act of boycott, coercion, or intimidation.

Section 4. Nothing contained in this chapter shall be construed to affect in any manner the application to the business of insurance of the Act of July 5, 1935, as amended, known as the National Labor

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federal priority statute discussed *supra* in Part I.B.7 and the provisions of the Internal Revenue Act of 1939 that assessed payroll taxes against all employers without separately identifying insurance companies. *See* Internal Revenue Act of 1939, ch. 9, § 1600, 53 Stat. 183 (1939). Nor is it likely that Congress was relying on the "specifically relates" language to protect federal statutes that included the word insurance in their text from preemption. The Act's legislative history does not give a single example of an existing statute that "specifically relates to insurance" or give any other guidance about the meaning of the phrase. Furthermore, as is noted in Part II.B.4, when Congress excluded certain existing commerce clause statutes from the Act's preemptive effect, it ignored the specifically related clause and designated by name Section 29 of the Merchant Marine Act of 1920, a statute that relates only to the insurance business. *See* Merchant Marine Act of 1920, ch. 250, 41 Stat. 988 (1920).

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Relations Act, or the Act of June 25, 1938, as amended, known as the Fair Labor Standards Act of 1938, or the Act of June 5, 1920, known as the Merchant Marine Act, 1920.

Section 5. As used in this chapter, the term "State" includes the several States, Alaska, Hawaii, Puerto Rico, Guam, and the District of Columbia.

Section 6. If any provision of this Act, or the application of such provision to any person or circumstance shall be held invalid, the remainder of the Act, and the application of such provision to persons or circumstances other than those to which it is held invalid, shall not be affected.

[Section 4 of the Act is identical to Section 5 of the NAIC Legislative Proposal, except that Section 4 of the Act includes the Merchant Marine Act of 1920 among the laws that are unaffected by the Act.]

Labor has toiled for its legislative gains and it is essential that no Federal act should be passed, which would constitute either by incident or otherwise a backward step in that direction. Consequently, this section has been included in the proposed legislation in order to assure labor that the proposals, if enacted into law, would not abrogate, weaken or qualify the application of either the National Labor Relations Act or the Fair Labor Standards Act to the insurance business.

The preemption exception establishes a general rule that conflicts between federal commerce clause laws and state insurance laws will be resolved in favor of state law. The Section 2(b) proviso, Section 3, and Section 4 identify seven pieces of federal legislation that, in varying degrees, apply to the business of insurance despite the preemption exception. Each of these laws, the Sherman Act, the Clayton Act, the Federal Trade Commission Act, the Robinson-Patman Act, the National Labor Relations Act, the Fair Labor Standards Act and the Merchant Marine Act of 1920, involves the exercise of federal commerce clause authority.[277] Congress understood that it was only necessary to exempt

277. The inclusion of the Merchant Marine Act of 1920 within this list of laws requires some explanation. The *Thames* case implied that, *Paul* notwithstanding, marine insurance could be considered interstate or foreign commerce, depending on the destination of the goods insured. *See supra* Part I.B.1. Congress responded by passing Section 29 of the

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commerce clause laws from the operation of the preemption exception.[278] It is also clear that some effort was expended to make certain that the list of laws selected for such treatment was complete.[279] This is further evidence of the Act's commerce clause limitation. Accepting the opposite conclusion requires a belief that Congress determined that that there was not a single existing non-commerce clause federal law that it wished to protect against preemption by current or future state insurance laws. Again, it should be noted that two pieces of war power legislation, the Emergency Price Control Act and the War Labor Disputes Act, neither of which "specifically relates" to insurance, were being applied to the insurance industry at the time the Act passed.[280]

Merchant Marine Act of 1920, which provided a broad exemption from the Clayton Act for collective activities in the transaction of the marine insurance and reinsurance business. *See supra* Part II.B.2. In order to avoid the implication that the qualified Clayton Act exemption in Section 2(b) of the Act had the effect of narrowing the broad exemption granted the marine insurance industry by Section 29, it was necessary to include the Merchant Marine Act among the laws listed in Section 4, thereby insuring that its application to the business of insurance would be unaffected.

278. In discussing Section 4, Senator O'Mahoney stated:

> Section 4 specifically declares that the National Labor Relations Act, the Fair Labor Standards Act, and the Merchant Marine Act shall apply. Nothing in the proposed Act shall be construed to affect their application. In other words, there is a positive declaration that those three specific Federal laws which were enacted by Congress to apply to *commerce* apply also to insurance (emphasis added).

91 CONG. REC. 1443 (1945).

279. Senator O'Mahoney explained the provisions of the Act that exempted various laws from the operation of the Act as follows:

> In drafting these two bills we sought to spell out each particular law which might apply to insurance. We referred specifically to the Federal Trade Commission Act, the Robinson-Patman Act, The National Labor Relations Act and the Fair Labor Standards Act. In other words a good-faith attempt was made to specify every single law which had an application, or might have an application, to insurance.

91 CONG. REC. 483 (1945). Senator O'Mahoney made this statement on January 25, 1945. The Merchant Marine Act was added later to the Acts of Congress listed in Section 4. Compare H. R. REP. NO. 79-143, at 1 (1945), with S. REP. NO. 79-20, at 3 (1945).

280. *See supra* notes 275-76.

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5. Summary

There are a number of factors that point to the conclusion that the preemption provision of Section 2(b) should be applied only to federal commerce clause laws. First, the language of the Act supports this result. The statement in the Act's declaration of policy that "silence on the part of Congress" shall not be a barrier to the regulation of insurance signals that the Act is seeking to overcome the restrictions imposed by the commerce clause. The language of Section 2(a) that "the business of insurance . . . shall be subject to the laws of the several States" points in the same direction. It parallels the wording used in earlier federal statutes that had as their sole function the expansion of state authority over interstate commerce.

The Act's historical context provides additional support for the exclusion of non-commerce clause laws from its coverage. It is universally agreed that the Act was a reaction to *SEUA*'s transformation of insurance into interstate commerce. It did not need to reach beyond the commerce clause to achieve a return to the pre-*SEUA* order. Conversely, if the scope of the Act is not restricted to commerce clause-based laws, its transfer of power to the states has to be interpreted as applicable to all constitutional grants of authority to the federal government and to all constitutional restrictions on state authority, including the equal protection and due process restraints. This interpretation is untenable, if for no other reason than because contemporary Supreme Court decisions had made it abundantly clear that there was a constitutional barrier to the transfer of federal admiralty power to the states. At the time the Act was passed, there existed a large corpus of federal non-commerce clause law, including war powers legislation that applied to the business of insurance, and federal insurance programs provided a significant proportion of the nation's insurance coverage. It is incredible to believe that, in the midst of World War II, Congress would choose to make these federal laws and programs subject to state insurance law.

The legislative history of the Act reveals that Congress was determined to restore the pre-*SEUA* regime of state regulation and taxation of insurance, modified only by the limited application of the antitrust laws. The floor debates reveal a thorough understanding of how the state insurance regulatory regime was threatened by the dormant commerce clause and by the incidental application of general federal commerce clause laws and how the Act would overcome these threats. No mention is made of the numerous and important federal non-commerce clause laws

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that were applicable to insurance. Congressional comments clearly and specifically state that the Act was not intended to expand or contract pre-*SEUA* state authority over insurance–to the point of specifically affirming the continued validity of all relevant Supreme Court decisions. Congressional comments on the preemption exception are equally specific in limiting its application to commerce clause laws. The NAIC, with the knowledge and acquiescence of Congress, performed the function of a legislative drafting service with respect to the Act. The NAIC Legislative Memorandum contains an exposition of the Act's jurisprudential context and a statement of the purpose and meaning of its key provisions. It explains the effect of *SEUA* on state insurance regulation. It ties the words of the Act to specific legal theories and Supreme Court decisions interpreting the commerce clause. The fact that the NAIC Legislative Memorandum, like the other aspects of the Act's legislative history, deals only with commerce clause matters supports the conclusion that the preemption exception applies only to commerce clause laws. In evaluating the guidance provided by the NAIC Memorandum, it should be borne in mind that the NAIC was not only the historic champion of state authority to regulate insurance, but was also aware of the existence of the insurance programs enacted pursuant to federal non-commerce clause authority, having expressed approval of, and facilitated industry participation in, a number of them.[281]

6. Defining the Commerce Clause Limitation

The Act establishes the commerce clause limitation, but does not define it. The Constitution's grants of authority to the federal government are numerous and the powers conferred overlap. This raises the issue of how to distinguish the commerce clause laws that are subject to the preemption exception from the non-commerce clause laws that are not. A look at the Act's historical context and legislative history, together with a reality test, make it plain that the preemption exception protects state insurance laws only from federal laws that can be sustained solely as exercises of commerce clause authority.

The *Paul* case denied commerce clause authority over insurance to the federal government. Yet, prior to *SEUA,* the federal government exercised extensive authority over insurance, and these laws were upheld when they

281. *See supra* note 194 and accompanying text.

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conflicted with state statutes.[282] These laws had to be exercises of non-commerce clause authority because federal commerce clause authority over insurance did not exist. The *SEUA* decision transformed insurance into interstate commerce and made the insurance industry subject to the federal anti-trust laws and every other federal law that applied to interstate commerce. *SEUA* also meant that the same federal authority over insurance that previously had been exercisable only pursuant to the war powers, the admiralty power, the currency power, etc., could now, in some instances, also be exercised pursuant to the commerce clause. The Act's legislative history makes it clear that there was no intent to enlarge the states' pre-*SEUA* authority over insurance at the expense of the federal government.[283] If the federal non-commerce clause laws that prior to *SEUA* would have preempted state law were now preempted by state law simply because of their dual status as commerce clause laws, that is precisely what would have occurred. The core legislative objectives of the Act were to avoid the application of the dormant commerce clause to state insurance laws, and to avoid the application of the anti-trust laws and other commerce laws based laws to the insurance industry, none of which had been applicable prior to *SEUA*. There is nothing in these legislative objectives that requires limiting the application to the insurance industry of the federal non-commerce clause laws to which the industry had always been subject. Perhaps the most compelling argument for interpreting the preemption exception, as only applicable to pure commerce clause laws is the fact that the opposite result simply is not credible. It would mean that any federal law that arguably could be sustained as an exercise of commerce clause authority, no matter how clearly it exercised another constitutional power, would be subordinated to state insurance law. Prior to the Act, the application of the War Labor Disputes Act[284] providing for federal resolution of labor disputes to the insurance industry was purely an exercise of federal war powers and would have preempted conflicting state law.[285] Subsequent to *SEUA,* such legislation would, as applied to the

282. *See supra* Part I.B.13; *supra* note 149.

283. *See supra* pp. 46-47.

284. *See* War Labor Disputes Act, ch. 144, 57 Stat. 163 (1943).

285. *Cf.* United States v. Barker, 36 F.2d 556, 557 (9th Cir. 1929) (conflict between war risk insurance policy and state law); Cassarello v. United States, 271 F. 486, 488 (M.D. Pa. 1919) *aff'd* 279 F. 396 (3d Cir. 1922) (conflict between war risk insurance policy and

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insurance industry, also have been sustainable as an exercise of federal commerce clause authority. It strains credibility beyond the breaking point to believe that Congress intended the Act, which was passed during World War II, to subordinate such legislation to state insurance laws.[286]

III. CASES DECIDED UNDER THE ACT RESOLVING CONFLICTS BETWEEN FEDERAL NON-INTERSTATE COMMERCE LAW AND STATE INSURANCE LAWS

A. Introduction

Part III.B reviews the cases decided subsequent to the Act involving conflicts between state insurance laws and federal laws that are based on constitutional authority other than the interstate commerce clause. The cases are grouped by the constitutional provision that authorizes the conflicting federal law, for example, the tax power, the foreign commerce clause, etc. The order of presentment is, with some exceptions, the same as was used to catalogue the exercises of federal authority over insurance during the *Paul-SEUA* era in Part II.B. There are no cases involving the exercise of federal authority over the District of Columbia or the census power. However, Part III.B includes cases covering five constitutional provisions that did not appear in Part II.B. They are the cases involving the copyright power, the postal power, the necessary and proper clause, the jurisdiction of the federal courts, and the cases involving federal civil rights legislation. The civil rights cases have been combined with the due process clause and equal protection cases. This organizational structure has been chosen because the case law generally has developed within each category of non-commerce clause authority, rather than across the spectrum of federal non-commerce clause powers. It also facilitates comparison of the *Paul-SEUA* era exercise of a particular federal authority with the post-Act judicial treatment of conflicts between the same grant of authority and state insurance laws.

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state law); Garvan v. $20,000 Bonds, 265 F. 477, 479-80 (2d Cir. 1920) (conflict between the Trading with the Enemy Act and state law); COUCH, *supra* note 68, at § 84.2.

286. The contention that the Act caused state insurance law to supersede the War Labor Disputes Act was rejected in *Paris v. Metropolitan Life Insurance Co.*, 68 F. Supp. 64, 69 (S.D.N.Y. 1946), *rev'd on other grounds*, 167 F.2d 834 (2d Cir. 1948), *cert. denied* 335 U.S. 827 (1948), discussed *infra* Part III.B.3.

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All of the cases discussed in Part III involve an exercise of federal power derived from a source other than the commerce clause. The fact that some of the cases involve federal statutes that could be sustained as exercises of commerce clause authority does not affect their relevance for purposes of assessing judicial support for the commerce clause limitation.[287] A clear majority of the cases decided under the Act support the principle that the Act's preemption exception does not invalidate federal non-interstate commerce clause based laws, and that normal supremacy clause rules apply.

Part III.C presents a second analysis of the case law. Here the focus is on the reasoning used by the courts rather than the result reached. The objective is to determine the extent to which that reasoning supports the adoption of the commerce clause limitation and to explore how failure to recognize the commerce clause limitation has narrowed the application of the preemption exception to commerce clause legislation.

B. The Cases

1. Taxation (U.S. CONST. art. I, § 8, cl. 1)

The courts have rejected all attempts to utilize the Act's preemption exception to invalidate provisions of federal law that exercise the tax power. The Fourth and Fifth Circuits upheld IRS determinations that a corporation was not an insurance company for federal tax purposes and should be taxed as an ordinary business corporation despite the fact that it was chartered and regulated as an insurance company by a state.[288] The Tax Court denied a motion for summary judgement based on the argument that an IRS determination that a corporation was not a mutual insurance company violated the Act.[289] The First Circuit sustained a provision of the Internal Revenue Code and implementing regulations that limited insurance company deductions for unpaid losses to "a fair and reasonable estimate of the amount the company will be required to pay," despite the fact that this enabled the the IRS to fix unpaid losses at a different amount

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287. *See supra* Part II.B.6.

288. *See* Security Indus. Ins. Co. v. United States, 702 F.2d 1234, 1250 (5th Cir. 1983); Industrial Life Ins. Co v. United States, 344 F. Supp. 870, 874-77 (D.S.C. 1972), aff'd 481 F.2d 609, 610 (4th Cir. 1973) (per curiam), *cert. denied*, 414 U.S. 1143 (1974).

289. *See* Oklahoma State Union v. Commissioner, 68 T.C. 651, 664 (1977).

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than that utilized for state insurance regulatory purposes. [290] The rationale most frequently given for these decisions is that "the power of the federal government to tax was not delegated to the states" by the Act. [291] These cases clearly establish that the Act's preemption provision does not apply to acts of Congress that exercise the federal tax power. On the other hand, the Supreme Court has held that the Act authorizes the states to impose taxes on the insurance industry that would otherwise violate the dormant commerce clause.[292] These two lines of authority neatly demonstrate the existence of the Act's commerce clause limitation. When Section 2(a) of the Act states that "the business of insurance . . . shall be subject to the laws of the several States which relate to the . . . taxation of such business," it removes the dormant commerce clause inhibition against discriminatory and burdensome state taxation. When the Act's preemption exception states that "[n]o act of Congress shall be construed to invalidate, impair, or supersede any law . . . which imposes a fee or tax upon such business," it is referring to acts of Congress that exercise the *commerce clause power*, not the tax power. Therefore, acts of Congress that exercise the tax power do preempt state insurance laws.

2. Foreign Commerce (U.S. CONST. art. I, § 8, cl. 3)

The Foreign Sovereign Immunity Act ("FSIA") is an exercise of congressional authority to regulate commerce with foreign nations.[293] The

290. Hanover Ins. Co.v. Commissioner, 598 F.2d 1211, 1218-19 (1st Cir. 1979), *aff'g* 65 T.C. 715 (1976) and 69 T.C. 260 (1977).

291. *Hanover*, 598 F.2d at 1218; Industrial Life Ins. Co. v. United States, 481 F.2d 609, 610 (4th Cir. 1973) (per curiam), *cert denied*, 414 U.S. 1143 (1974). Statements to the same effect are made in *Industrial Life Ins. Co. v. United States*, 344 F. Supp. 870, 874 (D.S.C. 1972) and *Hanover Ins. Co. v. Commissioner*, 65 T.C. 715, 722 (1976). The First Circuit also noted that the regulation at issue specifically related to the business of insurance. *See Hanover*, 598 F.2d at 1218.

292. *See* Prudential Ins. Co. v. Benjamin, 328 U.S. 408, 427-28 (1946) (upholding a three percent tax on the income of out-of-state insurance companies); Western & S. Life Ins. Co. v. State Bd. of Equalization, 451 U.S. 648, 653-55 (1981) (upholding a retaliatory tax on out-of state insurers). Both these cases rejected due process and equal protection clause challenges to the state tax statute at issue. *See Benjamin*, 328 U.S. at 437-38; *Western & S. Life Ins. Co.*, 451 U.S. at 655-74.

293. *See* Verlinden B.V. v. Central Bank of Nig., 461 U.S. 480, 496 (1983); Stephens v. National Distillers & Chem. Corp., 69 F.3d 1226, 1231 (2d Cir. 1996). Congress also relied on other non-interstate commerce clause powers. *See Verlinden B.V.*, 461 U.S. at 493-94, n.19 (Frankfurter, J., dissenting).

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FSIA sets forth rules governing the use of the federal courts to resolve controversies involving foreign sovereigns.[294] It provides that, subject to certain exceptions, "a foreign state shall be immune from attachment, arrest and execution."[295] Section 1213 (c)(1) of the New York insurance law, on the other hand, requires that insurers who are not authorized to do business in the state must post security before filing an answer in an action brought in New York.[296] This requirement is the functional equivalent of a pre-judgment attachment.[297] Cases involving unauthorized insurers that qualify as foreign sovereigns have resolved this conflict in favor of the FSIA, and a number of the opinions have relied on the Act's interstate commerce limitation to reach that result. In *Moore v. National Distillers & Chemical Corporation*,[298] a federal magistrate held that Section 1213(c)(1) was preempted by the FSIA, basing her decision in part on the fact that the Act exempts the insurance industry only from commerce clause restrictions. The federal District Court for the Southern District of New York affirmed the magistrate's order and adopted the portion of the opinion that asserted the existence of the interstate commerce clause limitation.[299] In a related state court proceeding, the New York Supreme Court, Appellate Division, also held that the FSIA preempted Section 1213(c)(1) and endorsed the interstate commerce clause limitation that had been advanced by Magistrate Roberts:

> The magistrate correctly concluded, that while the McCarran-Ferguson Act (15 U.S.C. § 1011 et seq.) provides the states with the power and privilege to regulate the business of insurance, the Supreme Court of the United States has held that the preemptive effect of the McCarran-Ferguson Act only "exempts the insurance industry from Commerce Clause restrictions" (143 F.R.D. at 533 citing *Metropolitan Life Ins. Co. v.*

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294. *See* Foreign Sovereign Immunities Act of 1976, Pub. L. 94-583, 90 Stat. 2891, 2898 (1976) (codified at 28 U.S.C. §§ 1330(a), 1441(d), 1602-1611 (1994)).

295. 28 U.S.C. § 1609 (1994).

296. *See* N.Y. INS. LAW § 1213(c)(1)(A) (McKinney 1985).

297. *See Stephens*, 69 F.3d at 1229-30.

298. 143 F.R.D. 526, 533 (S.D.N.Y. 1992), *aff'd sub nom.* Stephens v. National Distillers & Chem. Corp., 69 F.3d 1226 (2d Cir. 1996).

299. *See* Stephens v. National Distillers & Chem. Corp., No. 91 CIV 2901 (JSM) (KAR), 1993 WL 228851, at *3 (S.D.N.Y. June 18, 1993) (mem. order).

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> *Ward*, 470 U.S. 869, 880, 105 S. Ct. 1676, 1683, 84 L.Ed.2d 751 (1985))[*reh'g denied (mem.)*, 471 U.S. 1120, 105 S. Ct. 2370, 86 L.Ed.2d 269 (U.S. Ala. May 20, 1985).]. It has long been held that the McCarran-Ferguson Act does not preempt the application of the Constitution and other Federal Laws (*id.* at 533-34, citing *State Bd. of Ins. v. Todd Shipyards Corp.*, 370 U.S. 451, 82 S. Ct. 1380, 8 L.Ed. 2d 620 [(1962)]). Moreover, it is settled that "[i]n enacting the FSIA, 'Congress expressly exercised its power to regulate foreign commerce, along with other specified Art. I powers[.]'" (*id.* at 534-35, citing *Verlinden B.V. v. Central Bank of Nigeria*, 461 U.S. 480, 496, 103 S. Ct. 1962, 1972, 76 L.Ed.2d 81 [(1983)]).[300]

Subsequent to the above-quoted state decision, the federal district court's decision was appealed. The Second Circuit affirmed the district court's holding that the FSIA preempted Section 1213(c)(1).[301] The court considered the interstate commerce clause limitation suggested by the magistrate, but, based largely on the expansive interpretation of the Act by the Supreme Court in *Department of the Treasury v. Fabe*,[302] declined to adopt it, leaving the issue open for resolution on another occasion.[303] Instead, the court based its conclusion that the Act did not preempt the FSIA primarily on a special rule for construing the Act that had evolved within the Second Circuit (the "narrow application rule"). [304] The narrow application rule dictates that the Act will not be construed to cause state

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300. Moore v. Aegon Reins. Co., 196 A.D.2d 250, 261 (N.Y. App. Div. 1994), *cert. dismissed sub nom.*, Stephens v. Instituto de Resseguros do Brasil (IRB), 512 U.S. 1283 (1994).

301. *See* Stephens v. National Distillers & Chem. Corp., 69 F.3d 1226 (2d Cir. 1996).

302. 508 U.S. 491 (1993). *See* discussion *infra* Part III.B.7.

303. *See* Stephens, 69 F.3d at 1230-31.

304. *See id.* at 1232-33. The court also concluded that the FSIA was not "an Act of Congress" within the meaning of section 2(b) because, prior to the enactment of the FSIA, foreign sovereigns were immune from pre-judgment attachments as a matter of international law as recognized by federal common law, and the FSIA had simply codified this rule. *See id.* at 1233-34. *Cf.* Skandia Am. Reins. Corp. v. Caja Nacional De Ahorro Y Segoro, No. 96 Civ. 2301 (KMW), 1997 WL 278054 at *4 (S.D.N.Y. May 23, 1997) (citing the conclusion reached in *Stephens* that the Act did not preempt the FSIA). But compare, Stephens v. American Int'l Ins. Co., 66 F.3d 41 (2d Cir. 1995), discussed *infra* Part III.B.5.

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insurance laws to preempt federal non-commerce clause laws that relate to matters of national concern such as international commerce or civil rights. This rule has been relied upon both within the Second Circuit and in other federal courts as a basis for determining that state insurance laws do not preempt federal laws relating to international commerce and civil rights.[305]

Congress also has authority to regulate a third type of commerce–commerce with the Indian tribes. There appear to be no cases that have squarely addressed the issue of whether the Act's preemption exception would cause a state insurance statute to supersede federal Indian law or tribal law. However, dictum in an Oregon Supreme Court decision indicates that the preemption exception would not apply.[306] As economic development on Indian reservations occurs, the potential for conflicts between this type of federal law and state insurance law will increase.

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305. *See Stephens*, 69 F.3d at 1232-33. The narrow application rule was invoked in two cases in the Southern District of New York involving conflicts between state insurance law and the provisions of the federal Bankruptcy Code relating to ancillary proceedings involving foreign corporations. *See In re* Laitasalo, 193 B.R. 187, 192-93 (Bankr. S.D.N.Y. 1996); *In re* Rubin, 160 B.R. 269, 281-83 (Bankr. S.D.N.Y. 1993). These cases are discussed *infra* Part II.B.8. The narrow application rule was originally enunciated in *Women in City Government United v. New York*, 515 F. Supp. 295, 303 (S.D.N.Y. 1981). It was followed in *Spirt v. Teachers Insurance & Annuity Association*, 691 F.2d 1054 (2d Cir. 1982) and *EEOC v. Wooster Brush Co.*, 523 F. Supp. 1256, 1265 (N.D. Ohio 1981). These three cases involved a conflict between state insurance law and Title VII of the Civil Rights Act of 1964. The rule was also cited in *McDiarmid v. Economy Fire & Casualty Co.*, 604 F. Supp. 105, 108-09 (S.D. Ohio 1984) and *Pierce v. Metropolitan Property & Liability Insurance*, No. C-3-82-044, 1984 U.S. Dist. LEXIS 24653, at *4-6 (S.D. Ohio Aug. 1, 1984) (both holding that the Act did not prevent the application of the Fair Housing Act [Title VIII of the Civil Rights Act] to insurance redlining). *See* discussion *infra* Part III.B.14. *But cf.* Blackfeet Nat'l Bank v. Nelson, 171 F.3d 1237, 1244-45 n.10 (11th Cir. 1999) (determining that the narrow application rule would not apply to a conflict between provisions of the National Bank Act and state insurance law); *In re* Advanced Cellular Sys. v. Mayol, 235 B.R. 713 (Bankr. D. P.R. 1999) (determining that the narrow application rule would not apply to a conflict between the Bankruptcy Code and state law requiring that all proceedings relating to insurance company insolvencies be brought in state court).

306. *See* Warm Springs Forest Prods. Indus. v. Employer Benefits Ins. Co., 703 P.2d 1008, 1013-14 n.8 (Or. Ct. App. 1985). The court held that the parties had chosen to have the law of Oregon, rather than Indian Law, apply to an agreement to provide workers' compensation insurance. *See id.* at 1011-13.

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3. The War Powers (U.S. CONST. art. I, § 8, cl. 2 and art. II, § 2)

In *Paris v. Metropolitan Life Insurance Co.*,[307] a federal district court was called upon to resolve a conflict between an order of the National War Labor Board awarding retroactive pay increases to life insurance agents and a provision of the New York State insurance law that prohibited payment to insurance agents of compensation for services greater than that which had been agreed upon before the services were rendered. The War Labor Board's authority to issue the disputed order stemmed from the War Labor Disputes Act that gave it the authority to set wages, hours and other terms of employment whenever a labor dispute arose which might lead to substantial interference with the war effort.[308] The War Labor Disputes Act makes no specific reference to insurance or the business of insurance.[309] In ruling that the order of the War Labor Board took precedence over the New York insurance law, the court stated:

> I am convinced that it was not the intention of Congress in enacting Public Law 15 [the Act] to give to the states any greater power to regulate insurance than they had prior to the decision in South-Eastern Underwriters case. And the defendants' argument that Public Law 15 contravenes an order of the War Labor Board made under the Federal war power must accordingly fail.[310]

4. Admiralty and Maritime Jurisdiction (U.S. CONST. art. II, § 2, cl. 1)

The admiralty clause authorizes the federal courts to fashion substantive rules, and the Congress to legislate, with respect to marine insurance.[311] The Supreme Court's insistence on the preemptive effect of federal admiralty law reached its zenith with decisions holding that state workmen's compensation insurance laws could not be applied to

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307. 68 F. Supp. 64 (S.D.N.Y. 1946), *rev'd on other grounds*, 167 F.2d 834 (2d Cir. 1948), *cert. denied*, 335 U.S. 827 (1948).

308. *See* War Labor Disputes Act, Pub. L. No. 78-89, ch. 144, § 7, 57 Stat. 163, 166 (1943) (terminated six months after December 31, 1946, *and repealed by* Pub. L. No. 89-554, § 8(a), 80 Stat. 651 (1966)).

309. *See id.*

310. *Paris*, 68 F. Supp. at 69.

311. *See supra* Part I.B.4.

stevedores and that congressional attempts to legislate such applicability were unconstitutional.[312] During successive terms in the 1950s, the Supreme Court decided cases involving conflicts between federal and state law relating to marine insurance. The decisions came to opposite conclusions on the issue of preemption. In *Maryland Casualty Co. v. Cushing*,[313] a five-to-four decision, the Court held that a state statute that allowed plaintiffs to sue insurers without first proceeding against the insured was preempted by a federal admiralty statute prohibiting such actions. Justice Frankfurter, speaking for himself and three other justices, declared that the Act was "not relevant" because it did not give the states any power to regulate or tax the business of insurance beyond that which they possessed prior to *SEUA*.[314] Justice Clark wrote a concurring opinion that did not mention the Act.[315] Justice Black dissented, joined by Chief Justice Warren, and Justices Douglas and Minton. He construed the admiralty clause as not requiring preemption of the state direct action statute and, in addition, interpreted the Act as conferring on the states the right to regulate marine insurance.[316] In *Wilburn Boat Co. v. Fireman's Fund Insurance Co.*,[317] decided the next term, the Court by a seven-to-two vote upheld, against a claim of preemption based upon the admiralty clause, a state statute that provided that breach of warranty was not a defense to recovery on an insurance policy unless the breach contributed to the loss. No federal statute was at issue.[318] Justice Black, writing for the majority, concluded that there was no judicially established federal admiralty rule requiring strict compliance with warranties in marine insurance policies as a condition to recovery.[319] He also stated that the admiralty clause gave the Court the authority to create such a rule, but that it would decline to do so, citing among other factors the historic role of the states in the regulation of insurance, the Act's reflection of congressional intent that this should continue, and the difficulties that the court would

312. *See id.*
313. 347 U.S. 409 (1954).
314. *See id.* at 413 (quoting H.R. REP. NO. 79-143, at 3 (1945)).
315. *See Cushing*, 347 U.S. at 423-27 (Clark, J., concurring).
316. *See id.* at 427-38 (Black, J., dissenting).
317. 348 U.S. 310 (1955).
318. *See id.* at 314.
319. *See id.* at 314-16.

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face in determining exactly what rule to adopt.[320] While referring to the Act as continuing the role of the states with respect to marine insurance,[321] the opinion indicates that had there been a judicially established rule requiring strict compliance with warranties in marine insurance policies, the Act would not have saved the conflicting state insurance statute from preemption.[322] In reaching this conclusion, Justice Black correctly construed the preemption exception, reasoning that a judicially created admiralty rule is not an "Act of Congress," and that the authority to create such a rule flows directly from the Constitution.[323] The Supreme Court has not spoken on the Act's effect on federal admiralty law since *Wilburn*.

The Federal Arbitration Act (the "Arbitration Act") provides that agreements to arbitrate contained in maritime contracts, evidencing transactions in interstate and foreign commerce, shall be enforceable.[324] This has brought Arbitration Act into conflict with state statutes that contain generally applicable provisions limiting or prohibiting the enforcement of arbitration agreements. When called upon to resolve such conflicts, the Supreme Court has given strong support to the enforceability of arbitration agreements.[325] There also exist state anti-arbitration statutes

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320. *See id.* at 316-21.

321. *See id.* at 318.

322. *See id.* at 314. Justice Frankfurter wrote a concurring opinion that does not mention the Act. *See id.* at 321-24 (Frankfurter, J., concurring). Justices Reed and Burton dissented, indicating that a judicially established federal rule with respect to breach of warranties in marine insurance policies did in fact exist, and that the Act did not give the states any authority to legislate with respect to marine insurance. *See id.* at 324-28 (Reed & Burton, JJ., dissenting).

323. *See* ROTUNDA & NOWAK, *supra* note 78, § 3.4. *See also* Stephens v. National Distillers & Chem. Corp., 69 F.3d 1226, 1232-33 (2d Cir. 1996) (noting that the Act's preemption exception applies only to "Acts of Congress").

324. *See* 9 U.S.C.A. ch. 2. The inclusion of maritime agreements within the coverage of the Arbitration Act represents an exercise of congressional admiralty power. *See* Southland Corp. v. Keating, 465 U.S. 1, 11 (1984). The Arbitration Act provision making arbitration agreements enforceable also invokes congressional interstate and foreign commerce authority. *See* 9 U.S.C. chs. 1-2. The Convention on the Recognition and Enforcement of Foreign Arbitral Awards represents an exercise of the treaty power to the same end. *See* discussion *infra* Part III.B.5. Thus, state insurance laws that restrict the enforceability of arbitration agreements may conflict with four separate constitutional grants of authority to the federal government.

325. *See* Doctor's Assocs. v. Casarotto, 517 U.S. 681 (1996); *Keating*, 465 U.S. 1. *See also* Julie B. Klein, *Federal Arbitration Act and the Preemption Doctrine*, N.Y. L.J. Sept. 5, 1996, at 3.

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that apply only to arbitration agreements in insurance policies. In *Triton Lines v. Steamship Mutual Underwriting Association*,[326] a federal district court held that an agreement to arbitrate in a marine insurance policy was enforceable because the Arbitration Act preempted an anti-arbitration provision of the Texas Insurance Code. The court found that the Act's preemption provision was inapplicable because the state anti-arbitration provision did not regulate the business of insurance, but rather, dealt with enforcement of disputed claims.[327]

5. The Treaty Power (U.S. CONST. art. II, § 2, cl. 2)

The United States Senate ratified the Convention on the Recognition and Enforcement of Foreign Arbitral Awards (the "Convention")[328] in 1968.[329] In 1970, Congress adopted implementing legislation that is set forth in Chapter Two of the Arbitration Act.[330] The Convention, as implemented, provides for the enforcement in the federal courts of arbitration clauses in commercial agreements to which non-United States citizens are a party and of arbitration awards arising from such agreements.[331] In resolving conflicts between treaties and federal statutes, the Supreme Court has established the rule that a treaty is deemed to take precedence over a previously enacted, conflicting federal statute–unless the treaty in question is not self-executing, that is, if it requires implementing legislation before it takes effect as domestic law.[332] The Court has enforced an agreement to arbitrate covered by the Convention over objections that it contravened domestic law and public policy,[333]

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326. 707 F. Supp. 277, 278-79 (S.D. Tex. 1989). *Cf.* Dees v. AARCO Ins. Agency, 594 So. 2d 77, 79 (Ala. 1992) (citing *Triton Lines* and holding that an arbitration agreement in a marine insurance policy was enforceable because the Arbitration Act preempted an Alabama anti-arbitration statute that was part of the Commercial Law and Consumer Protection title of the Alabama Code).

327. *See Triton Lines*, 707 F. Supp. at 279.

328. *See* June 10, 1958, 21 U.S.T. 2517, 330 U.N.T.S. 38.

329. *See* 114 CONG. REC. 29605 (1968).

330. *See* Pub. L. No. 91-368, 84 Stat. 692 (1970) (codified at 9 U.S.C. §§ 201-208).

331. *See* 9 U.S.C. § 202. An agreement between United States citizens may also be enforced under the Convention if it involves property located abroad, envisages performance or enforcement abroad, or has some reasonable relationship with one or more foreign states. *See id.*

332. *See* ROTUNDA & NOWAK, *supra* note 78, at §§ 6.6 - 6.7.

333. *See* Mitsubishi Motors Corp. v. Soler Chrysler-Plymouth, Inc., 473 U.S. 614 (1985).

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citing concern for international comity, the need for orderliness and predictability in the resolution of disputes concerning international commercial agreements, and the encouragement of international trade and commerce.[334] The Court has noted that in light of the United States' adherence to the Convention, the "emphatic federal policy in favor of arbitral dispute resolution . . . applies with special force in the field of international commerce."[335]

In *Stephens v. American International Insurance Co.*,[336] the Kentucky Insurance Commissioner, as the liquidator of an insolvent insurance company, brought suit for premiums due against various insurers who had ceded risks to the insolvent company. One of the defendants moved to compel arbitration, citing the Convention.[337] The Insurance Commissioner cited a Kentucky statute that prohibited arbitration in the liquidation of insurance companies. The Second Circuit held that the Act protected the Kentucky anti-arbitration statute from preemption because the Convention was not a self-executing treaty, and therefore, the conflict was between the federal legislation implementing the treaty and the Act:

> The argument is that under the Supremacy Clause the Convention supersedes the Kentucky Liquidation Act. This argument fails because the Convention is not self executing, and therefore, relies upon an Act of Congress for its implementation.
>
> . . .
>
> McCarran-Ferguson states '[n]o Act of Congress shall be construed to . . . supersede any law . . . regulating the business of insurance.' [338]

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334. *See id.* at 628-31.

335. *Id.* at 631.

336. 66 F.3d 41 (2d Cir. 1995).

337. *See id.* at 43.

338. *Id.* at 45. *See also* Ideal Mut. Ins. Co. v. Phoenix Greek Gen. Ins. Co., No. 83 Civ. 4687, 1987 U.S. Dist. LEXIS 11573 at *1 (S.D.N.Y. Dec. 11, 1987) (involving an attempt to enforce an agreement to arbitrate governed by the Convention against the New York Insurance Commissioner as liquidator of an insolvent insurance company). The Court held that the Act preempted the Convention and that the agreement to arbitrate fell within one of the exceptions to enforceability specified in the Convention because it was contrary to the public policy of the United States as expressed by the Act. *See id.* at *3. Cf. Andrew M. Campbell, Annotation, *Refusal to Enforce Foreign Arbitration Awards on Public Policy Grounds*, 144 A.L.R. FED. 481 (1998). A number of the cases discussed indicate that a

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Courts other than those within the Second Circuit have reached the opposite result on this issue. In *Corcoran v. Ardra Insurance Co.*,[339] the New York Insurance Commissioner as liquidator of an insolvent New York insurance company, sued a Bermudan insurance company and two of its officers who responded by seeking to remove the action to the federal courts and to compel arbitration. The insurance commissioner contended that New York insurance law did not authorize him to enter into arbitration proceedings.[340] The New York Court of Appeals held that:

> The threshold question is preemption. The Supremacy Clause provides that "all Treaties made, or which shall be made, under Authority of the United States, shall be the supreme Law of the Land" (U.S. Const., art. VI, cl. 2). Any Federal or State law that "prevents the Federal Government from 'speaking with one voice' in international trade" must bow to superior authority (*Japan Line v . County of Los Angeles*, 441 U.S. 434, 453-454; 99 S. Ct. 1813, 1824, 60 L. Ed. 2d 336; *see also Mitsubishi Motors v. Soler Chrysler-Plymouth*, 473 U.S. 614, 631, 105 S. Ct. 3346, 3356, 87 L. Ed. 444; *Schernig v. Miller*, 389 U.S. 429, 441, 88 S. Ct. 664, 671, 19 L. Ed. 2d 683). If the Convention requires arbitration, it preempts the McCarran Ferguson Act, the Federal Arbitration Act and the State Insurance Law empowering the Superintendent to litigate on behalf of an insolvent insurance company (*see Cooper v. Ateliers de la Motorbecane*, 57 N.Y.2d, 411-12, 456 NY.S.2d 728, 442 N.E. 2d 1239 [proceeding to obtain attachment order prior to arbitration of dispute arising out of international agreement violates Convention]).[341]

However, the court went on to find that because the insurance commissioner was not authorized to enter into arbitration proceedings, the matter for which arbitration was sought fell within an exception to the enforceability of arbitration agreements specified within the Convention

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public policy defense to enforceability is valid only when the forum's most basic notions of morality and justice are offended. *See id.* at §§ 3, 5-7, 11[a], 13-15.

339. 77 N.Y.2d 225 (N.Y. 1990), *cert. denied*, 500 U.S. 953 (1991).

340. *See id.* at 232.

341. *Id.* at 230.

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itself.[342] In 1996, a federal district court in Louisiana granted a motion to confirm an arbitration award governed by the Convention despite the existence of an anti-arbitration provision in the Louisiana Insurance Code.[343] The court rejected the contention that the Act caused the Louisiana statute to preempt the Convention because the Act "was intended to apply to apply only to interstate commerce," and distinguished the Second Circuit's decision in *Stephens v. American International* on the basis that it dealt with activities that were intrastate in nature—that is, the liquidation of a domestic insurance company.[344] It also disagreed with the Second Circuit's characterization of the Convention as a non-self-executing treaty and criticized its failure to discuss the Supreme Court's rejection of subject matter exceptions to the Convention.[345] The court cited the strong federal policy in favor of the enforcement of arbitral awards as a reason for rejecting the argument that Louisiana anti-arbitration statute made the award unenforceable as a matter of public policy.[346] In 1992, a federal district court in Alaska held that an arbitration clause in an insurance policy that fell within the Convention was enforceable and that a stay of litigation should be issued.[347] The court determined that any state restriction on the enforceability of arbitration agreements dealt with disputed claims rather than the business of insurance, citing *Triton Lines*.[348]

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342. *See id.* at 231-34 (citing the Convention, art. V, para. 2 (a), 21 U.S.T. 2518, 2520 [matters not capable of settlement by arbitration under the laws of the country in which enforcement is sought]).

343. *See* McDermott Int'l, Inc. v. Underwriters at Lloyd's, Civ. A. No. 91-841, 1996 WL 291803 (E.D. La. May 30, 1996), *aff'd on other grounds*, 120 F.3d 583 (5th Cir. 1997).

344. *See id.* at *6.

345. *See id.*

346. *See id.* at *7.

347. *See* Organ v. Conner, 792 F. Supp. 693 (D. Alaska 1992).

348. *See id.* at 696-97. The argument against enforceability appears to have been based on public policy grounds. *See id.* at 697. In *Kokin v. Cologne Reinsurance, Ltd.*, 34 F. Supp. 2d 240 (M.D. Pa. 1999), a federal district court in Pennsylvania held that an arbitration agreement covered by the Convention was enforceable over the objections of the liquidator of an insurance company who was seeking to enforce the contract in state court, because the suit brought by the liquidator was not the business of insurance, and Pennsylvania insolvency law did not prohibit the arbitration of claims made by a liquidator. *See Kokin*, 34 F. Supp. 2d at 256.

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6. The Currency Power and the Power to Borrow (U.S. CONST. art. I, § 8, cls. 2 & 5)

Conflicts between the authority granted national banks to engage in insurance activities and state laws prohibiting them from doing so generated extensive litigation and were finally resolved only by congressional intervention. The state statutes at issue in these cases had the effect of restraining competition in the sale of insurance products rather than regulating conduct in their sale.[349] National banks are authorized to act as general insurance agents in towns with a population of 5,000 or less by 12 U.S.C. § 92. In *Barnett Bank of Marion County v. Nelson,*[350] the Supreme Court was called upon to decide whether the Act caused a state law that prohibited banking institutions from engaging in insurance activities to preempt Section 92. The Court determined that Section 92 "specifically related to insurance" and was not subject to the Act's preemption provision.[351] The Court held that normal supremacy clause rules would invalidate the state law because they would "forbid or significantly impair the exercise of a power that Congress explicitly granted."[352] *Owensboro*, a Sixth Circuit case that preceded *Barnett,*

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349. *See* Owensboro Nat'l Bank v. Stephens, 44 F.3d 388, 392 (6th Cir. 1994); Texas Bankers Ass'n v. Bomer, Civ. No. A-96-CA-694 JN, 1997 U.S. Dist. LEXIS 13422, at *6 (W.D. Tex. Aug. 7, 1997); *see also* David W. Roederer & Margo H.K. Tank, *The Emerging Legal Landscape for Bank Insurance Activities*, 17 ANN. REV. OF BANKING L. 393, 410 n.72 (1998) (list of state statutes prohibiting insurance activities by national banks that were in force prior to the Supreme Court's decision in *Barnett Bank of Marion County v. Nelson*, 517 U.S. 25 (1996)).

350. 517 U.S. 25 (1996), rev'g 43 F.3d 631 (11th Cir. 1995). The Court's decision resolved a split between the Eleventh Circuit, *see* Barnett Bank of Marion County v. Nelson, 43 F.3d 631 (1995) and the Louisiana Court of Appeals, *see* First Advantage Ins., Inc., 652 So. 2d 562 (La. Ct. App. 1995), *cert. denied*, 654 So. 2d 331 (La., May 5, 1995), both of which had sustained state statutes, and the Sixth Circuit, which had upheld Section 92 in *Owensboro*, 44 F.3d 388. Cf. Deposit Guar. Nat'l Bank v. Dale, 28 F. Supp. 2d 395 (1998) (holding that Section 92 preempted a Mississippi insurance statute that prohibited national banks from selling insurance, but without discussing the Act).

351. *Nelson*, 517 U.S. at 37-41. Section 92 uses the word "insurance" or the term "insurance company" five times, and provides that national bank insurance sales shall be subject to certain restrictions and be carried out pursuant to such rules and regulations as the Comptroller of the Currency may prescribe. The Court felt that the fact that the Section 92 described the insurance activities of banks did not make it a banking statute rather than a law that specifically related to insurance. *See id.* at 42.

352. *Id.* at 33.

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involved a conflict between the same type of state statute and Section 92. The court concluded that the preemption exception did not apply because the state statute did not regulate insurance, but rather sought to define the permissible activities of national banks.[353] Conflicts have also arisen over national bank sales of insurance products pursuant to federal laws that do not specifically relate to insurance. The Eighth and District of Columbia Circuit courts have upheld the authority of national banks to offer credit insurance.[354] Credit insurance is sold to the borrower at the time a loan is made. If the borrower dies before the loan is repaid, the debt is cancelled. National banks may underwrite this type of risk themselves by entering into a debt cancellation contract with the borrower,[355] or they may act as agents for the sale of a policy issued by an insurance company.[356] In *First National Bank of Eastern Arkansas v. Taylor*,[357] the Eighth Circuit held that the issuance of debt cancellation contracts by a national bank fell within the authority granted by the incidental powers clause of the National Bank Act and, therefore, did not constitute the business of insurance, as defined by the preemption exception. The District of Columbia Circuit court used the same reasoning to sustain a regulation issued by the Comptroller of the Currency authorizing national banks to sell credit insurance policies and restricting the receipt of the proceeds by bank insiders against a challenge based on the preemption exception.[358] Another line of cases involves conflicts between the authority granted national banks to sell annuities and prohibitions against such sales in state

353. *See Owensboro*, 44 F.3d at 391-92.

354. *See, e.g.*, First Nat'l Bank of Eastern Ark. v. Taylor, 907 F.2d 775 (8th Cir. 1990); Independent Bankers Assoc. of Am. v. Heimann, 613 F.2d 1164 (D.C. Cir. 1979).

355. *See* Debt Cancellation Contracts, 12 C.F.R. § 7.1013 (1999).

356. *See* Sales of Credit Life Insurance, 12 C.F.R., pt. 2. (1999).

357. 907 F.2d 775, 779-80 (8th Cir. 1990). The incidental powers clause provides that national banks may "exercise . . . all such incidental powers as may be necessary to carry on the business of banking; by discounting and negotiating promissory notes, drafts, bill of exchange, and other evidences of debt; by receiving deposits; by buying and selling exchange, coin, and bullion; by loaning money on personal security; and by obtaining, issuing and circulating notes according to the provisions of this title." 12 U.S.C. § 24(7).

358. *See Heimann*, 613 F.2d at 1169-71. The Court sustained the regulation's authorization to sell credit insurance pursuant to the incidental powers clause. *See id.* at 1170. It also sustained the restriction on the receipt of the proceeds of such sales by insiders as an exercise of the Comptroller's authority to prevent unsafe and unsound banking practices. *See id.* at 1168-69.

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insurance legislation.[359] In 1995, the Supreme Court held in the *VALIC* case that national banks had the authority to sell annuities pursuant to the incidental powers clause.[360] In reaching this result, the Court confirmed a determination by the Comptroller of the Currency that annuities were not insurance within the meaning of Section 92 (which limits national banks to act as general insurance agents in towns of 5,000 or less), but rather financial investment instruments that could be dealt in, without geographic restrictions, pursuant to the incidental powers clause.[361] *VALIC* did not involve a conflict between federal and state law, but it produced the analytical framework that has been used in subsequent cases involving state laws restricting the ability of national banks to sell annuities. In 1996, the Seventh Circuit held in *American Deposit Corporation v. Schacht*[362] that a national bank could not offer a certificate of deposit with annuity-like characteristics (the "Retirement CD") for sale in Illinois, because the Retirement CD fell within the definition of insurance under Illinois law and under the Act, and Illinois law did not allow a national bank to underwrite insurance. The Office of the Comptroller of the Currency had determined that the Retirement CD was a deposit and represented the exercise of a power specifically granted to national banks.[363] The court concluded that the National Bank Act, "like every other federal law, is

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359. The fact that that the authority of banks to sell annuities has been so fiercely litigated reflects the financial stakes involved. Sales of annuities in the United States in 1997 amounted to almost $200 billion, producing far more revenue than any other product sold by the insurance industry. *See* AMERICAN COUNCIL OF LIFE INSURANCE, 1998 LIFE INSURANCE FACT BOOK 64 (1998).

360. *See* NationsBank of North Carolina, N.A. v. Variable Annuity Life Ins. Co., 513 U.S. 251 (1995).

361. *See id.* at 260-64.

362. 84 F.3d 834 (1996) (2-1 decision), *cert. denied*, 519 U.S. 870 (1996).

363. *See Schacht*, 84 F.3d at 837. The court distinguished the conclusion reached in the *VALIC* case that annuities were not insurance, on the basis that *VALIC* involved the meaning of insurance for purposes of Section 92, not the Act, and that *VALIC* dealt with brokering rather than underwriting annuities. *See id.* at 838-39. The Eleventh Circuit held that the placement of an ad for the Retirement CD in the *Wall Street Journal* gave the Florida Commissioner of Insurance the authority to assert regulatory authority. *See* Blackfeet Nat'l Bank v. Nelson, 171 F.3d 1237, 1239, 1249 (11th Cir. 1999). The court determined that the Comptroller of the Currency did not have the authority to allow the issuance of the Retirement CD, but that even if he did have such authority, the Retirement CD was an annuity subject to state regulation. *See id.* at 1240-49.

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within the reach of the McCarran-Ferguson Act."[364] A subsequent Texas district court case, *Texas Bankers Association v. Bomer*,[365] held that a state insurance law that effectively barred national banks from obtaining the license necessary to sell annuities was preempted by the incidental powers clause. The court held that annuities were not insurance for purposes of the Act, citing *VALIC* and declining to follow *American Deposit*.[366]

The foregoing cases chronicle the Comptroller's vigorous espousal of the principle that the states may not prevent national banks from engaging in insurance activities authorized by federal law. Implicit in this position is the assumption that the preemption exception does not apply to the insurance activities of national banks. However, the Comptroller also took the position that the states have the right to regulate how those activities are carried out so long as such regulation does not violate the supremacy clause standard established by *Barnett*.[367] When Congress enacted the Graham-Leach Bliley Act in 1999, it established the general rule that the states could not prohibit the exercise of insurance powers granted to national banks and other depository institutions by federal law, and that state regulation of such activities must operate within the limits prescribed by the supremacy clause.[368] This finally removed the threat of state sanctions against national banks for exercising insurance powers granted by federal non-commerce clause laws.

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364. *Schacht*, 84 F.3d at 843-44.

365. Civ. No. A-96-CA-694, JN, 1997 U.S. Dist. LEXIS 13422 at *14 (W.D. Tex. Aug. 7, 1997); *cf.* Deposit Guar. Nat'l Bank v. Dale, 28 F. Supp. 2d 395 (S.D. Miss. 1998) (holding, without discussing the Act, that a Mississippi insurance statute that prohibited national banks from selling annuities was preempted by the incidental powers clause).

366. *See Bomer* at *11-12. The court also determined that the Texas statute was designed to exclude entities from the sale of insurance rather to regulate insurance, and, therefore, was not protected by the Act. *See id.* at *12-14.

367. *See* OCC Advisory Letter No. 96-8, 4 Fed. Banking L. Rep. (CCH) pp. 35,463, 35,756-57 (Oct. 8, 1996). *Cf.* Mitchell v. Florida Dept. of Ins., 679 So. 2d 334, 335-37 (Fla. Dist. Ct. App. 1996) (holding that an insurance agent selling annuities pursuant to a contact with a national bank is subject to the provisions of Florida insurance law which regulate unfair methods of competition and deceptive acts or practices. The court based its conclusion both on its construction of the supremacy clause and on the effect of the Act's preemption exception).

368. Gramm-Leach-Bliley Act, Pub. L. No. 106-102, §§ 104(c)(1), 104(d)(1), 104(d)(2)(A), 104(e), 113 Stat. 1338, 1357; S. Conf. Rep. No. 106-1352-53, at 5 (1999). The preemption standard established in *Barnett* is incorporated by reference. *See* Gramm-Leach-Bliley Act, Pub. L. No. 106-102, §§ 104(d)(2)(A), 104(d)(2)(C)(iii)(I). This same statement can be found in H. REP. NO. 106-434, 156-57 (1999).

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The operation of the federal deposit insurance system has also led to conflict with state insurance law. *Villafane-Neriz v. FDIC*[369] involved a dispute between the FDIC, as liquidator of an insolvent bank, and the Puerto Rico Insurance Commissioner, as receiver of an insolvent insurance company. The insurance company pledged a certificate of deposit issued by the bank to the insurance commissioner as collateral for its obligations to policyholders.[370] The certificate of deposit did not appear on the books of the bank at the time it became insolvent having previously been used to satisfy a debt to the bank.[371] The First Circuit affirmed a summary judgment in favor of the FDIC granted by the district court.[372] The court held that an FDIC regulation that allowed the agency to look solely to the books of an insolvent bank to determine the existence of an insured deposit did not invalidate, impair or supersede a Puerto Rican statutory requirement that insurance companies pledge deposits with the Insurance Commissioner.[373] The bottom line issue in this case is whether the preemption exception allows shifting of the costs of satisfying policyholder claims from the state insurance guaranty fund to the federal deposit insurance fund.[374]

7. Exercising a Sovereign Prerogative–The Federal Priority Statute

In 1936, the Supreme Court unanimously determined, in *United States v. Knott*,[375] that the statute granting the federal government a first priority in insolvency proceedings preempted contrary provisions in state insurance law. Between 1962 and 1989, three appellate court decisions held that the Act did not cause state insurance company insolvency laws that gave preferences to various classes of creditors to preempt the federal priority

369. 75 F.3d 727 (1st Cir. 1996).

370. *See id.* at 729, 735.

371. *See id.* at 729.

372. *See id.* at 728-29.

373. *See id.* at 735-36.

374. Puerto Rico, like all of the states, requires insurance companies doing business in the jurisdiction to fund policyholder claims against insolvent insurers. *See* P.R. LAWS ANN. tit. 26 §§ 3806, 3808, 3906, 3908-3909 (1999).

375. 298 U.S. 544 (1936).

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statute.[376] The basis for these decisions was that the state insurance insolvency statutes did not regulate the business of insurance because (1) the liquidation of insurance companies was not the business of insurance and/or (2) the purpose of the statutes was to regulate the priorities among policyholders and other classes of creditors.[377] In 1991, the Sixth Circuit, in a two-to-one decision, held that the Ohio insurance insolvency statute that preferred certain claims over those of the federal government regulated the business of insurance and, therefore, preempted the federal priority statute.[378] The Supreme Court granted certiorari and, by a five-to-four vote, overruled *Knott*,[379] holding that the Act caused the provisions of the Ohio insurance company insolvency statute that ranked the claims of policyholders and of guaranty associations and administrative costs ahead of the claims of the federal government to preempt the federal priority statute.[380] The majority opinion addressed the contention that by interpreting the Act to overrule *Knott*, it was giving the states greater power over insurance than they had prior to *SEUA*. Justice Blackmun discussed the history of the Act, repeating at the outset the myth that the states exercised "virtually exclusive domain" over the insurance industry prior to *SEUA*.[381] He rejected the federal government's argument that the Court had determined in *Securities & Exchange Commission v. National Securities, Inc.*[382] that the Act was an attempt to turn back the clock to give the states the same power they had before *SEUA*.[383] He also refused to give any weight to the words "[i]t is not the intention of Congress . . . to clothe the States with any power to regulate or tax the business of insurance

376. *See* Soward v. United States, 858 F.2d 445, 455 (9th Cir. 1989); Gordon v. United States, 846 F.2d 272, 274 (4th Cir. 1988) (*per curiam*); Langdeau v. United States, 363 S.W.2d 327, 328-29, 332 (Tex. App. 1962).

377. *See Soward*, 858 F.2d at 452-53; *Gordon*, 846 F.2d at 273-74; *Langdeau*, 363 S.W.2d at 330-31. *Cf. In re* Arrow Carrier Corp., 154 B.R. 642, 645 (Bankr. D. N.J. 1993) (deciding prior to the Supreme Court's decision in *Fabe* that state laws providing that claims for unpaid workman's compensation insurance premiums are entitled to a preference in insolvency proceedings do not regulate the business of insurance and are preempted by the Bankruptcy Code).

378. *See* Fabe v. United States, 939 F.2d 341, 350-52 (6th Cir. 1991).

379. *See* United States Dep't of the Treasury v. Fabe, 508 U.S. 491 (1993).

380. *See id.* at 493, 508-10.

381. *Id.* at 499.

382. *See id.*, discussing Securities & Exch. Comm'n v. National Secs., Inc., 393 U.S. 453 (1969).

383. *See Fabe*, 508 U.S. at 506.

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beyond that which they had been held to possess prior to the decision of the United States Supreme Court in *SEUA*,"[384] characterizing it as a "single statement in a House Report."[385] In point of fact, the Act's co-sponsor, Senator McCarran had quoted this language on the floor of the Senate the day before it approved the Act and then summarized it as follows: "In other words, we give to the states no more powers than those they had, and we take none from them."[386] Justice Blackmun then set forth his interpretation of the Act's preemption exception, citing in a footnote a statement by Senator Ferguson to substantiate his view:

> Ordinarily, a federal law supersedes any inconsistent state law. The first clause of s 2(b) reverses this by imposing . . . a rule that state laws enacted "for the purpose of regulating the business of insurance" do not yield to conflicting federal statutes unless a federal statute specifically requires otherwise. That Congress understood the effect of its language becomes apparent when we examine other parts of the legislative history.[FN7]
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> FN 7. Elaborating on the purpose animating the first clause of § 2(b) of the McCarran-Ferguson Act, Senator Ferguson observed:
>
> What we have in mind is that the insurance business, being *interstate commerce*, if we merely enact a law relating to *interstate commerce*, or if there is a law now on the books relating in some way to *interstate commerce*, it would not apply to insurance. We wanted to be sure that the Congress, in its wisdom, would act specifically with reference to insurance in enacting the law. 91 Cong. Rec. 1487 (1945). (emphasis added).[387]

As has been demonstrated earlier, the federal priority statute is not a law relating to interstate commerce, and its application to the insurance business does not depend on the fact that insurance is interstate

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384. *Id.* (quoting H.R. REP. NO. 79-143, at 3 (1945)).

385. *Id.* at 506.

386. 90 CONG. REC. 1442 (1945). The statement also appears in another House Report. *See* H.R. REP. NO. 79-68 at 2 (1944).

387. *Fabe*, 508 U.S. at 507.

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commerce.[388] Therefore, the quoted passage rebuts rather than supports Justice Blackmun's contention that Section 2(b) preempts the priority statute.[389]

Much of the majority opinion is devoted to the issue of whether the provisions of the Ohio insolvency statute that give preference to claims of policyholders and guaranty associations and to the costs of administering the insolvent estate are laws enacted for the purpose of regulating the business of insurance.[390] Justice Blackmun reasoned that these provisions regulated the business of insurance, because their enforcement increased the likelihood that the insurance contracts issued by the insurer prior to insolvency would be performed.[391] However, an examination of the

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388. *See* discussion *supra* Part I.B.7.

389. For additional support for the proposition that section 2(b) is applicable only to commerce clause statutes *see supra* Parts II.B.3, II.B.6.

390. *See Fabe*, 508 U.S. at 501-06, 509-10. In his dissent, Justice Kennedy argues that the Ohio statute was not enacted for the purpose of regulating the business of insurance because: (i) its purpose was to regulate the priorities of policyholders and other competing classes of creditors, and (ii) insolvency and the liquidation of insurance companies are not the business of insurance. *See id.* at 510-19 (Kennedy, J., dissenting).

391. The Court phrases this conclusion in a variety of ways: (i) "the Ohio priority statute escapes preemption to the extent that it protects policyholders"; (ii) "federal law must yield to the extent that the Ohio statute furthers the interests of policyholders"; and (iii) "by insuring the payment of policyholders'claims . . . Ohio's law is one 'enacted by any State for the purpose of regulating the business of insurance.'" *Id.* at 493, 502, 504. However, the Court felt that the provisions of the Ohio insolvency statute that preferred claims for unpaid wages and claims of general creditors were not laws that regulated the business of insurance, because these two categories of claims had only a tenuous connection to the performance of insurance policies. *See id.* at 508-09. The Court's remand instructed that the issue of severability be addressed, i.e, whether the Ohio insolvency statute could be sustained in light of the invalidity of these two provisions. *See id.* at 509-10. The federal district court ruled that the invalid provisions were not severable. *See* Duryee v. United States, 6 F. Supp. 2d 700 (S.D. Ohio 1995). At this point, the Ohio legislature amended the insolvency statute to conform to the Supreme Court's decision and made its provisions retroactively applicable to the insolvency proceedings that had given rise to the *Fabe* litigation. *See* 1995-1996 Ohio Laws, § 3 of sub. H.B. 374, 4406, 4478 (effective Dec. 4, 1995). The amending statute provided that its validity could only be contested in the Supreme Court of Ohio. *See id.* For a discussion of the constitutionality of provisions barring access to the federal courts, *see infra* Part III.B.12. The NAIC has promulgated a new Insurers Rehabilitation and Liquidation Model Act that contains a ranking of claims that conforms to the *Fabe* decision. *See* NAIC, Model Laws, Regulation and Guidelines, 555-1, 555-52, § 47 (1998). It has been adopted in most jurisdictions. *See* Insurers Rehabilitation and Liquidation Model Act, Westlaw database NAIC-MODLRG, Citation NAIC 555-63 (2000).

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relevant provisions of state insurance law reveals that Justice Blackmun's conclusion about the relationship between the preference afforded guaranty associations and the performance of insurance contracts is fundamentally flawed. Every state requires solvent insurance companies doing business in the jurisdiction to belong to a guaranty association.[392] The guaranty association is obligated to pay the claims of policyholders against insolvent insurers on an expedited basis outside the context of the insolvency proceedings by assessing its members.[393] The guaranty association is then subrogated to the rights of the policyholders and is entitled to assert those rights in the insolvency proceedings.[394] These subrogation claims make up the largest category of claims against the estate of most insolvent insurance companies.[395] The obligation of the insurance companies to contribute to the guaranty association is unconditional. It does not depend on whether the funds paid to the guaranty association can be recovered in insolvency proceedings. Therefore, the provision of the Ohio law that prefers guaranty association claims to those of the federal government does not increase the chances that insurance contracts will be honored. It fails Justice Blackmun's own test for identifying a law that regulates the business of insurance.[396]

Further analysis of state insurance law reveals a public policy objection to the result reached by *Fabe*. The assessments paid to guaranty

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392. *See* OHIO REV. CODE ANN. § 3955.01(F) (Page 1996) (providing that all entities that write insurance in the state are members of the guaranty association); Howard, *supra* note 25, at 14; INSURANCE INFORMATION INSTITUTE, 1999 FACT BOOK 41-43 (1998) (a general description of property/casualty guaranty associations).

393. *See* OHIO REV. CODE ANN. §§ 3955.08(A)(1) (obligation of the guaranty association to pay policyholder claims), 3955.08(A)(3) (authority of the guaranty association to assess members) (Anderson 1996); *see also* Howard, *supra* note 25, at 14-17. States have separate guaranty associations for different types of insurance. *See id.* at 15.

394. *See* OHIO REV. CODE ANN. §§ 3903.42(C), 3955.12 (Page 1996); Howard, *supra* note 25, at 15.

395. *See* INSURANCE INFORMATION INSTITUTE, 1999 FACT BOOK, inside cover (1998) (indicating that losses paid on policies are the largest expense of property/casualty insurers); *see id.* at 43 (listing the amounts that property and casualty insurers have been assessed by guaranty associations since 1969).

396. In *Costle v. Fremont Indemnity Co.*, 839 F. Supp. 265 (D. Vt. 1993), decided just after *Fabe*, the court held that a liquidation order implementing state law authorizing the collection of debts owed an insolvent insurance company did not regulate the business of insurance because policyholder claims had already been satisfied. *See Costle*, 839 F. Supp. at 274.

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associations by insurance companies may by recouped by offsets against state premium taxes or by increasing premium rates.[397] This means that the cost of paying the claims of the policyholders of insolvent insurance companies initially falls on the solvent insurance companies, but is then shared by the state's residents in the form of increased taxes or reduced services resulting from a decrease in premium tax collections and in the form of higher insurance premiums. By denying the federal government the right to enforce the priority statute, the *Fabe* decision makes it possible to shift part of this financial burden to the federal government and, ultimately, to federal taxpayers. The state insurance regulators and, in some states, the state guaranty associations[398] are responsible for monitoring and assuring insurance company solvency. The profits from the state's insurance industry flow to the insurance companies doing business in the state. The residents of the state have the political power to elect or fail to reelect state governments that pursue lax insurance regulatory policies that result in higher taxes, reduced services and/or higher insurance rates. It would seem axiomatic that the cost of failed insurance regulatory policies should remain at the state governmental level where they are formulated and apportioned among the parties that interact at that level of government.[399]

Cases decided subsequent to *Fabe* involving conflicts between the federal priority statute and state insurance company insolvency statutes have produced mixed results. In *Garcia v. Island Program Designer*,[400] a case involving an HMO, the First Circuit, per Judge (now Justice) Breyer, concluded that the priority statute entitled a late filed-federal claim to first priority, despite a provision of Puerto Rican insurance law that relegated

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397. *See* INSURANCE INFORMATION INSTITUTE, 1999 FACT BOOK 42 (1998).

398. Guaranty associations play a role in the detection and prevention of insurance company insolvencies. *See* OHIO REV. CODE ANN. § 3955.14 (Page 1996); *see also* Howard, *supra* note 25, at 17-18.

399. For other examples of the use of the preemption exception to shift insurance insolvency costs to the federal government by invalidating non-commerce clause laws, *see infra* pp. 78-79, *infra* n. 400, and Part III.B.11.

400. 4 F.3d 57, 62 (1st Cir. 1993); *but see* West Virginia *ex rel.* Clark v. Blue Cross Blue Shield of West Virginia, Inc., 510 S.E.2d 764, 786 (W. Va. 1998). The court ruled that the Act preempted the federal priority statute with respect to claims filed by the Department of Veterans Affairs, the Health Care Administration (Medicare), and the federal Office of Personnel Management. *See West Virginia ex rel. Clark*, 510 S.E.2d at 770-72, 781-86.

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late-filed claims to a sixth priority, reasoning that the late-filing penalty redounded to the benefit of all creditors, and, therefore, the statute was not enacted for the purpose of regulating the business of insurance.[401] On remand from the First Circuit, the District Court considered the issue of whether the claims of health service providers were entitled to prevail over the claims of the federal government.[402] The court held that since the Puerto Rican insolvency statute provided no separate category for such claims, they would be considered under the provisions relating to wage claims or to the claims of general creditors, and that neither of these provisions was a law regulating the business of insurance.[403] The court rejected an argument, which doubtless will be raised again, that it is the nature of the claim and its relationship to the performance of the insurance contract rather than the statutory category under which it is filed that determines whether the claim should prevail over the priority statute.[404] In 1997, a federal district court held that the Illinois insurance company insolvency statute that ranked federal government claims behind costs of administering the estate, policyholders claims and the claims of the Illinois insurance guaranty fund was a law regulating insurance and, therefore, preempted the federal priority statute. [405]

In assessing how the Court might resolve issues relating to the federal priority statute in the future, it is interesting to note that only three of the five-Justice majority in *Fabe* remain on the Court, Chief Justice Rehnquist, Justice Stevens and Justice O'Connor. All four of the dissenters, Justice Kennedy, Justice Scalia, Justice Souter and Justice Thomas still serve. Justice Breyer joined the Court after *Fabe.* His opinion in *Garcia* would indicate a less-than-enthusiastic view of the majority's position.

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401. *See Garcia*, 4 F.3d at 61-62.

402. *See* Garcia v. Island Program Designer, 875 F. Supp. 940, 942-43 (D. P.R. 1994), aff'd, 62 F.3d 1411 (1st Cir. 1995).

403. *See id.* at 944-45.

404. *See id.* at 942-44.

405. *See* Bozell v. United States, 979 F. Supp. 670 (N.D. Ill. 1997); *see also* Union Indem. Ins. Co. of New York v. United States, 216 A.D.2d 48, 49-50 (1995) (holding that claims of the United States ranked behind claims for the costs and expenses of administering the liquidation of an insolvent insurer).

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8. Bankruptcy

Domestic insurance company insolvencies have not been administered under the Bankruptcy Act since 1910.[406] However, this does not prevent conflicts between federal bankruptcy law and state insurance law. Section 304 of the Bankruptcy Code authorizes representatives in foreign bankruptcy proceedings to institute ancillary proceedings in U.S. bankruptcy courts.[407] A pair of cases decided in the Bankruptcy Court for the Southern District of New York held that Section 304 of the Bankruptcy Code preempted Section 1213 of the New York Insurance Code.[408] In *In re Laitasalo*,[409] the bankruptcy court enjoined the Pennsylvania insurance commissioner from seeking to require that an insolvent Finnish insurance company post security as required by Section 1213. In *In re Rubin*,[410] the bankruptcy court stayed various actions against an Israeli insurance company that was not admitted to do business in the state of New York and authorized the claims of American creditors to be determined in an Israeli insolvency proceeding.[411] This meant that the Israeli insurance company wouldn't have to post the security required by Section 1213. In *In re Jacobs*,[412] a bankruptcy court enjoined the Oklahoma insurance commissioner from revoking an insurance agent's license for failure to repay to an insurance company an indebtedness that had been discharged in bankruptcy. *In re Arrow Carrier Corp.*[413] involved an issue analogous to that faced by the Supreme Court in *Fabe*.[414] The laws of various states give claims for unpaid workman's compensation premiums a priority status in bankruptcy.[415] The Bankruptcy Code does not.[416] The Court held that the Act did not cause the state statutes to prevail over the Bankruptcy

406. *See* discussion *supra* Part I.B.8.

407. *See* 11 U.S.C. § 304.

408. *See* N.Y. INS. LAW § 1213(c)(1) (McKinney 1985). This is the same provision of New York insurance law that was at issue in the cases discussed *supra* in Part III.B.2.

409. 193 B.R. 187, 194-95 (Bankr. S.D.N.Y. 1996).

410. 160 B.R. 269, 281-83 (Bankr. S.D.N.Y. 1993).

411. *See id.* at 279.

412. 149 B.R. 983, 993 (Bankr. N.D. Okla. 1993).

413. 154 B.R. 642 (Bankr. D. N.J. 1993).

414. *See* discussion *supra* Part III.B.8. *Arrow Carrier* was decided shortly before *Fabe*.

415. *See In re* Arrow Carrier Corp., 154 B.R. 642, 644 (Bankr. D. N.J. 1993).

416. *See id.* at 646.

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Code.[417] However, a bankruptcy court in Puerto Rico reached an opposite conclusion. It held that the Act caused a provision of Commonwealth law that required all suits against insolvent insurance companies to be brought in state court to preempt the provisions of the Bankruptcy Code authorizing a debtor to secure the turnover of property.[418]

The *Laitasalo* and *Rubin* cases invoke the Second Circuit narrow application rule. They noted that the international law aspects of Section 304 of the Bankruptcy Code are far different from the type of federal statute that the Act was designed to protect against and concluded that the Act was not intended to preempt federal laws dealing with matters of national concern.[419] The *Jacobs* case also states that the Act should be narrowly construed.[420] The court in *Arrow Carrier* concluded that the state laws that granted priority to claims for unpaid workmen's compensation premiums did not regulate the business of insurance.[421]

9. Copyright (U.S. CONST. art. I, § 8, cl. 8)

The copyright statute was enacted pursuant to congressional authority to promote "Science and the Useful Arts."[422] Competition within the insurance industry has sparked an increasing interest among insurance companies in securing the right to market products exclusively by obtaining copyright or other intellectual property law protection.[423] This development has brought the copyright statute into conflict with state insurance statutes and administrative policies that allow policies and forms

417. *See id.* at 647.

418. *See In re* Advanced Cellular Sys., 235 B.R. 713 (Bankr. D. P.R. 1999). The court determined that the Commonwealth statute at issue was enacted for the purpose of regulating the business of insurance and would be impaired by the conflicting provision of the Bankruptcy Code. *See id.* at 717-20.

419. *See In re* Laitasalo, 193 B.R. 187, 192-93 (Bankr. S.D.N.Y. 1996); *In re* Rubin, 160 B.R. 269, 278-81 (Bankr. S.D.N.Y. 1993).

420. *See In re* Jacobs, 149 B.R. 983, 989-90 (Bankr. N.D. Okla. 1993).

421. *See In re* Arrow Carrier Corp., 154 B.R. 642, 645 (Bankr. D. N.J. 1993).

422. U.S. CONST. art. I, § 8, cl. 8.

423. *See* Bruce Foudree & Peter Tryzna, *Toward Exclusive Right to Market Innovative Insurance Products: The Use of Intellectual Property Law in the Business of Insurance*, 41 DRAKE L. REV. 587, 589, 596 (1992). Insurance policies and underwriting guidelines may be copyrighted. *See id.* at 593-94.

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filed with insurance regulators to be copied and utilized by competitors.[424] In *Progressive Corp. v. Integon P & C Corp.*,[425] an unpublished opinion, the Fourth Circuit upheld the dismissal of a claim for copyright infringement based on the copying of an automobile insurance rate manual.[426] Virginia insurance law required that all rate information be filed with the commissioner and that such information be available for public inspection and copying.[427] The court reasoned that granting copyright protection to such material was not permissible under the Act because this would interfere with the state's regulation of insurance.[428] A subsequent Louisiana district court decision, *B & S Underwriters, Inc. v. Clarendon National Insurance Co.*,[429] declined to follow *Progressive* and denied a defendant's motion for summary judgment directed against a claim for copyright infringement based on the copying of a workman's compensation program.[430] The court held that the copyright statute was not preempted by the combination of an Alabama statute that required all policies to be filed with the insurance commissioner and the commissioner's administrative policy of approving policies that were copies of policies that had been previously filed.[431] The court stated that the Alabama insurance commissioner's policy of approving copied policies did not regulate the business of insurance, and therefore, enforcement of the copyright statute did not interfere with the Commissioner's authority to approve or disapprove policies.[432]

The United States is a party to a number of international agreements relating to copyright, the most important of which is the Berne

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424. Such utilization of policies and forms by competitors is apparently a widespread practice. *See* B & S Underwriters, Inc. v. Clarendon Nat'l Ins. Co., 892 F. Supp. 815, 818-19 (W.D. La. 1995).

425. 20 U.S.P.Q. 2d 1682, 1683 (1991).

426. *See id.* at 1684-87.

427. *See id.* at 1685. The court dealt with the issue of the conflict between the copyright law and state insurance regulation, even though it determined that the material that was the subject to the infringement claim was in the public domain. *See id.* at 1685-86.

428. *See id.* at 1686-87. The court also felt that this result was dictated by the provision in the Copyright Act that preserves rights under other federal statutes. *See id.* at 1687. For a criticism of the *Progressive* case, *see* Foudree & Tryzna, *supra* note 423, at 595.

429. 892 F. Supp. 815, 817-18 (W.D. La. 1995).

430. *See id.* at 816-19.

431. *See id.* at 819.

432. *See id.*

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Convention.[433] The Berne Convention and its implementing legislation provide that the United States will give the authors of works originating in any of the countries subscribing to the Berne Convention "national treatment," i.e., these works will be provided the same level of copyright protection that is given to works of American nationals.[434] The Berne Convention also provides for certain "minimum rights irrespective of domestic law."[435] State insurance laws of the type that were at issue in the *Progressive* and *B & S Underwriters* cases may conflict not only with federal copyright power, but also with the treaty power, raising the same issues as were present in the cases discussed *supra* Part III.B.5.

10. The Postal Power (U.S. CONST. art. I, § 8, cl. 7)

The federal statute making mail fraud a crime is an exercise of congressional authority to establish post offices and post roads.[436] Just six years after the passage of the Act, the Seventh Circuit held that the Act did not cause Illinois insurance law to preempt the mail fraud statute even though the activities that gave rise to the indictment, misrepresentations made in connection with the sale of insurance policies through the mail, could have been prosecuted under Illinois law.[437] The court concluded that:

> [I]t was not the intent of Congress, by its passage of the McCarran Act, to surrender control of the use of the mails or to cease to authorize the federal courts to determine whether the mails have been utilized in attempted execution of a scheme to defraud . . . .[438]

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433. For a listing of these agreements and the signatory countries, *see* William A. Tanenbaum, *An Analysis and Guide to the Berne Convention Implementation Act: Amendments to the United States Copyright Act*, 13 HAMLINE L. REV. 253, app. at 278-83 (1990).

434. MELVILLE B. NIMMER & PAUL EDWARD GELLER, INTERNATIONAL COPYRIGHT LAW AND PRACTICE, §§ 2[3] (b), 5[4] (b) (1988); Berne Convention Implementation Act of 1988, Pub L. No. 100-568, 102 Stat. 2853 (1988).

435. NIMMER & GELLER, *supra* note 434, at § 5[4] (a).

436. *See* U.S. CONST. art. I, § 8, cl. 7. *See, e.g.*, United States v. Loring, 91 F. 881, 882-83 (N.D. Ill. 1884).

437. *See* United States v. Sylvanus, 192 F.2d 96, 100 (7th Cir. 1951).

438. *Id.* This language is quoted in United States v. Stewart, 955 F. Supp. 385, 390-91 (E.D. Pa. 1997). The Seventh Circuit also indicated that the prosecution would not interfere with the regulation of insurance companies by the state. *See Sylvanus*, 192 F.2d at 100.

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A series of more recent cases have upheld federal convictions based on the use of the mails to misrepresent the financial condition of insurance companies to state insurance regulators, to siphon off assets or to sell worthless insurance policies.[439] The opinions indicate that a criminal prosecution for such activity does not invalidate, impair or supersede state insurance law despite the fact that the conduct upon which the convictions were based involved interaction with state insurance regulators as required by state insurance law or were the subject of other provisions of state law.[440] One of the cases distinguishes decisions that hold that the Act does cause state insurance statutes to preempt civil RICO suits by stating:

> RICO is based on the commerce clause, and exactly the sort of statute which the McCarran-Ferguson Act intended to supplant. The mail fraud statute is based on Congress' power to regulate the use of the mails, a power which it had no intention of surrendering when it passed McCarran-Ferguson.[441]

The mail fraud statute is the only non-commerce clause criminal law that has been the subject of decisions involving the Act's preemption exception. However, there would appear to be nothing in the language of the Act or its legislative history that would warrant treating criminal statutes differently from other federal laws.

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439. *See* United States v. Blumeyer, 114 F.3d 758 (8th Cir. 1997); United States v. Krenning, 93 F.3d 1257 (5th Cir. 1996); United States v. Cavin, 39 F.3d 1299 (5th Cir. 1994); United States v. Stewart, 955 F. Supp. 385 (E.D. Pa. 1997); United States v. Schmittzehe, Crim. A. No. 91-514, WL 635030 (E.D. La. Nov. 10, 1994). In *United States v. Cooper*, the court declined to review the issue of whether the Act would cause preemption of the federal mail fraud statute (but indicated by way of dictum that if it were to do so, it would be instructed by the fact that the three circuit courts that had directly faced the issue had determined that the mail fraud statute was not preempted). *See* United States v. Cooper, 132 F.3d 1400, 1404, n.3 (11th Cir. 1999). *But cf.* United States v. O'Brien, 501 F. Supp. 140 (E.D. Pa. 1980) (court looked to state law to determine whether the conduct upon which the conviction was based constituted fraud).

440. *See Blumeyer*, 114 F.3d at 768; *Krenning*, 93 F.3d at 1268, n.16; *Cavin*, 39 F.3d at 1305; *Stewart*, 955 F. Supp. at 391; *Schmittzehe*, Crim. A. No. 91-514 WL 635030, at *3-4. The court in *Schmittzehe* also indicated that the defendant's conduct did not fall within the business of insurance. *See id.* at *3; *accord Stewart*, 955 F. Supp. at 389.

441. *Schmittzehe*, Crim. A. No. 91-514, WL 635030, at *4; *cf. Blumeyer*, 114 F.3d at 768.

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11. The Necessary and Proper Clause (U.S. CONST. art. I, § 8, cl. 18)

Congressional authority to implement the powers specifically conferred on the federal government includes the establishment of departments and agencies[442] and the provision of compensation and benefits for their employees.[443] The Federal Employees Compensation Act ("FECA") provides for payments to federal employees who are injured in the course of their employment.[444] It also provides that the federal government is subrogated to the claims of employees against third parties with respect to injuries that are compensable under FECA.[445] The Rhode Island Insurer's Insolvency Fund Act establishes a mechanism whereby insurers doing business in the state provide a guaranty fund to pay claims against insolvent companies. The statute also provides that no subrogation claim due any insurer can be maintained against the guaranty fund.[446] A federal district court held that the Act caused the Rhode Island bar against subrogation claims to preempt the federal government's authority to pursue such claims pursuant to FECA.[447] In the course of reaching this conclusion, the court determined that FECA did not specifically relate to insurance,[448] that the Rhode Island Insurer's Insolvency Fund Act was enacted for the purpose of regulating the business of insurance,[449] and that the United States was an "insurer" for purposes of the provision of the Rhode Island statute that barred subrogation claims by such entities against the guaranty fund.[450] The effect of the decision is to increase the cost to the federal government, and ultimately to federal taxpayers, of administering FECA and to decrease the size of the assessment payable into the guaranty fund by the solvent insurance companies in Rhode Island.

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442. *See* U.S. Const. art. I, § 8, cl. 18; *see also* Graves v. New York ex rel. O'Keefe, 306 U.S. 466, 477 (1939); Pittman v. Home Owner's Loan Corp., 308 U.S. 21, 32-33 (1939); 16 C.J.S. Constitutional Law § 55 (1984).

443. *See, e.g.*, Atkins v. United States, 556 F.2d 1028, 1061 (1977), cert. denied, 434 U.S. 1009 (1978).

444. *See* 5 U.S.C. § 8102(a) (1987).

445. *See* 5 U.S.C. § 8131 (1987).

446. *See, e.g.*, Kachanis v. United States, 844 F. Supp. 877, 879 (D. R.I. 1994).

447. *See id.*at 889.

448. *See id.* at 882-83.

449. *See id.* at 883-85.

450. *See id.* at 887-89.

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12. The Jurisdiction of the Federal Courts (U.S. CONST. art. III, § 2, cl. 1)

The statute providing for the removal of cases from state courts is a congressional implementation of the constitutional provision establishing the jurisdiction of the federal courts.[451] An Ohio statute effectively prohibited out-of-state insurance companies from exercising their rights under the removal statute by providing that if they did so, the superintendent of insurance would revoke their authority to do business in the state.[452] The Eighth Circuit held that the removal statute preempted the Ohio statute.[453] The court determined that the Ohio statute did not regulate the business of insurance and, on that basis, rejected the argument that the Act saved it from preemption.[454]

13. Due Process, Equal Protection and Civil Rights Laws

During the *Paul-SEUA* era, the Supreme Court had applied due process and equal protection clause limitations to state insurance legislation with some frequency.[455] The Court has held that these constitutional protections also apply to state insurance legislation in cases decided subsequent to the Act. In *State Board of Insurance v. Todd Shipyards Corp.*,[456] the Court struck down a Texas statute that taxed out-of state insurance companies on premiums received outside the state on policies written outside the state covering properties located within the state. Justice Douglas cited the Act's legislative history indicating that Congress did not wish to overturn the pre-*SEUA* cases applying due

451. *See* U.S. CONST., art. III, § 2, cl. 1; *see also* 28 U.S.C. § 1441 (1999).

452. *See* OHIO REV. CODE ANN. § 3927.05 (Baldwin 1995).

453. *See* International Ins. Co. v. Duryee, 96 F.3d 837, 838 (8th Cir. 1996). The Supreme Court case cited by the Eighth Circuit as the basis for its decision indicates that such a statute would violate the equal protection and due process clauses. *See* Terral v. Burke Constr. Co., 257 U.S. 529, 532-33 (1922). *Cf.* Ben v. GMAC, 374 F. Supp. 1199, 1202-03 (D. Colo. 1974) (holding that the Act did not prevent a plaintiff from pursuing a claim based on discrimination against native Americans in the sale of insurance in federal court).

454. *See Duryee*, 96 F.3d at 838-40.

455. *See* cases cited *supra* note 128.

456. 370 U.S. 451 (1962).

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process protections to the insurance industry.[457] He also asserted that the Court, not the Congress, had the final say as to what constitutes due process under the Fourteenth Amendment.[458] In *Metropolitan Life Insurance Co. v. Ward*,[459] the Court, in a five-to-four decision, struck down an Alabama statute that imposed a higher tax on premiums earned by out-of-state insurers than on premiums earned by domestic insurers. Writing for the majority, Justice Powell stated:

> Although the McCarran-Ferguson Act exempts the insurance industry from Commerce Clause restrictions, it does not purport to limit in any way the applicability of the Equal Protection Clause . . . . [O]ur opinion in *Western & Southern* expressly reaffirmed the viability of equal protection restraints on discriminatory taxation in the insurance context.[FN8]
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> [FN8] In fact, as we noted in *Western & Southern,* the legislative history of the McCarran-Ferguson Act reveals the Act was Congress' response only to *United States v. South-Eastern Underwriters Assn.,* 322 U.S. 533, 64 S. Ct. 1162, 88 L.Ed. 1440 (1944), and that Congress did not intend thereby to give the States any power to tax or regulate the insurance industry other than what they had previously possessed.[460]

The Fourteenth Amendment specifically authorizes Congress to pass legislation for the purpose of enforcing the rights granted by the equal protection clause.[461] Conflicts between state insurance laws and federal

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457. *See id.* at 455-56. Justice Douglas quoted Senator McCarran's statement during the Senate debate: ". . . we give to the states no more power than they previously had, and we take none from them." *Id.* at 455.

458. *See id.* at 457.

459. 470 U.S. 869 (1985).

460. *See id.* at 881.

461. *See* U.S. CONST. amend. XIV, § 5. When a conflict occurs between federal civil rights legislation and the Act's preemption provision, the civil rights legislation is a fortiori being applied to state action, i.e., the conflicting state insurance law which authorizes or requires a violation of the civil rights legislation. This principle is not affected by the fact that to avoid doubts that may have existed as to its authority under Section 5 to extend Fourteenth Amendment rights to places of public accommodation, Congress has in some instances relied upon its commerce clause powers in passing civil rights legislation. *See* 4

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civil rights legislation have given rise to a significant volume of litigation. One line of cases involves the prohibition against discrimination in terms of employment contained in Title VII of the Civil Rights Act of 1964.[462] The Supreme Court determined that the use by employer-sponsored retirement plans of sex-based actuarial tables that required higher contributions from, and/or provided smaller benefits to, women based upon their greater life expectancy constituted a violation of Title VII.[463] In *Arizona Governing Committee v. Norris*,[464] Justice Marshall, speaking for the majority, found that Title VII governed the actions of the employers who established the plans, not the actions of the insurance companies that administered the plans. This led him to conclude that any Arizona statute that allowed employers to utilize sex-based classifications would not be a law regulating the business of insurance. Justice Marshall also questioned whether the issue of the Act's effect on Title VII was properly before the Court.[465] In a dissenting opinion, Justice Powell relied on the Act's objective of preserving state regulation of insurance to support his position that Congress did not intend Title VII to prohibit the use of single-sex mortality tables, but he did not assert that the Act's preemption provision caused state insurance law to prevail over Title VII.[466] Two earlier decisions within the Second Circuit reached the same conclusion as *Norris* but dealt more directly with the conflict between the Act's preemption provision and state insurance law. In *Spirt v. Teachers Insurance & Annuity Association*,[467] the Second Circuit held that the Act did not shield insurers that administered employer annuity plans from Title VII's prohibition on the use of sex-based mortality tables. The court cited the Act's legislative history as indicating that Congress intended to address the

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RONALD D. ROTUNDA & JOHN E. NOWAK, TREATISE ON CONSTITUTIONAL LAW SUBSTANCE & PROCEDURE § 19.2, at 5 (3d ed. 1999).

462. 42 U.S.C. § 2000e-2(a) (1).

463. *See, e.g.*, Los Angeles Dep't of Water & Power v. Manhart, 435 U.S. 702 (1978); Arizona Governing Comm. v. Norris, 463 U.S. 1073 (1983) (five-to-four decision on the issue of whether the employer sponsored retirement plan violated Title VII).

464. 463 U.S. 1073, 1087 (1983).

465. *See id.*

466. *See id.* at 1099-1103.

467. 691 F.2d 1054 (2d Cir. 1982). *See also* Peters v. Wayne State Univ., 476 F. Supp. 1343, 1351 (E.D. Mich. 1979) (holding that Teachers Insurance and Annuity Association (TIAA) was subject to Title VII because it was not engaged in the business of insurance), *rev'd on other grounds*, 691 F.2d 235 (6th Cir. 1982).

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concern that traditional forms of state regulation and taxation of insurance could be invalidated on commerce clause grounds, but did not intend to clothe the states with powers that they did not possess prior to *SEUA*.[468] The court concluded that in passing the Act, Congress did not intend that "subsequently enacted civil rights legislation would be inapplicable to any and all of the activities of an insurance company that can be classified as 'the business of insurance.'"[469] The court also cited the fact that Title VII contains broad language indicating an intent to preempt state law.[470] A year before *Spirt*, a decision in the Southern District of New York, *Women in City Government United v. New York*,[471] had invalidated the use of sex-based mortality tables by the city of New York Retirement System. The decision used essentially the same reasoning as *Spirt*, and made the following statement:

> [T]he Act should not be applied indiscriminately to subsequent federal legislation, the overriding purpose of which is not the regulation of commerce but the protection of other important federal interests, solely because that legislation fails specifically to state that it is applicable in circumstances where insurance interests are implicated.[472]

The *Spirt* and *Women in City Government United* cases gave rise to the Second Circuit's narrow application rule that dictates that the Act will not be construed to cause state insurance laws to preempt federal non-commerce clause laws that relate to matters of national concern such as international commerce or civil rights. The rule has been generally followed within the Second Circuit in cases involving such conflicts.[473] In

468. *See* Spirt, 691 F.2d at 1064-65 (2d Cir. 1982).

469. *Id.* at 1065; *accord* Women in City Gov't United v. New York, 515 F. Supp. 295, 303 (S.D.N.Y. 1981); Hannahs v. New York State Teacher's Retirement Sys., No. CIV.A.78-Civ. 2541 CSH, 1981 WL 226, at *9 (S.D.N.Y. July 10, 1981). The court in *Hannah* also determined that Title VII specifically related to insurance even though the business of insurance is not mentioned in its text. *See id.* at *9.

470. *See Spirt*, 691 F.2d at 1065; *accord Women in City Gov't United*, 515 F. Supp. at 303.

471. 515 F. Supp. 295 (S.D.N.Y. 1981).

472. *Id.* at 303.

473. *See supra* note 305 and accompanying text.

EEOC v. Wooster Brush Co.,[474] a federal district court relied on the narrow application rule to reach the conclusion that the preemption exception did not shield an employer sponsored and supported disability plan that did not cover disabilities arising from pregnancies from the application of Title VIII.

Title VIII of the Civil Rights Act of 1968, known as the Fair Housing Act ("FHA"), was intended to eliminate racial discrimination in the field of housing.[475] It can be enforced by private civil actions that may be tried before a jury and result in the award of punitive damages.[476] The FHA has been construed to apply to the sale of homeowners' insurance,[477] which means that it covers conduct that is also the subject of state insurance laws. However, the courts have unanimously concluded that the FHA does not invalidate, impair or supersede state insurance law despite the fact that it duplicates such law and provides additional remedies for the same type of conduct.[478] The FHA is, therefore, not preempted by the Act.[479] However, in *NAACP v. American Family Mutual Insurance Co.*,[480] the Seventh Circuit indicated that if a state insurance law did authorize racial discrimination, the Act would cause such a law to prevail over the Fair Housing Act. The existence of a state statute that could be construed as authorizing intentional discrimination in the sale of homeowners' insurance is highly unlikely. However, the courts have interpreted the

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474. 523 F. Supp. 1256, 1265 (N.D. Ohio 1981). The court also determined that the entity providing the disability benefits was not engaged in the business of insurance and that no state insurance law was invalidated, impaired or superseded by the application of Title VII. *See id.* at 1265-67.

475. *See* Fair Housing Act of 1968, Pub. L. No. 90-284, Title VIII § § 801-809, 82 Stat. 81-89 (codified at 42 U.S.C. §§ 3601-3631).

476. *See* 42 U.S.C. § 3612; *see also* Nationwide Mut. Ins. Co. v. Cisneros, 52 F.3d 1351, 1363 (6th Cir. 1995), *cert. denied*, 516 U.S. 1140 (1990).

477. *See Cisneros*, 52 F.3d at 1355-60; United Farm Bureau Mut. Ins. Co. v. Metropolitan Human Relations Comm'n, 24 F.3d 1008, 1013-16 (7th Cir. 1994); NAACP v. American Family Mut. Ins. Co., 978 F.2d 287, 297-301 (7th Cir. 1992), *cert. denied*, 508 U.S. 907; Strange v. Nationwide Mut. Ins. Co., 867 F. Supp. 1209, 1214 (E.D. Pa. 1994); McDiarmid v. Economy Fire & Cas. Co., 604 F. Supp. 105, 107-08 (S.D. Ohio 1984); Pierce v. Metropolitan Prop. & Liab. Ins., No. C-3-82-044, 1984 U.S. Dist. LEXIS 24653, at *3-4 (S.D. Ohio Aug. 1, 1984); Dunn v. Midwestern Indem. Co., 472 F. Supp. 1106, 1108-11 (S.D. Ohio 1979); *but see* Mackey v. Nationwide Ins. Cos., 724 F.2d 419, 422-24 (4th Cir. 1984).

478. *See id.*

479. *See id.*

480. 978 F.2d 287, 297 (7th Cir. 1992).

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FHA in contexts other than the sale of insurance as prohibiting practices that have a "disparate impact" on minorities.[481] If the FHA was interpreted to prohibit homeowners insurance underwriting practices that were facially neutral but had a disparate impact on minorities, it would conflict directly with state insurance statutes that allow the use of specific underwriting criteria.[482] Under such circumstances, the reasoning in the cases referred to above, i.e., that duplication of purpose and the provision of additional remedies by a federal law doesn't impair a state insurance statute, would not be applicable, and absent some other legal theory, the FHA would be preempted.

There has also been litigation involving the application of the Act's preemption provision to the Civil Rights Act's guarantee that all citizens shall enjoy the same property rights as white citizens.[483] A Colorado federal district court denied a motion to dismiss a claim that the practice of charging native Americans higher insurance premiums for auto insurance violated the Civil Rights Act, holding that despite the existence of a comprehensive scheme of state insurance regulation and the availability of state law remedies, the plaintiff was not foreclosed by the Act from bringing suit in federal court pursuant to the Civil Rights Act.[484] The court concluded that the intent of Congress in passing the Act was to continue state regulation of the business of insurance, but that there was no intent to deprive citizens of access to the federal courts for the purposes of redressing civil rights violations. [485]

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481. *See* Metropolitan Housing Dev. Corp. v. Village of Arlington Heights, 558 F.2d 1283 (7th Cir. 1977), *cert. denied*, 434 U.S. 1025 (1978). For a discussion of HUD's efforts, under the impetus of an executive order, to produce a regulation clarifying the application of Title VIII to the insurance industry, *see* Gregory D. Squires, *Why an Insurance Regulation to Prohibit Redlining?*, 31 J. MARSHALL L. REV. 489 (1996).

482. This issue was raised in Cisneros, but the court determined that it was not ripe for decision because HUD had not yet applied the disparate impact analysis to insurance companies. *See Cisneros*, 52 F.3d 1351, 1361-63. The consent decree entered as a result of *NAACP v. American Family Mutual Insurance Co.* required that American Family refrain from discrimination by "intent or effect." United States v. American Family Mut. Ins. Co., No. 90-C-0759 at 4 (E.D. Wis. 1995) (consent decree).

483. *See* 12 U.S.C. §§ 1982, 1985(3).

484. *See* Ben v. GMAC, 374 F. Supp. 1199, 1202-03 (D.C. Colo. 1974).

485. *See id.*

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Federal civil rights legislation prohibiting age discrimination in employment ("ADEA") was originally passed in 1967.[486] The Eighth Circuit held that a district court had improperly dismissed an ADEA-based complaint by a former employee of an insolvent insurance company on the basis of an order issued by a state receivership court enjoining all persons from obtaining judgments.[487] The Circuit Court held that the prosecution of the ADEA claim would not invalidate, impair or supersede the Missouri Insurers Supervision, Rehabilitation and Insolvency Act because ADEA did not contradict anything contained in the state statute.[488]

Litigation has begun to arise over whether the Act prevents the application of the Americans with Disabilities Act (the "ADA") to insurance practices.[489] The Third Circuit has held that an ADA-based challenge to an insurance plan that treated mental and physical disabilities differently could not be sustained because the ADA does not specifically relate to insurance.[490] In contrast, an Illinois district court held that an ADA-based claim that an insurance plan that imposed a lower cap on benefits for AIDS-related medical care than for other medical care stated a valid cause of action.[491] The court found that ADA specifically relates to insurance and that it did not impair, invalidate or supersede any state insurance law.[492]

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486. *See* Age Discrimination in Employment Act, Pub. L. No. 91-202, 81 Stat. 603 (1967)(codified as amended 29 U.S.C. § 623 (1999)).

487. *See* Murff v. Professional Med. Ins. Co., 97 F.3d 289, 290, 293 (8th Cir. 1996).

488. *See id.* at 291-93.

489. *See* 42 U.S.C. §§ 12101 - 12213 (1994).

490. *See* Ford v. Schering-Plough Corp., 145 F.3d 601, 611-12 (3d Cir. 1998) (court indicates that sustaining a claim that mental and physical disabilities must be given equal treatment would disrupt insurance practices but does not cite any specific provision of state insurance law); *Cf.* Leonard v. Israel Discount Bank, 967 F. Supp. 802, 805 (S.D.N.Y. 1997) (pointing to the Act as an indication that the ADA should not be construed to require that insurance plans provide equal treatment for mental and physical disabilities).

491. *See* Doe v. Mutual of Omaha, 999 F. Supp. 1188, 1197 (N.D. Ill. 1998), *rev'd on other grounds*, 179 F.3d 557 (7th Cir. 1999) (2-1 decision), *cert. denied*, 120 S. Ct. 845 (2000). The Seventh Circuit construed the ADA as inapplicable to the content of insurance policies, but also stated that the Act's preemption exception required this interpretation. *See Mutual of Omaha*, 179 F.3d at 563-65.

492. *See id.* at 1195-96. The Civil Rights Division of the Justice Department, which appeared *amicus curiae*, supported the plaintiff's position that the Act did not apply. *See id.* at 1188, 1195.

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14. Summary

The decisions reviewed in Part III.B indicate widespread support for limiting the application of the Act's preemption exception to commerce clause based laws. The cases reject its application to federal non-commerce clause laws by a ratio of approximately four to one. This preponderance is reflected in the decisions of the Supreme Court[493] as well as those of the lower courts. This result has been achieved without the unifying influence of federal agency interpretations entitled to deference under *Chevron* and without the existence of a common judicial rationale. The cases within most of the thirteen categories of constitutional authority covered in Part III.B uphold the federal laws at issue against preemption by the Act unanimously or with minor exceptions (taxation, foreign commerce, war powers, admiralty and maritime jurisdiction, bankruptcy power, postal power, the jurisdiction of the federal courts, due process, equal protection and civil rights). The cases relating to the currency power reject the application of the Act by a less overwhelming margin. The cases involving the treaty and copyright powers are rather evenly split. The single case involving the necessary and proper clause supports the application of the preemption exception to federal non-commerce clause law. It is only with respect to the federal priority statute–the expression of a sovereign prerogative that is not based on any specific grant of Constitutional authority–that the weight of authority based on a significant number of cases supports the application of the preemption exception to sustain state insurance law.

The largest block of cases involves the federal civil rights laws. This is not surprising in view of the size and scope of the insurance business and that recent civil rights legislation has targeted equality of treatment in the workplace and in the provision of goods and services. Another significant group of cases relates to international commerce. These decisions involve the foreign commerce clause and the treaty power, as well as the application of admiralty and bankruptcy law to international transactions. The state laws that have generated the most conflict are those relating to

493. *See, e.g.*, Barnett Bank of Marion County v. Nelson, 517 U.S. 25 (1996); Metropolitan Life Ins. Co. v. Ward, 470 U.S. 869 (1985); Arizona Governing Committee v. Norris, 463 U.S. 1073 (1983); State Bd. of Ins. v. Todd Shipyard Corp., 370 U.S. 451 (1962); Maryland Cas. Co. v. Cushing, 347 U.S. 409 (1954); *but see* United States v. Fabe, 508 U.S. 491 (1993).

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the liquidation of insolvent insurance companies. These laws have not only given rise to *Fabe* and other decisions involving the federal priority statute, but have produced conflicts with the treaty power, federal authority under the necessary and proper clause, the bankruptcy power, and with a civil rights statute, the ADEA. State insurance statutes that prohibit the enforcement of arbitration agreements outside of the insolvency context have given rise to conflicts with treaties and federal admiralty-based law.

Prior to *SEUA*, the federal government utilized the treaty power, the currency power, its prerogatives as a sovereign state (the federal priority statute), and the bankruptcy power to exercise authority over insurance.[494] These exercises of federal power prevailed over conflicting state law.[495] Therefore, the cases holding that the preemption exception causes state insurance statutes to prevail over federal law exercising those powers allow the states to exercise greater authority than they could have prior to *SEUA*.[496] With the exception of *Fabe,* none of these decisions sought to determine what authority the federal government exercised prior to *SEUA*, or whether the Act was intended to expand state authority. It is interesting to speculate whether these cases might have been decided differently if the myth of pre-*SEUA* federal noninvolvement with the business of insurance did not exist, and the courts had been aware of the role that the federal government had in fact played.

C. A Second Look at the Cases

Set forth below is a synthesis of the reasoning the courts have used to support their decisions. What emerges is a set of rules and rationales that have been used to reject or accept the application of the preemption exception to non-commerce clause laws. There are half a dozen decisions that explicitly assert the commerce clause limitation as the basis for rejecting the applicability of the preemption exception. There is a larger body of case law that employs rationales for rejecting the preemption exception that provide direct but less explicit support for the adoption of the commerce clause limitation. Some of these decisions have in turn been relied on to narrow the applicability of the preemption exception to

494. *See supra* Parts I.B.5., I.B.6, I.B.7 and I.B.8.

495. *See supra* note 149 and accompanying text.

496. *See* cases discussed *supra* Parts III.B.5, III.B.6, III.B.7 and III.B.8. *See also infra* note 504 and accompanying text (cases affirming that the Act is not intended to give the states greater power to regulate insurance than they had prior to *SEUA*).

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commerce clause based laws. The Supreme Court's five-to-four decision in *Fabe* and the Seventh Circuit's two-to-one decision in *American Deposit* are the only cases that specifically rely on reasoning that is inconsistent with the commerce clause limitation.[497]

1. Cases Limiting the Scope of the Act

Cases that recognize that the Act's transfer of authority to the states was limited have used a variety of formulae to express that conclusion:

The Act removes only commerce clause restrictions on state insurance law.[498]

These cases explicitly state the thesis advocated by this article.

Congress did not intend to delegate a specific non-commerce clause power at issue in the case to the states, i.e., the power to tax,[499] *the power to control the mails,*[500] *or the power to enforce federally guaranteed civil rights.*[501]

These cases determine that the Act's transfer of authority was limited, not plenary.[502] None of these opinions ascribe to the non-commerce clause

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497. *See* discussion *infra* pp. 79-80; *see also supra* note 364 and accompanying text.

498. *See* Metropolitan Life Ins. Co. v. Ward, 470 U.S. 869, 881 (1985); McDermott Int'l, Inc. v. Underwiters at Lloyd's, No. CIV. A. 91-841, 1996 WL 291803, at *6 (E.D. La. 1996), *aff'd on other grounds*, McDermott Int'l, Inc. v. Lloyd's Underwriters of London, 120 F.3d 583 (5th Cir. 1997); United States v. Schmittzehe, Crim. A. No. 91-514, WL 635030, at *4 (E.D. La. Nov. 10, 1994); Stephens v. National Distillers & Chem. Corp., No. 91-CIV.-2901 (JSM) (KAR), 1993 WL 228851 at *3 (S.D.N.Y. 1993) (mem. order); Moore v. National Distillers & Chem. Corp., 143 F.R.D. 526, 533 (S.D.N.Y. 1992); Moore v. Aegon Reins. Co. of Am., 196 A.D.2d 250, 260, 608 N.Y.S.2d 166, 173 (N.Y. App. Div. 1994), *cert. dismissed sub nom.*, Stephens v. Instituto de Resseguros do Brasil (IRB), 512 U.S. 1283 (1994). But *see* American Deposit Corp. v. Schacht, 84 F.3d 834, 844 (7th Cir. 1996), *cert. denied*, 519 U.S. 870 (1996). Howard takes the position the preemption exception should be liberally construed, but recognizes that the preemption exception applies only to federal laws that "exist under the Commerce Clause." Howard, *supra* note 25, at 28 n.80.

499. *See, e.g.*, Hanover Ins. Co. v. Commissioner, 598 F.2d 1211, 1218 (1st Cir. 1979); Industrial Life Ins. Co. v. United States, 481 F.2d 609, 610 (4th Cir. 1973) (per curiam), *cert. denied*, 414 U.S. 1143 (1974); Industrial Life Ins. Co. v. U.S., 344 F. Supp. 870, 874 (D.S.C. 1972); Hanover Ins. Co. v. Commissioner, 65 T.C. 715, 722 (1976).

500. *See* United States v. Sylvanus, 192 F.2d 96, 100 (7th Cir. 1951).

501. *See* Ben v. GMAC, 374 F. Supp. 1199, 1202-03 (D. Colo. 1974).

502. *But see* American Deposit Corp. v. Schacht, 84 F.3d 834, 844 (7th Cir. 1996), *cert. denied*, 519 U.S. 870 (1996) (holding that the Act was applicable to the National Bank Act).

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power at issue any attribute that would lead to the conclusion that it was not delegated to the states while other non-commerce clause powers were. Therefore, these decisions are supportive of the broader conclusion that none of the non-commerce clause powers were delegated.

The Act should not be construed to cause state insurance laws to preempt federal non-commerce clause laws that relate to matters of national concern such as international commerce or civil rights.[503]

Federal laws relating to international commerce and civil rights unquestionably deal with matters of national concern. However, it would seem equally clear that all laws enacted pursuant to grants of non-commerce clause authority relate to matters of national concern. That is precisely why the Constitution specifically entrusted them to the federal government.

It was not the intention of Congress in passing the Act to give the states any greater power to regulate insurance than they had prior to SEUA.[504]

Prior to *SEUA*, state authority over insurance was subordinate to the federal government's exercise of its non-commerce clause powers. Whenever a conflict occurred, the supremacy clause caused the federal law to prevail.[505] Given the broad range of non-commerce clause powers that the federal government utilized to exercise dominion over insurance prior to *SEUA*,[506] recognition that the Act continued this limitation on state

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503. *See supra* note 305 and accompanying text.

504. *See* Metropolitan Life Ins. Co. v. Ward, 470 U.S. 869, 880 n.8 (1985); State Bd. of Ins. v. Todd Shipyards Corp., 370 U.S. 451, 455-56 (1962); Maryland Cas. Co. v. Cushing, 347 U.S. 409, 413 (1954); First Nat'l Bank of E. Ark. v. Taylor, 907 F.2d 775, 779-80 (8th Cir. 1990); Spirt v. Teachers Ins. & Annuity Ass'n, 691 F.2d 1054, 1064-65 (2d Cir. 1982); Women in City Gov't United v. New York, 515 F. Supp. 295, 302 (S.D.N.Y. 1981); Paris v. Metropolitan Life Ins. Co., 68 F. Supp. 64, 69 (S.D.N.Y. 1946), *rev'd on other grounds*, 167 F.2d 834 (2d Cir. 1948), *cert. denied*, 335 U.S. 827 (1948); Fabe v. United States Dep't of Treasury, 508 U.S. 491, 507-08 (1993). A number of Supreme Court decisions involving issues other than conflicts between non-commerce clause statutes and state insurance laws also express the view that the Act did not intend to give the states any power to regulate insurance that they did not possess prior to *SEUA*. *See, e.g.*, Western and S. Life Ins. Co., 451 U.S. 648, 656 n.6 (1981); Securities & Exch. Comm'n v. National Sec., Inc., 393 U.S. 453, 459 (1969); Federal Trade Comm'n. v. Travelers Health Ass'n, 362 U.S. 293, 300-01 (1960).

505. *See supra* note 149 and accompanying text.

506. *See supra* Part I.B.13.

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power is synonymous with determining that the Act does not affect federal non-commerce clause laws.

2. Cases Construing the Act's Preemption Provision as Inapplicable to Specific Non-Commerce Clause Laws

A number of the cases conclude that as a matter of statutory construction the preemption exception is inapplicable. These cases are organized below according to the particular requirement of the preemption exception that the court determined had not been met. A description of the statutory provisions or activities involved is indicated parenthetically.

The federal statute at issue authorized or prohibited an activity that did not constitute the business of insurance (sales of credit insurance[507] *and annuities*[508] *by banks, utilizing gender-based actuarial tables to compute retirement benefits,*[509] *engaging in bribery, fraud and other forms of financial manipulation as part of mail fraud).*[510]

The conflicting state insurance law was not enacted for the purpose of regulating the business of insurance (statutes prohibiting the enforcement of arbitration clauses,[511] *the sale of insurance products*[512] *and annuities*[513] *by banks, granting preferences in bankruptcy proceedings to claims for unpaid workmen's compensation premiums,*[514] *authorizing suit by an*

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507. *See* First Nat'l Bank of E. Ark. v. Taylor, 907 F.2d 775, 779-80 (8th Cir. 1990); Independent Bakers Assoc. of Am. v. Heimann, 613 F.2d 1164, 1169-71 (D.C. Cir. 1980).

508. *See* Texas Bankers Ass'n v. Bomer, Civ. No. A-96-CA-694 JN, 1997 U.S. Dist. LEXIS 13422, at *14 (W.D. Tex. Aug. 7, 1997).

509. *See* Arizona Governing Comm. v. Norris, 463 U.S. 1073, 1087 (1983); Peters v. Wayne State Univ., 476 F. Supp. 1343, 1351 (E.D. Mich. 1979), *rev'd on other grounds*, 691 F.2d 235 (6th Cir. 1982).

510. *See* United States v. Schmittzehe, Crim. A. No. 91-514, 1994 WL 635030, at *3 (E.D. La. Nov. 10, 1994).

511. *See* Organ v. Connor, 792 F. Supp. 693, 696-97 (D. Alaska 1992); Triton Lines v. Steamship Mut. Underwriting Ass'n, 707 F. Supp. 277, 279 (S.D. Tex. 1989); *but see* Stephens v. American Int'l Ins. Co., 66 F.3d 41, 44-45 (2d Cir. 1995).

512. *See* Owensboro Nat'l Bank v. Stephens, 44 F.3d 388, 391-92 (6th Cir. 1994). *But see* James Mitchell & Co. v. Florida Dept. of Ins. & Treasurer, 679 So. 2d 334, 337 (Fla. Dist. Ct. App. 1996).

513. *See* Texas Bankers Ass'n v. Bomer, Civ. No. A-96-CA-694 JN, 1997 U.S. Dist. LEXIS 13422, at *12-*14 (W.D. Tex. Aug. 7, 1997); *but see* Blackfeet Nat'l Bank v. Nelson, 171 F.3d 1237, 1240, 1248 (11th Cir. 1999); American Deposit Corp. v. Schacht, 84 F.3d 834, 838 (7th Cir. 1996).

514. *See In re* Arrow Carrier Corp., 154 B.R. 642, 645 (Bankr. D. N.J. 1993).

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insurance company liquidator for breach of contract,[515] *denying out-of-state insurance companies access to the federal courts,*[516] *an insurance commissioner's administrative policy of allowing duplication of copyrighted materials).*[517]

These two lines of cases can be combined to yield a single rule for construing the preemption exception: If the federal law at issue relates to something other than the business of insurance or if the state law at issue doesn't regulate the business of insurance, then the preemption exception doesn't apply. The rule can be understood as a reflection of the inherent difference between federal commerce clause and non-commerce clause authority. When the federal government exercises its non-commerce clause power, its objective is something other than the regulation of insurance qua insurance. This is true even though in the process it may incidentally exercise authority over some aspect of the business of insurance, i.e., eliminating discrimination in conditions of employment by proscribing insurance-company-administered retirement plans that utilize sex-based actuarial tables.[518] Conversely, when a state attempts to use its delegated commerce clause power to control matters that fall within federal non-commerce clause authority, it does not act primarily for the purpose of regulating the business of insurance. State prohibitions on the sales of insurance products and annuities by national banks are examples of such intrusions.[519] The cases referred to above do not articulate the analysis just suggested. However, the number of decisions that uphold federal non-

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515. *See* Koken v. Cologne Reins. Co., 34 F. Supp. 2d 240, 256 (M.D. Pa. 1999).

516. *See* International Ins. Co. v. Duryee, 96 F.3d 837, 839-40 (6th Cir. 1996).

517. *See* B & S Underwriters, Inc. v. Clarendon Nat'l Ins. Co., 892 F. Supp. 815, 818 (W.D. La. 1995); *but see* Progressive Corp. v. Integon P & C Corp., 20 U.S.P.Q.2d 1682, 1686-87 (4th Cir. 1991) (unpublished opinion).

518. *See* Arizona Governing Comm. v. Norris, 463 U.S. 1073, 1074-75 (1993). Another example of the exercise of federal commerce clause authority that incidentally regulates the business of insurance are tax statutes and regulations that require insurance companies to maintain separate books for tax purposes or to use figures that are different from those used for state insurance law purposes. *See* Hanover Ins. Co. v. Commissioner, 598 F.2d 1211, 1218 (1st Cir. 1979); Hanover Ins. Co. v. Commissioner, 65 T.C. 715, 722-23 (1976); Penn Mut. Indem. Co. v. Commissioner, 32 T.C. 653, 658 (1959) (citing Steward Mach. Co. v. Davis, 301 U.S. 548 (1937)).

519. *See* Owensboro Nat'l Bank v. Stephens, 44 F.3d 388, 391-92 (6th Cir. 1994); *see also* Roederer & Tank, *supra* note 349, at 410 n.72 (list of the state statutes prohibiting insurance activities by banks that were in force prior to the Supreme Court's decision in *Barnett Bank of Marion County v. Nelson*, 517 U.S. 25 (1996)).

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commerce clause laws after applying the rule perhaps indicates tacit recognition that the subject matter of federal non-commerce clause laws and of the state laws that conflict with them are not what the Act was concerned with when it declared that continued regulation and taxation of the business of insurance was in the public interest.

The federal statute specifically relates to the business of insurance (Section 92 authorizing national banks to sell insurance in small towns,[520] *Title VII of the Civil Rights Act of 1964 prohibiting discrimination in terms of employment).* [521]

The federal law did not impair, invalidate or supersede, state insurance law by providing different or additional remedies for the same conduct that is prohibited by state law (the federal mail-fraud statute applied to bribery, fraud and other forms of financial manipulation by insurance company employees, the Fair Housing Act applied to the sale of homeowner's insurance,[522] *FDIC rule looking solely to the books of an insolvent bank to determine whether or not a deposit exists applied to a CD pledged to an insurance regulator,*[523] *federal age discrimination complaint enforced against an insolvent insurance company despite a state court stay of litigation).* [524]

3. Cases Narrowing the Preemption Exception's Application to Commerce Clause Laws

The cases described in Parts III.C.1 and III.C.2 involve federal non-commerce clause laws, but, with a few exceptions, they reach their result without distinguishing between federal commerce clause and non-

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520. *See* Barnett Bank of Marion County v. Nelson, 517 U.S. 25, 37-41 (1996).

521. *See* Hannahs v. New York State Teacher's Retirement Sys., No. CIV.A.78-Civ. 2541 CSH, 1981 WL 226, at *9 (S.D.N.Y. July 10, 1981).

522. *See* Nationwide Mut. Ins. Co. v Cisneros, 52 F.3d 1351, 1363 (6th Cir. 1995), *cert. denied*, 516 U.S. 1140 (1996); United Farm Bureau Mut. Ins. Co. v. Metropolitan Human Relations Comm'n, 24 F.3d 1008, 1016 (7th Cir. 1994); NAACP v. American Family Mut. Ins. Co., 978 F.2d 287, 295 (7th Cir. 1992), *cert. denied*, American Family Mut. Ins. Co. v. NAACP, 508 U.S. 907 (1993); Mackey v. Nationwide Ins. Cos., 724 F.2d 419, 421 (4th Cir. 1984); McDiarmid v. Economy Fire & Cas. Co., 604 F. Supp. 105, 108-09 (S.D. Ohio 1984); Pierce v. Metropolitan Prop. & Liab. Ins., No. C-3-82-044, 1984 U.S. Dist. LEXIS 24653, at *5-6 (S.D. Ohio Aug. 1, 1984). *See also* Dunn v. Midwestern Indem. Co., 472 F. Supp. 1106, 1111-12 (S.D. Ohio 1979).

523. *See* Villafane-Neriz v. FDIC, 75 F.3d 727, 735-36 (1st Cir. 1996).

524. *See* Murff v. Professional Med. Ins. Co., 97 F.3d 289, 291-93 (8th Cir. 1996).

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commerce clause laws. As long as the courts do not recognize that the Act is inapplicable to non-commerce clause laws, these decisions will be part of a single body of case law interpreting the preemption exception. There is no question that the Act represents a strong expression of congressional policy that state regulation and taxation of insurance should prevail within the bounds of the commerce clause vacuum that existed prior to *SEUA*. However, courts faced with a choice between that policy and the policies expressed in non-commerce clause laws in areas such as civil rights and international commerce will tend to produce decisions rejecting the Act's application. The inevitable impact of these precedents is to narrow the application of the preemption exception to federal commerce clause statutes. The Seventh Circuit determined in *American Family Mutual Insurance Co.* that the Act's preemption exception did not apply to the federal Fair Housing Act because the FHA's provision of additional remedies for conduct proscribed by state insurance law did not invalidate, impair or supersede state insurance law.[525] To reach this result, the court felt compelled to overrule its earlier decision holding that the Act's preemption exception caused state insurance law to supersede the federal Truth-in-Lending Act, an exercise of federal commerce clause authority, because Truth-in-Lending provided different remedies than state insurance law.[526] The *American Family Mutual* case was in turn relied on by the Supreme Court in deciding that the preemption exception did not preclude the applicability of RICO, a commerce clause law, to the business of insurance because RICO's provision for different remedies did not impair, invalidate or supersede the state insurance law at issue.[527] The Second Circuit's narrow application rule construes the Act as inapplicable to federal laws that relate to matters of national concern.[528] Prior to 1997, it had been utilized only to defeat preemption exception challenges to non-commerce clause laws in the areas of international commerce, civil rights and bankruptcy.[529] In *Dornberger v. Metropolitan Life Insurance Co.*,[530] the rule was invoked to defeat the application of the preemption exception

525. *See* NAACP v. American Family Mut. Ins. Co., 978 F.2d 287, 295-97 (7th Cir. 1992).

526. *See id.* at 296-97.

527. *See* Humana, Inc. v. Forsyth, 525 U.S. 299, 305 n.6 (1999).

528. *See supra* note 305 and accompanying text.

529. *See id.*

530. 961 F. Supp. 506, 520 (S.D.N.Y. 1997).

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to RICO on the grounds that RICO dealt with an area of national concern. A decision holding that the preemption exception was inapplicable to a criminal prosecution under the commerce clause based Securities Act of 1933[531] relied heavily on the restrictive interpretation of the Act set forth in *United States v. Sylvanus*[532] and *Maryland Casualty Co. v. Cushing,*[533] two cases that rejected the application of the preemption to non-commerce clause laws. The strength of the public policy expressed by the civil rights laws is evident in a case that asserts that a civil rights statute does not fall within the preemption exception because it specifically relates to insurance–even though the statute does not contain the word "insurance" nor have any other specific relationship to insurance.[534] If this interpretation were generally accepted, the preemption exception's restraining influence on federal law would all but disappear.

IV. PUBLIC POLICY AND THE COMMERCE CLAUSE LIMITATION

The text, historical context and legislative history of the Act, as well as a heavy preponderance of the case law, all support the conclusion that the preemption exception applies only to federal commerce clause-based laws. Public policy considerations point to the same conclusion. Successful challenges to non-commerce clause laws based on the preemption exception have led to the frustration of national interests in a number of areas. Unsuccessful efforts to challenge non-commerce clause laws have, ironically, provided the rationales for limiting the application of the preemption exception to federal commerce clause laws. Both the successful and the non-successful efforts consume judicial resources unnecessarily and unproductively.

A. The Frustration of National Interests

Failure to recognize the commerce clause limitation has led to the striking down of a number of federal non-commerce clause laws. It has also led to the de facto nullification of other federal non-commerce clause laws because of the risk, expense and delay attendant on challenging

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531. *See* United States v. Meade, 179 F. Supp 868, 875 (S.D. Ind. 1960).

532. 192 F.2d 96, 100 (7th Cir. 1951).

533. 347 U.S. 409, 413 (1954).

534. *See* Hannahs v. New York State Teacher's Retirement Sys., No. CIV.A.78-Civ. 2541 CSH, 1981 WL 226, at *9 (S.D.N.Y. July 10, 1981).

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conflicting state laws. The result in both instances is to substitute a state view of public policy for a federal perspective on matters of national concern. Some areas in which this is a matter of particular concern are discussed below.

The fortunes of the insurance industry along with the rest of American business have become increasingly linked to the global economy.[535] Exports account for $1.17 trillion, thirteen percent of our gross domestic product[536]—a percentage that has trebled in the last thirty years.[537] The Constitution bids the United States to speak with "one voice" on matters that concern international trade.[538] This is impossible as long as treaties and federal laws relating to such matters as uniform international rules for the treatment of sovereign entities and the enforceability of arbitration clauses in international commercial contracts are threatened with nullification by state insurance laws.[539] Parochialism in such matters carries with it the threat of retaliation against the nation as a whole.[540]

The enactment and enforcement of legislation implementing constitutional guarantees of individual rights has been one of the most significant developments in American law during the latter part of the twentieth century. One of the basic objectives of civil rights legislation has

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535. Growth in premium income for both life insurance and property/casualty insurance have been greater worldwide than in the United States in recent years. *See* ACLI LIFE INSURANCE HANDBOOK 1999, 88 (1999); INSURANCE INSTITUTE FACT BOOK 2000 at §§ 1.7, 1.28 (1999).

536. *See* Christopher L. Bach, *U.S. International Transactions, Fourth Quarter and Year 1998*, SURVEY OF CURRENT BUSINESS, Apr. 1999 at 18 (Table A, Line 1). The gross domestic product for 1998 was $8.76 trillion. *See* SURVEY OF CURRENT BUSINESS, Nov. 1999 at 16 (Table 3A).

537. *See* Survey of Current Business, Apr. 1999 at D-47.

538. *See* Japan Line Ltd. v. County of Los Angeles, 441 U.S. 434, 453-54 (1979) (imposition by individual states of taxes on containers used exclusively in foreign commerce makes it impossible for the nation to speak with one voice and thus violates the foreign commerce clause).

539. Conflicts have occurred over the enforcement of the Foreign Sovereign Immunity Act (discussed *supra* Part III.B.2), federal laws and treaties mandating the enforcement of arbitration agreements and awards (discussed *supra* Parts III.B.4 and III.B.5), and provisions of the Bankruptcy Code relating to ancillary proceedings involving foreign companies (discussed *supra* Part III.B.8). The potential exists for conflicts with international copyright agreements to which the United States is a party. *See supra* Part III.B.9).

540. *See Japan Line Ltd.*, 441 U.S. at 450-53.

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been to overcome the obstacles embedded in state legal systems.[541] In recent years, the focus of civil rights legislation and enforcement has shifted to the protection of individuals in their capacities as employees and consumers of goods and services.[542] The public policy behind the civil rights laws argues persuasively that state insurance laws should not be allowed to create exceptions to their enforcement.

One of the primary objectives of state insurance company insolvency laws is to provide sufficient assets to pay the claims of policyholders. Solvent insurers doing business in the state are required to make up any shortfall necessary to pay such claims, but are then subrogated to the rights of the policyholders in the insolvency proceedings. In a number of jurisdictions payments made to satisfy policyholder claims may be recouped by offsets against state premium taxes or by increasing premium rates. The preemption exception has enabled state insurance insolvency laws to subordinate claims made by the federal government pursuant to the federal priority statute and other federal non-commerce clause laws to those of solvent insurance companies as subrogees of policyholders.[543] This shifts a portion of the cost of satisfying policyholder claims to the federal government and ultimately to the federal taxpayer. The result is the creation of a federal subsidy for the insurance industry and the taxpayers of states whose insurance regulatory systems have failed to prevent insolvencies.

The saga of the state insurance laws that nullified the authority of national banks to sell insurance demonstrates that application of the preemption exception to non-commerce clause laws not only results in questionable public policy, but is cumbersome to correct. These statutes were on the books of almost half of the states for decades.[544] They frustrated the federal legislative objective of reducing national bank dependence on income from lending activities,[545] and at the same time stifled competition in the sale of insurance products. It took extensive litigation culminating in the Supreme Court's decision in *Barnett* to

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541. *See* Ben v. GMAC, 374 F. Supp. 1199, 1202-03 (D. Colo. 1974).

542. *See* discussion of cases involving civil rights statutes *supra* Part III.B.13.

543. *See* discussion of Fabe case *supra* pp. 81-83, note 400, and Part II.B.11. *But see supra* pp. 78 (discussing *Villafrane-Nerz v. FDIC*, which rejected an attempt to shift cost of an insurance company insolvency to the federal deposit insurance fund).

544. *See* Roederer & Tank, *supra* note 349.

545. *See* discussion of the legislative purpose behind 12 U.S.C. § 92 *supra* at p.20.

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remove these obstacles to the exercise of the insurance powers granted national banks pursuant to Section 92. Congress finished the job when it passed the Gramm-Leach-Bliley Act in 1999. This legislation provides that the states cannot prohibit the conduct of any insurance activities of national banks or other depository institutions that are authorized by federal law.[546] Congress also affirmed the authority of the states to regulate such activities within the parameters allowed by the supremacy clause.[547] Thus, it took a Supreme Court decision followed by congressional action to accomplish the same result that would have been achieved by recognition of the commerce clause limitation.

B. Interpreting the Act Correctly; Judicial Economy

The Act represents a strong expression of congressional policy in favor of state regulation of insurance within the bounds of the commerce clause. However, failure to recognize the existence of the Act's commerce clause limitation means that precedents and rationales created by the numerous decisions refusing to apply the Act's preemption exception to non-commerce clause federal laws will provide support for narrowing its applicability to commerce clause based federal laws. Thus, the unsuccessful efforts to apply the preemption exception to non-commerce clause laws may, in the end, undermine the Act's universally acknowledged objective of protecting state insurance law from federal commerce clause authority.

As is evident from the review of the cases, determining whether the Act's preemption exception applies to non-commerce clause laws absorbs significant judicial resources, but has not yielded a coherent body of case law. The insurance industry and the state insurance regulators have enormous resources at their disposal. No federal insurance regulator has the authority to provide an initial interpretation of the Act's meaning. This set of circumstances provides an incentive to litigate, in multiple venues, the applicability of any federal statute or regulation that might impose additional costs or restrictions on the insurance industry, allow competitors onto its turf, or conflict with state regulatory authority. A court that determines that the enforcement of a state insurance law would violate the

546. *See supra* note 368 and accompanying text.
547. *See id.*

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supremacy clause must then go on to address one or more of the following issues before reaching a final resolution:

Does the federal statute at issue specifically relate to insurance?

Does the federal statute at issue require, authorize or prohibit an activity that constitutes the business of insurance?

Was the conflicting state insurance statute enacted for the purpose of regulating the business of insurance?

Does the activity or practice to which the state statute has been applied constitute the business of insurance?

Courts that reach different conclusions with respect to any one of these four questions can reach opposite conclusions as to the applicability of the preemption exception. The work product of each session of Congress and of the state legislatures inevitably increases the potential for conflict between federal non-commerce clause laws and state insurance laws. All of this is compounded by the provisions of state law that prohibit the use of arbitration in the resolution of disputes involving insurance. If the commerce clause limitation were recognized, a court faced with a putative conflict between federal and state law could resolve the issue solely by resorting to supremacy clause jurisprudence. This would allow greater use of arbitration, deter litigation where a clear conflict between federal and state law existed, and simplify the disposition cases that do arise.

The Supreme Court's insistence for three-quarters of a century that insurance was not interstate commerce hopelessly warped the federal/state division of authority over the industry. The inevitable correction precipitated a Constitutional crisis and led to the passage of the Act. Hopefully, the *Fabe* majority's failure to recognize the Act's commerce clause limitation will be corrected in a more timely manner.

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RISK IN CONTEMPORARY SOCIETY

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INTRODUCTION

Risk occupies a prominent place in contemporary societies. It can be found everywhere: in the business world, where it defines the scope of an entrepreneur; in the financial world, where it is synonymous with the impending threat of a crash; in the realm of welfare, where institutions offering private or public coverage are concerned with protection from risk; in the legal world, where it is the basis for establishing liability; in the moral world, where concerns are raised about the number of government-aid recipients; in the medical world, where it represents the unexpected in therapy; and in the military world, where the notion of "zero risk" strategy was first conceived. Risk also manifests itself in nature in the form of

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serious ecological threats. In addition, it is inherent to the process of scientific research, where it is sought to be mastered in ethical terms, as for example, in technological development and its industrial applications where the will-to-power is more and more feared.

Risk has become ubiquitous and a kind of conceptual umbrella used to cover all sorts of events, be they individual or collective, minor or catastrophic. Risk presents itself as the modern approach to an event and the way in which, in our societies, we reflect upon issues that concern us. Risk is the single point upon which contemporary societies question themselves, analyze themselves, seek their values and, perhaps, recognize their limits.

This systematic and proliferating use of the risk concept is a recent phenomenon. The concept first made its way into Western culture at the end of the Middle Ages with the emergence of the insurance contract. It remained confined to that usage for quite a while. In fact, it was not until the end of the Nineteenth Century when the issue of work-related accidents was considered that the concept took on full legal status as a result of the creation of an "occupational hazard" category soon extended to that of "social risk." And it was not until the 1970s, no doubt under the pressure of ecologists' demands, that the notion was extended to the point it has presently reached, where some, like Ulrich Beck, go so far as to speak of a "society of risk."[1] This development constitutes in itself an event worthy of consideration. In light of the contemporary use of the risk concept, what does it really mean to us? What do we experience about ourselves when we look at ourselves and our actions through the prism of risk?

I will consider the experience of risk under three aspects: moral, social and legal.

I. THE MORAL PERCEPTION OF RISK

In contemporary society, risk lies at the source of moral values. This is what initially comes to mind when we talk about risk. Risk is what makes our values have value.

Everyone remembers the scene in *Rebel Without a Cause*[2] when James Dean engages his adversary in a fatal contest where the winner is the last person to jump from a car speeding towards the edge of a cliff. This scene

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1. *See generally* ULRICH BECK, RISK SOCIETY: TOWARDS A NEW MODERNITY (Mark Ritter, trans., Sage Publications 1992).

2. REBEL WITHOUT A CAUSE (Warner Bros. 1955).

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constitutes both an eminent and derisory representation of the enhanced value of risk. What is at stake in this confrontation, which comes down to knowing how far one is willing to risk one's life, is power; who will set the rules and impose one's values. As we know, this scene in the movie is the American version of a famous passage from *The Phenomenology of the Spirits* by Hegel: the dialectic of the master and the slave.[3] It is by risking his life that man becomes aware of himself as a man, one whose worth does not solely result from his biological existence and who is capable of risking his existence for something else. Value reveals itself thanks to man's capacity to take risk for what matters to him. Through this process, risk gives rise to a hierarchy: whoever takes the risk of confronting death becomes the master of one who does not have the courage to so do. Man's humanity requires taking risks and, more precisely, risking one's life. Animals, on the other hand, are deprived of this risk-taking capacity. In other words, the inability to confront risk leads to the life of a beast.

Indeed, in the French tradition, risk is associated with courage, heroism, and the ability to gamble one's life and sacrifice oneself. The value I attach to that for which I am willing to take a risk is measured by the risk I confront: the fatherland in war, liberty in the French Resistance, love in the sacrifice of my personal comfort. What makes a value valuable is what I am willing to risk for it.

While risk forces the emergence of values, it does not, however, determine what these values will be. Whilst courage is a virtue, temerity is nót. The glorification of risk may lead to the worst abominations, as the past century illustrated. Lauding self-sacrifice can border on a fanaticism that we have reason to fear. Risk cannot be an end in itself. Besides, in the dialectic of the master and the slave, Hegel comes down on the side of the slave who, through his labor, will acquire real power. The morality of risk-taking has a limit, which is life itself. One can ascribe an enhanced value to risk but only to the extent that it is at the service of life. Risk makes life more valuable, so long as it does not destroy life. Thus the ethic of risk bears a limit: serving life. It does not ascribe an absolute value. Not all forms of heroism are healthy. The ethic of risk is played out between the extremes of exacerbated heroism, for which finally nothing retains any value, and the pusillanimous retreat of the coward or unadventurous who

3. *See* G.W.F. HEGEL, Selbständigkeit und Unselbständigkeit des Selbstbewu tseins: Herrschaft und Knechtschaft, PHÄNOMENOLOGIE DES GEISTES, Erster Teil, Kapitel ch. IV, § A (1807).

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prefers in all circumstances to preserve his own position regardless of what is happening around him. The value of risk lies in its measure and proportion, neither too much nor too little. The morality of risk is a morality of balance.

Today, such a debate on the value of risk occurs in a variety of contexts. It can be found in the realm of politics. Thus, for example, on February 1, 1998, in Brussels, Dominique Strauss-Kahn, French Minister of Economy and Finance, delivered an important speech on the spiritual condition of Europe in which he expressed concern about a European culture emphasizing conservatism to the detriment of innovation and favoring steady returns over risk: "no progress without risk."[4] There is a vague sense of having entered a period in which risk is more feared than confronted and in which entrepreneurship is undermined. In the same way one can question the strategy of zero-risk warfare. What value have we assigned to our values if we are willing to defend them only on the condition of not dying for them?

This debate on the ethics of risk also takes place in the context of extreme sports and arises regularly in connection with a long-distance race or mountaineering expedition. The recent incident involving three hikers in the *Vanoise*[5] illustrates the ambivalence we maintain with respect to risk. On the one hand, it shows a fascination for the adventure and the transgression of limits (the "frontier" in the American sense) that keeps us from condemning those who, nonetheless, infringe safety regulations. On the other hand, it demonstrates a sense that those who fail to comply with community rules do not deserve the protection of the community: do they have the right to expect other men to risk their lives for them?[6]

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4. *Cf.* Dominique Strauss-Khan, *Rente et Risque*, 36 RISQUES 1, 9 (1998).

5. In February 1999, three hikers were lost in the Alps for a number of days. Every means was mobilized to save them, means that ultimately proved successful. A debate ensued subsequent to their rescue as to the hikers' irresponsibility in disregarding or discounting the ominous weather forecasts that indicated limited access to the mountains. *See Only Dust and Snow: Central Europe's Heaviest Snow for 40 Years*, THE GUARDIAN (London), Feb. 25, 1999, at 7. The entire affair captivated the elite press and aptly demonstrates the ambivalence we feel with respect to risk. We were in awe of their sense of adventure, yet should their foolish desire to transgress the limits, to get a rush, entitle them to expect others would risk their own lives to save them?

6. In our societies, significant moral debates are resolved with cold, hard cash. Dramas make the front cover of the magazine *Paris-Match*, which needs more stories than those of Caroline or Stephanie of Monaco, and does not hesitate to give money to its heroes.

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II. THE SOCIAL PERCEPTION OF RISK

This is the domain of insurance. Here risk pertains to a future event, one that may also be possible, probable, contingent, fortunate or unfortunate. In any case, one that is feared for its possible consequences to property. In this realm, risk is always potential. However, insurance gives a current value to risk and ascribes it a cost–an insurance premium or fee. Thus, with regard to insurance, risk remains within the confines of monetary valuation. In fact, insurance risk is nothing but the assessment of a value. Insurance is what gives a price to risk in the economic sense, a monetary value, which is really what quantifies value.

How does one establish the cost of risk? Two theories apply. Under the first one, of a largely psychological nature, the cost of risk is measured by the aversion to risk of the individual who wishes to avoid it. In this case, quantification is not required. The cost of risk is the total premium agreed upon between the individual who wishes to transfer it and the one who agrees to assume it. The following anecdote illustrates this point. In an effort to promote his whiskey, the president of the Cutty Sark distillery had offered a large monetary sum to the first person to see the Loch Ness Monster. It may be that one night he had a nightmare or suffered remorse, but he would have to keep his foolish promise nonetheless, which would undoubtedly endanger his company's financial well being. He therefore hastened to find an insurer, someone to whom he could transfer the risk he had taken so brashly. And he found one, Lloyd's of London, with which he agreed on a premium. The coverage of this unsurpassable, potential, and exceptional risk involved a cost–a risk transfer. There was insurance without any need to quantify. The concept of insurance risk is not so much tied to the notion of danger as it is to that of expectation or fear. Risk is the measure of an expectation—a mathematical expectation that, according to Pascal,[7] is the product of the probability of the event multiplied by its value. A moral expectation (or, in Daniel Bernoulli's words, an expectation of utility)[8] which relates to what I am willing to and what I ought to pay, in terms of mathematical expectation in order to avoid risk. The "additional cost" would measure exactly what the value of the risk is

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And, as far as the government is concerned, there have been thoughts about no longer allowing adventure-seekers to set out without an insurance policy covering the cost of any rescue operation they may need.

7. *See* PASCAL, LA RÉGLE DES PARTIES 75 (1954).

8. *See generally* Daniel Bernoulli, *De Mensura Sortis*, 31 RISQUES 123 (1997).

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for me.

In the words of Michel Albert who initially made the distinction, this purely contractual vision of insurance corresponds to a more "maritime" than "riparian" view of insurance.[9] In continental Europe, France in particular, one views insurance as tied to the concept of mutuality, or as a function of statistics and probability. This view stems from the fact that, in France, insurance had to set itself apart from gambling and betting to be recognized. It follows that risk reflects the probability that an event will take place in a given population. Consider the population of French drivers, the road conditions, and the number of cars on the road. There are currently about 8,000 annual road deaths. In the words of the well-known sociologist Adolphe Quetelet, these deaths represent the "budget" that the French population commits to road travel each year. One can anticipate that, all things being equal, this figure will remain constant from year to year, within a few standard deviations. The average premium per inhabitant or per driver can then be established. At the same time, it is possible to assess the chance that any one individual has of being among the 8,000 victims. This chance is a function of a car's power, a driver's experience, the places where he drives and so forth, and these criteria are used to calculate an individual's insurance premium. Indeed, not everyone represents the same risk to the group. Some individuals drive less carefully than others. This is another way of establishing the cost of risk; it corresponds to the greater or lesser probability of incurring an accident in relation to the average. This cost is called the equitable cost.

Under this second analysis (more sociological than psychological) the group outweighs the individual. Risk influences the group. It affects it with a depressing regularity and affects every individual as members of the group. Risk has a defining and unifying effect on the group and gives it a personality and an identity. This is the paradox of freedom: each member can feel as free as he will; through his actions he will contribute in one way or another to reproducing the common statistics. Such a group, identified on the basis of its risk, is what is called a mutuality.[10]

By assessing the cost of risk so that it can become the subject of a

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9. *See* Michel Albert, *Le Rôle Economique et Social de l'Assurance*, ENCYCLOPEDIE DE L'ASSURANCE 3 (1938).

10. In fact, the two visions complement rather than contradict each other. Indeed, contractual theory defines an insurer as usually more risk tolerant. This is so because he has access to information. Statistical information, for example, enables the insurer to determine how far he can reasonably commit himself and enables him to master his own risk tolerance.

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contract, insurance gives existence to non-existence, immediacy to the non-current, and form to potential. It inverts the course of time. The feared event exists whereas it has not taken place and may in fact never take place. Risk exists, materialized through a contract, in the form of an infinitesimal fraction of what it will become. That is, it exists in such a manner that its presence, while thoroughly real, remains almost imperceptible. This is what makes insurance doubly effective. The fragmentation of that risk renders feared events no longer feared. Insurance eradicates and decimates adversity. It makes these fears more bearable.[11] Sometimes too much so.

But the merit of insurance extends beyond what would otherwise closely amount to a public-aid dynamic. It transforms the perception of events in such a way so that not to carry insurance becomes a fault. This point was well illustrated last century by Edmond About in his booklet *Insurance*:

> As you know, as the wheels of horse-drawn carriages wear out on cobbles, they shed more than 20 kilos of iron every day on the streets of Paris. These 20 kilos of precious metal are not completely destroyed but they are lost. If you will, their infinitesimal division makes them useless by dint of making them irretrievable. Suppose that a patient and ingenious worker manages, however, to pick up these atoms of iron, restore their cohesion, resistance and all useful qualities. Further suppose that he forges them into a lever. Will he not have created capital for individuals to use? A *centime* is no more capital than a wisp of iron is a lever. It has barely any value. You will find very few individuals who are sensitive to the loss or gain of a *centime* because a single *centime* amounts to nothing. But he who would obtain by honest means this useless *centime* from his fellow citizens would create a capital of 10 millions centimes; that is, a nice lever for moving mountains.[12]

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11. *Cf.* PIERRE-ANDRÉ CHIAPPORI, RISQUE ET ASSURANCE 32-33 (1996). "In the words of Maurice Allais, the Nobel Prize winner in economics, the equivalent risk can be 'eliminated as a whole': it is important at the level of each unit but irrelevant when applied to the collectivity as a whole. Risk does not affect (or at least not significantly) the total amount of resources in the economic system, but only the allocation of the said resources among individuals." *Id.*

12. EDMOND ABOUT, L'ASSURANCE 35 (1865).

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The merit of insurance ensues from pricing expectation and giving reality to potentiality so that any individual who does not account for the possibility of risk in his conduct becomes a factor of individual and collective loss. An individual loss with regard to what his situation will be if the risk becomes real; a collective one as he deprives society of the power to move mountains. Insurance owes its economic effectiveness to solidarity. As it turns potential events into reality, insurance becomes the mechanism by which a possible loss transforms itself into capital. It is simultaneously a combination of protection and an economic mechanism that inverts symbols and turns a loss into a principle of yield. Its value lies in its being much more than a simple mechanism of allocation of liability.

Insurance suggests a social experience of risk to both liberalism and democracy. To the former because liberalism is a political philosophy that advocates risk management as a principle of government. Individuals must face risk in order to become truly aware of their real identity; finding resources in themselves in the form of foresight and, in others, in the form of voluntary association. But insurance, at least in its practical form, is also the product of democracy to which it gives its image of solidarity. Thus, for two centuries, insurance has continuously prompted us to be aware of ourselves both individually and collectively. As the Baron de Beauverger said in 1868 during a parliamentary debate on industrial accidents: "As a system, our society is nothing but an all encompassing insurance, insurance against weaknesses, insurance against misfortune, insurance against ignorance. Look at institutions through that prism and you will see that they all seek the same goal, a noble and generous goal."[13]

This analysis of risk was seriously undermined when an attempt was made to make insurance resolve social problems linked to the development of an industrial society. With the rise of social insurance, insuring oneself becomes mandatory. It is no longer a matter of forging the lever that Edmond About, a century before Mao-Tse Tung, thought capable of moving mountains. It is a matter of seeing to it that individuals are protected against certain risks of a welfare nature. The concept is twofold: regardless of his income, every individual must be protected from these risks since such risks are not equally allocated throughout society. Solidarism, the official social doctrine of the Third Republic, finds its origin in this concept.[14] If there are social risks, it is because society itself

13. M. le Baron de Beauverger, *Corps Législatif*, SÉANCE, May 30, 1868.
14. *Cf.* LÉON BOURGEOIS, SOLIDARITÉ (7th ed. 1912).

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generates them as it develops without regard to a fair allocation. Compensating for inequalities in the face of risks, establishing equalities in the face of opportunities, such is the solidarists' agenda. Social insurance makes coverage against social risks no longer an act, but an entitlement. It is first a salaried worker's entitlement, and the institution of social security makes it a citizen's entitlement. The actualization of the potential, of which the economic translation is capitalization, gives way to a sort of generalized assistance based on allocation.

This rationale regarding insurance became extremely widespread. Today, welfare outlays in the nation of France exceed the budget of the state of France. And the gap continues to widen in accordance with a rationale under which the nature of covered risks (health and retirement) hardly suggests a shift. Yet, the limit beyond which welfare outlays seem destined to ruin their own sources of supply has been reached: social costs are exhausting the economy. The economic rationale couples with a moral rationale: instead of creating an incentive to take risks, health and welfare services engender phenomena of "demoralization" that are counterproductive. Insurance no longer operates as an incentive to take risks, indeed, it directs us to never have to take any.

We have considered some of the issues regarding the necessary limit to risk-taking and the danger of excessive risk-taking. We now find ourselves facing an inverse situation: what we may fear is not excessive risk-taking, but, on the contrary, the absence thereof. Once again, there arises an issue of balance.

III. THE LEGAL PERCEPTION OF RISK

The legal form of risk is exposure. In this realm, risk appears as a threat, a danger, a calamity, and an accident. Liability rules operate, if not as a mean of shifting risk, at least as a means of spreading the cost of risk. Rules governing liability regulate the allocation of the cost of risk within society. The same way every cause has in principle an effect, one individual's act never fails to affect those of others, favorably or adversely. This is true within a family–the relationship between parents and children or between husband and wife. This is also true in the economic realm where competition confers the right to cause harm with impunity. We live at each other's expense. Legal liability simultaneously distinguishes those acts that should not remain a burden on victims and orders the transfer of that burden. Of course, most of the consequences of living in society do not lead to suits to recover damages, otherwise life would be impossible. Usually a court does not settle matters of politeness and civility, nor does a

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court generally settle family conflicts. The market economy would be unable to function if its protagonists could institute actions to redress every wrong they cause each other. Thus, by establishing that damages can be awarded only where caused by a wrong, Article 1382 of the French Civil Code[15] has considerably limited the resort to legal action for damages. Accidents as a phenomenon that characterize modern society, however, have progressively caused liability to be linked to the concept of risk.

We also encounter risk in an "industrial" form. It was not until the end of the Nineteenth Century that the concept first appeared in the form of legislation regulating work-related accidents, thus, not until the rise of industry. More to the point, it can be argued that the concept of risk arose in order to address the problems of allocating costs linked to an industrial society. How to articulate liability as experienced in terms of risks?

Consider Aristotle. According to him, men are destined to be prudent (*phronèsis*), our equivalent for what we call "responsible."[16] We do not have the option of escaping responsibility. We must be prudent because the world is imperfect and uncertain; the future is unforeseeable. This is the destiny that the gods have dictated for men. Through their actions individuals have to complete this imperfect world. The fate of man on earth is to remove uncertainty in such a way that, thanks to the choices he will make, the world will find the path to its perfection. In the world of the gods, that of the astronomical regularity or immutable mathematical laws, there is no room for liability since there is no uncertainty. By contrast, it is the lot of men on this imperfect earth to be confronted with uncertainty and their destiny to remove it. In order to achieve this, they cannot apply laws, which in and of themselves are lacking. They must make choices, decide, and set the future on an irreversible course affecting future generations. It is for this reason that these choices must be "prudent" or, in our vocabulary, responsible. Yet again, an issue of limit.

Along the lines of the Aristotelian model of prudence, one could identify in Western history the major frameworks of choice or decision within which a particular world suddenly emerged and at the same time mirrored its limits. The industrial choice is one such world. And, it is within this framework that liability explicitly took on the form of risk: first, entrepreneurial risk, as early as the Eighteenth Century; then, occupational risk in the Nineteenth Century with the occurrence of work-related

15. C. CIV. art. 1382 (Fr.)

16. *Cf.* PIERRE AUBERQUE, LA PRUDENCE CHEZ ARISTOTLE (1963).

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accidents, and, social risk with the expansion of salaried workers; and later, health risk, technological risk, and environmental risk.

The experience of risk encompasses three dimensions. The first dimension is power. Today, issues of liability and risk are linked to the extraordinary technological capability that we put at work. The industrial "will to power," in Nietzsche's words, asserts itself through considerably efficient technological devices. This has been stressed, highlighted, described or depicted time and time again. It is indeed beyond dispute that industrial power in the late 1900s is no longer solely associated with the concept of accident but also with that of catastrophe. When large corporations producing genetically modified organisms (GMOs) announce that world hunger will soon be eradicated and that agricultural environmental problems are already history, we interpret this as alarming news.[17] This news is alarming because we are dealing with extraordinary manifestations of power. This is precisely what Hans Jonas argues in his *Principe Responsabilité*.[18] Modern industrial power is a hyperpower, a power such that the landscape of liability can only extend itself over the very long term.[19] We are responsible for future generations. In an effort to liberate men from their worries, the Stoics suggested that they distinguish between "that which depends upon us and that which does not depend upon us" with the understanding that we have to answer only for that which depends upon us. The problem is that, with industrial power, it seems that there is no longer anything that does depend upon us. This limitless liability is troubling. There is no longer room for innocence as shown by the increasing disappearance in the law of the concepts of chance occurrence or acts of God. But this limitlessness only reflects our awareness of contemporary industrial power.

The second dimension of liability as risk concerns the interactions of individuals among themselves. Technology involves not only a relationship with nature, but a social relationship as well. The power of an industrial society is affected by relationships of power. These relationships are fundamentally asymmetrical. Modern technology leads to dependence, not equality. The more technologically developed societies become, the less they seem capable of operating within a contractual framework. The

17. These announcements appeared in advertising by Monsanto in French newspapers during June 1997.

18. *See generally* HANS JONAS, LE PRINCIPE RESPONSABILITÉ (1990).

19. *See id.*

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asymmetry between employers and employees is recognized by the concept of a labor contract, which defines the subordination of employees and the division of work-related liability. The asymmetry between producers and consumers, merchants and non-merchants, is at the root of consumer law. Today, issues of liability largely address these asymmetries. This may explain why the issue of medical malpractice finds itself at the center of current debates on liability. The physician-patient relationship is fundamentally asymmetrical whereas, legally speaking, it continues to be regarded as a contract with all the attendant implications in terms of risk allocation.[20] This aspect of asymmetry, with the attendant notion of dependence, lies at the core of the highly publicized cases that have been making headlines in France since the early 1990s: contaminated blood,[21] asbestos,[22] and mad cow disease.[23] The victims realize that they have been placed in a risky situation, where the individual in control of the industrial process was fully cognizant of the risks and that that same individual chose to make them assume the risk without necessarily informing them of it. Dependency reveals itself after events have reached their final outcomes. Risk represents not only a danger but also a social relationship. It is a relationship between an individual who possesses technological power and one who may profit from it or perhaps be subjected to it.

So far, two dimensions of risk as encountered in law have been considered–power within the context of nature, and rights in the relationship of individuals among themselves. There remains a third dimension–damages. In an industrial society, it is believed that there can be no risk-free activity, or business. Raymond Saleilles, in his comments

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20. *See* Thomas E. Carbonneau, *The Principles of Medical and Psychiatric Liability in French Law*, 29 INT'L & COMP. L.Q. 742 (1980).

21. From 1981-1985, a scandal erupted over the delivery of HIV-contaminated blood to 6,000 transfusion recipients and hemophiliacs. The result was a multitude of lawsuits directed against the French government, government ministers, and others responsible for the blood transfusions. The trials are still in process. For a discussion of the crisis, see *Murder by Bureaucracy*, WALL ST. J., Aug. 5, 1992, at A14.

22. For an overview of the highly-publicized asbestos litigation, see William B. Johnston, Annotation, *Products Liability: Inhalation of Asbestos*, 39 A.L.R.4th 399 (1985).

23. Hundreds of thousands of English cattle were contaminated with BSE, an animal prion-based disease that bears a resemblance to Kreutzfeld-Jakob's disease in human beings. The question is whether the animal disease can be transmitted to people who eat beef. *See* Samen K. Fodor, *How Does the European Union Solve Crises—With Solutions or By Avoidance? A Study of the "Mad Cow Disease" Crisis*, 27 GA. J. INT'L & COMP. L. 249 (1988).

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on the then-new legislation on industrial liability, underscored this fact a century ago: "Modern life is more than ever a question of risks."[24] Risk is inevitable and beyond debate; the only issue therefore is the allocation of its cost.

> The issue is not to inflict a penalty, but to determine who, between the one who caused the risk and the one who suffered from it, must bear the cost. Penal considerations are irrelevant; only social considerations come into play. It is not properly speaking an issue of liability but an issue of risks: who must bear the risks? Reason and legal fairness dictate that it must be borne by the individual who by virtue of his actions has assumed the consequences of his deed and activity.[25]

It is inconceivable to require that, as a condition of acceptance, an activity or a business must be free from risk to others. There is nonetheless a condition. The burden must not be borne by those individuals who are *subjected to* the risks; those who *impose* such risks must bear their costs. Rules governing liability regulate such transfers on the basis of risk, hence the existence of objective liability and presumptions of liability whose rationale lies in placing the burden of risk on the individual who creates or profits from it. Thus, the response to risk is indemnification rather than prevention. In other words, insurance has developed considerably with the multiplication of required liability coverage (there are about a hundred of them in France). Until recently, nobody was concerned about this new social contract–the contract of solidarity–according to which, risk is acceptable so long as it is indemnified and its cost not borne by the victim.

Today, we are witnessing a remarkable shift in this pattern. The issue is no longer so much that of multiplying risk liabilities and structuring through insurance the solvency of those liable as it is to prevent certain risks from being taken. Not only is prevention outpacing indemnification, but efforts are also made to avert risks that have not yet been recognized. Precaution governs.[26] Several factors account for these recent developments. First, damages no longer pertain to individual accidents as much as they pertain to catastrophes. The amounts currently involved

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24. RAYMOND SALEILLES, LES ACCIDENTS DU TRAVAIL ET LA RESPONSABILITÉ CIVILE 4 (1897).

25. *Id.*

26. For a discussion of the precautionary principle, see François Ewald, *The Return of the Crafty Genius: An Outline of a Philosophy of Precaution*, 6 CONN. INS. L.J. 47 (1999).

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exceed the limits of what can be insured as well as indemnified. Second, the cost of liability is also being reevaluated. The first World War provides a good scale by which to weigh this new method of measuring risk. During the war, a general could send 300,000 men every two weeks off to be killed, as was the case during the *Chemin des Dames* battle.[27] Today, only "zero-risk" wars can be waged. A peculiar transmutation of values, indeed! Under the traditional cost-benefit analysis, it was enough that advantages outweighed risks to feel justified in taking risks and thus in accepting a portion of loss. Today, risk tends to be measured on the basis of the loss portion: what justifies the sacrifice? Do not those unfortunate enough to make up the loss portion count as much as others? Such is the method of valuation underlying the zero-risk problematic.

The rationale of precaution does not advocate, as it has been said, a change of focus from risk to fault. It results from a twofold reassessment of risk. First, it results from the technological powers that are now at work and over which we know we fail to exercise full control. We are witnessing an excess of might over power that we do not really know how to express from a legal standpoint. It can be characterized as a developmental risk, principle of precaution depending on whether we look at it from a legal or political standpoint. Second, the rationale of precaution results from a sort of backlash of victims who no longer accept the cynicism arising from the traditional formula for the acceptance of liability. What they challenge is not so much the amount of damages as the imbalance of power linked to technological risks. And, today, as a result of this backlash, liability tends to be assessed on the basis of what was hitherto considered negligible.

Here again is another case of how the experience of risk has its limits. Given the inordinate power now in existence (which can be measured by the fact that we cannot measure its effects), the relations of asymmetry and dependence (with the sense of a loss of autonomy that ensues), and the magnitude of the risks created, should it be appropriate, short of putting an end to the process, at least to take a pause that would allow us to regain control over the changes governing us? Time for precaution is time for moratoria.

CONCLUSION

Consideration of the moral, social and legal perceptions of risk do not

27. This was a celebrated and extremely bloody battle during World War I.

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provide an exhaustive account of the experience of risk. In order to explore it thoroughly, it would be necessary to include: risk as perceived in the military, probably one of the oldest aspects under which it is experienced; risk as perceived in gambling, which from Pascal to Von Neumann and Morgenstern, has held an important place in the formalization of behaviors in the face of risk and remains so much part of the financial world; and risk as perceived in the medical field that, due to the progress in medical sciences and to society's growing reliance on medicines, has become central to our perception of risk. We should also include risk as perceived in psychology where it constitutes one of the correlates of contemporary individualism.

The purpose was not to consider every experience of risk. The intent was solely to understand how risk could be at the core of contemporary society. Not simply because of the threats hovering over us, but more importantly, as a general principle of valuation. By seeking the value of values through risk, contemporary society found itself inexorably subjected to the dialectic of risk. The morality of risk, while encouraging sacrifice, sets it as its limit.

The perception of risk constitutes a defining experience for contemporary society: how far is too far? While valuing risk, adventure and entrepreneurship, contemporary society seeks to keep it within measure. Thus, while risk stands as a principle of valuation, motivation, and action, it also constitutes a principle of limitation, restriction, and prohibition. When overvalued or undervalued, risk quickly turns human experiences into inhuman ones. There is therefore no need to set a morality of risk against a morality of protection. Indeed, the morality of risk is inextricably a morality of protection. Risk and safety are not opposite concepts independent from each other. Risk both affirms and negates. It arises from the need to surpass oneself, from the necessity to transcend the accepted frontier and also from the pressing awareness of the danger of going beyond the limit. This is precisely why, by taking on risks, individuals in contemporary society have set the conditions for feeling perpetually restless, better still, have dedicated themselves to anxiety and responsibility.

"The vague restlessness that causes man to fear his fulfilled desire."[28]

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28. VICTOR HUGO, LES FEUILLES D'AUTOMNE (1831).

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INSURANCE AND THE UTOPIAN IDEA

*Carol Weisbrod**

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INTRODUCTION

In 1887, Reverend R. Heber Newton[1] produced a list of enterprises under the heading "American Co-operation."[2] The list included fire and life insurance companies, Brook farm and Owenite and Fourierite groups, and building and loan associations.[3]

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* Ellen Ash Peters Professor of Law, University of Connecticut. This work was supported by a grant from the Insurance Law Center of the University of Connecticut School of Law. One version of this paper was prepared for a conference ('A Millenium of Utopias') held at the University of East Anglia, June, 1999. In the event, the paper was not delivered as I was unable to attend the conference. Another version of the paper was given as part of a panel discussion of Insurance as a Site of Historical Research at the annual meeting of the American Society for Legal History, October, 1999 held in Toronto. I am grateful for the comments offered there. Thanks are also due to Tom Baker, Brian Glenn, Carolyn Jones, Richard Kay, Lyman Tower Sargent, Aviam Soifer, and Stephen Wilf; to the participants in the discussion at the New England Insurance and Society Reading Group; and to the seminar in Religion, Risk and Responsibility (Spring 2000).

1. Rev. Newton (Protestant Episcopal) was the Rector of All Souls' Church in New York. His entry in D.A.B. notes the range of his interests.

2. *See* R. HEBER NEWTON, SOCIAL STUDIES 86 (1887).

3. *See id.*

> The chief entries now to be recorded in the annals of American co-operation may be tabulated as follows: Share System introduced into New England Fisheries (about 1730); Fire Assurance introduced in

By 1897, when the list was published as an "interesting table" in the Bliss Encyclopedia of Social Reform, the writer of the article on cooperation was able to say first, that some of the enterprises on the list had failed, and second, that the list had been broken down in the encyclopedia. Utopias were discussed under the heading Utopias and Insurance companies were discussed under the heading insurance.[4] This division remains standard.

At the moment, the history of insurance is often told with an emphasis on its connections to commercial activity, to risk and to the actuarial approaches that have made risk more ascertainable and controllable. The theme of risk and the management of risk identified with modernity, can be seen as central to twentieth century life. Thus, we see a reference to "the popular contemporary theme that late modernity is characteri[z]ed by the rise of the risk or insurance principle."[5]

> Philadelphia (1752), "The Philadelphia Contributionship for the Insurance of Houses from Loss by Fire," Benjamin Franklin, First Director (the corporation is still prospering); Life Insurance introduced in Philadelphia (1767), "The Corporation for the Relief of Widows and Children of Clergymen in the Communion of the Church of England in America," composed of clergymen and still flourishing; Mutual Assurance bodied in a national order called The Odd Fellows (1819); Owen's Movement, which was Socialistic (1820-1830); Loan and Building Societies formed in Philadelphia, New England Association of Farmers and Mechanics agitate the formation of stores, Labor Organizations in New England open some stores (1830-1840); Brook Farm, Hopedale, etc., Pourierite Phalanxes, New England Protective Union builds up a system of stores which, at their height, did a business of about $2,000,000 per annum, and some of which still survive (1840-1850); The earliest essay in Co-operative Production, Tailors' Association in Boston (1849); Loan Associations arise in Massachusetts, Associate Dairies started in New York, Anaheim (1850-1860); Stores and Productive Societies started in several states, Revival of Building and Loan Associations in Pennsylvania, Mutual Assurance assumes business forms, Renewed attempts at Co-operative Production, (1860-1870); Ship-yard in Baltimore (1865); Ship-yard in Boston (1866); Machine Shop in Philadelphia (1866); Foundries in various cities; Shoe Manufactory in Lynn and in North Adams (about 1868); Cigar Manufactory in Westfield, Mass (1869).

Id. at 86-87.

4. *See* THE NEW ENCYCLOPEDIA OF SOCIAL REFORM 366 (William D.P. Bliss et al. eds., 1970).

5. ALAN HUNT & GARY WICKHAM, FOUCAULT AND LAW 66 (1994).

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This article is an attempt to suggest an outline of the connections that Reverend Newton saw. The first steps in the reconnection involve seeing the links between insurance and political thought, particularly utopian and religious political thought.

If we say that insurance is a political metaphor, we might mean the modern liberal, and even consciously secular politics of the modern West. But we might also include the politics of religious orientations, which may or may not be modern. That churches have social and political views is not a new idea. It is strange only if one adopts a fairly narrow view of religion, which focuses on individual belief and ritual observances. Because there are such things as religiously-based politics and economics, however, we can appropriately include material on insurance and religion in a review of the metaphoric uses of insurance.

The religious and secular treatments can perhaps be linked through the idea of utopia.[6] The rhetoric of utopia is invoked by writers on risk, or insurance, operating from different political orientations. Thus, François Ewald writes: "The 19th century's dream of security becomes a utopia of a science always ever more capable of controlling risks."[7] Anthony Giddens speaks of utopian realism.[8] The idea of Utopia as substantive may also overlap with the description of Germany as Eldorado, a place of wealth and caution, as offered by Ulrich Beck.[9] Some of these descriptions see a society as a utopia in practice precisely because of insurance, and particularly state insurance.[10]

The rhetoric of the projected utopia, the planned ideal society may invoke insurance from various orientations. Thus, as noted below, Edward Bellamy conceived his future State in terms of insurance. Today, from the

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6. "Utopia" is used here evocatively and not with definitional precision. *See* Lyman Tower Sargent, *"Utopia: The Problem of Definition,"* EXTRAPOLATION, Vol. 16, May 1975, at 137-48.

7. François Ewald, *The Return of the Crafty Genius: An Outline of a Philosophy of Precaution*, 6 CONN. INS. L.J. 47, 58 (1999). "While one cannot eliminate them (there is never zero risk), they will have been sufficiently reduced to be able to be dealt with collectively: accidents are the waste aspect, necessary although always more marginalized, of scientific and technical progress." *Id.*

8. *See* ANTHONY GIDDENS, THE CONSEQUENCES OF MODERNITY 154-58 (1990).

9. *See* Ulrich Beck, *From Industrial Society to the Risk Society; Questions on Survival, Social Structure and Ecological Enlightenment*, *in* 9 THEORY, CULTURE AND SOCIETY 97 (1982).

10. Another view might be that in utopia no insurance would ever be needed.

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libertarian side, Murray Rothbard, in a scheme for a future libertarian society, sees a policing role for insurance companies.[11]

Beyond rhetoric, we can connect insurance and utopia in their discrete historical incarnations. One way of suggesting the connections is to follow the lead of Morton Keller and see insurance companies as voluntary associations, alternative to the state, which provide social benefits.[12] We may also invoke that smallest state, the family. The Oneida community was, as an observer said, a family of two hundred.[13] And the Metropolitan Life Insurance Company was a "family of thirty million."[14]

This paper is a sketch of an answer to the question: What relations might there be between insurance and the vision of an ideal society? Two approaches are outlined here, one based on a reading which stresses continuity and sees insurance as a form of mutual aid. This approach may include the idea of insurance as a meliorist alternative to collective or state-sponsored forms of protection and security. A second perspective sees insurance, and the insurance idea, (whether embodied in official or unofficial forms) as a distortion and corruption of the communitarian idea. The third section of the paper raises some issues which might be explored in work which tried to research this kind of question over time.

The effort here is not to offer a history, but to suggest some of the background which might be relevant to the historical inquiry.

I. RELIGION AND INSURANCE

> You have no need to pray to God any more when the thunderclouds stand overhead; but you must be insured.[15]

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11. *See* MURRAY N. ROTHBARD, FOR A NEW LIBERTY: THE LIBERTARIAN MANIFESTO 217-19 (1989). Some libertarian arguments reject insurance. *See, e.g.*, LUDWIG VON MISES, SOCIALISM: AN ECONOMIC AND SOCIOLOGICAL ANALYSIS 475-78 (1951). Von Mises writes: "Social insurance has thus made the neurosis of the insured a dangerous public disease. Should the institution be extended and developed, the disease will spread. No reform can be of any assistance. We cannot weaken or destroy the will to health without producing illness." *Id.* at 478.

12. *See generally* MORTON KELLER, THE LIFE INSURANCE ENTERPRISE, 1885-1910: A STUDY IN THE LIMITS OF CORPORATE POWER (1963).

13. *See* CAROL WEISBROD, THE BOUNDARIES OF UTOPIA 177 (1980) (T.W. Higginson referred to the Oneida community as "a family of two hundred living in apparent harmony and among the comforts which associated life secures." *Id.*).

14. LOUIS I. DUBLIN, A FAMILY OF THIRTY MILLION (1943).

15. BERTOLT BRECHT, THE MOTHER 115 (1965).

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There are some familiar connections between religion and insurance. In telling the story of insurance we invoke images of London underwriters, sitting in coffee houses while they consider maritime risks. We recall Pascal, working out the answer to a question posed by a French nobleman: how could one assess winnings in a card game which was not yet completed? The answers given by Pascal as mathematician continue to be important to us in connection with the risks involved in calculating premiums for modern insurance. Both the London coffeehouses and Pascal are used by Peter Bernstein in *Against the Gods*[16] with the implicit idea that Pascal's most famous comment on risk and uncertainty – his wager on the existence of God – exists in an altogether different dimension from that of his mathematical inquiry.[17] This is not, however, the only way to look at the issue.

Thus affinities between religion and insurance have sometimes been suggested. Franz Kafka, whose connection to insurance is well known, said of the enterprise that "insurance is like the religions of primitive peoples who believe they can ward off evil by all kinds of manipulations."[18] William Sumner suggested that religion was a kind of insurance,[19] with insurance was described as: "a generic conception covering the methods of attaining security, of which the modern devices are but specific, highly elaborated, and scientifically tested examples..."[20] Insurance "is a grand device" Summer said, with very old roots, since mankind "has tried in all ages somehow to insure himself – to take out a

16. *See generally* Peter L. BERNSTEIN, AGAINST THE GODS: THE REMARKABLE STORY OF RISK (1996).

17. *See id.* Pascal is viewed as having been torn between "pursuing a career in mathematics and yielding to religious convictions that were essentially anti-intellectual." *Id.* at 58.

18. MAX BROD, FRANZ KAFKA: A BIOGRAPHY 79-80 (G. Humphreys Roberts & Richard Winston trans., Schocken Books 2d. ed. 1960) (discussing Kafka's daily work). Kafka worked first for the Assicurazioni Generali, then the Workingman's Accident Insurance Institute in Prague. *See id.* Ernest Pawel described the Workingman's Accident Institute in Prague as "semi-governmental." *See* ERNEST PAWEL, FRANZ KAFKA: THE NIGHTMARE OF REASON 183 (1984).

19. *See* Spencer L. Kimball, *The Purpose of Insurance Regulation: A Preliminary Inquiry in the Theory of Insurance Law*, 45 MINN. L. REV. 471, 479-80 (1961) (quoting SUMNER & KELLER, THE SCIENCE OF SOCIETY 749 (1927)).

20. *Id.* at 479.

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"policy" of some sort on which he has paid regular premiums in some form of self-denial or sacrifice."[21]

Some historical work on the insurance/religion nexus has been done in the United States and also in other countries. As Viviana Zelizer has indicated, religious values opposing insurance were evident in the nineteenth century American discussion.[22] The insurance industry responded to those arguments by insisting that insurance was an aspect of responsibility.

Move and countermove were clear at the end of the nineteenth century. William Standen wrote in 1897, "[t]ime was...that life insurance could only be availed of by the impious and ungodly."[23] There was a time, "when even ministers of the gospel of grace and peace put themselves on record against the benefits of life insurance, by claiming that it was a defiance of divine power"[24]; At that time, "a man who insured his life was betting against his God;" and the divine being, who is the protector of the widow, the orphan and the fatherless, would resent and punish as a crime the natural protection that life insurance alone can give."[25]

But at the end of the nineteenth century, "[T]hanks to the change wrought by time, such an absurdity is rarely uttered to-day."[26] Standen continues: "[l]ife insurance instead of being denounced as something intolerable to the religious man, is now regarded as the bounden duty of all."[27]

The good father would protect his family. Zelizer quotes Henry Ward Beecher, on the responsibilities of a Christian father, seeing the religious struggle as fundamentalists against liberals, and particularly liberal Protestants.[28] As Tom Baker has summarized the issue: "Eventually, the

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21. *Id.* at 480.

22. *See generally* VIVIANA ZELIZER, MORALS AND MARKETS: THE DEVELOPMENT OF LIFE INSURANCE IN THE UNITED STATES (1979). Zelizer describes her study as one which "analyzes life insurance as a social mechanism to cope with the uncertainty of the time of the time of an individual's death." *Id.* at 73. She suggests a somewhat more precise question in her conclusion: the study in part responds to the question left open by Stalton and others as to why aggressive tactics were needed to sell life insurance particularly. *See id.* at 149-50. Zelizer also refers to cooperative and mutual aid ideas. *See id.* at 91, 95.

23. WILLIAM T. STANDEN, THE IDEAL PROTECTION 119 (1897).

24. *Id.*

25. *Id.*

26. *Id.*

27. *Id.*

28. *See generally* ZELIZER, *supra* note 22.

objection that insurance interfered with the Divine Plan was turned on its head as the insurance men turned calamity into chance and linked insurance to the cultural values of self-reliance, thrift, and acquisitiveness."[29] Indeed, insurance became one of the protective devices through which Providence works, and it was immoral to fail to get insurance.

The relation between insurance and the history of Christianity, and particularly Christian post millennial thinking was also noted. Charles Loring Brace, writing in 1882, addressed the question of insurance as "the greatest practical benevolent discovery of modern life, and one destined yet to produce enormous effects in diminishing poverty and relieving misfortune."[30] He conceded that the "application of insurance to human ills is not directly a fruit of Christianity,"[31] and yet he saw the stimulus which Christianity gave to benevolence as an indirect source. He described insurance as "the application of the savings of the fortunate to the assistance of the unfortunate, and yet not necessarily through benevolent motives."[32] He noted that insurance, whether to alleviate problems of he working class through government programs or private insurance "will be one of the greatest blessings of modern society, and will undoubtedly be stimulated, if not caused by the influence of Christ in the world."[33]

Jean Halpérin, working from European materials, noted that insurance has been both discouraged and encouraged by religious issues and questions. It was discouraged in the sense that the Orthodox saw in insurance an attempted interference with the Divine Plan and a kind of "insult to Providence."[34]

Halpérin also noted that, in Germany, even in the first decades of the nineteenth century, there was opposition by clerical parties to private companies which were insuring against fire. These efforts were attacked on the grounds that they deprived God of the means of punishing men.[35]

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29. Tom Baker, *The Genealogy of Moral Hazard,* 75 TEX. L. REV. 237, 255 (1996).

30. CHARLES LORING BRACE, GESTA CHRISTI: A HISTORY OF HUMANE PROGRESS UNDER CHRISTIANITY 416 (1882).

31. *Id.*

32. *Id.*

33. *Id.*

34. *See* JEAN HALPÉRIN, LES ASSURANCES EN SUISSE ET DANS LE MONDE 116 (1946). Thanks to Laura Schwartz for assistance with the French materials.

35. *See id.* Halpérin notes that similar arguments were made concerning the umbrella in England. Certain religious figures opposed this, saying that according to the bible, God let the rain fall on the just as well as the wicked. *Id.* (citing A.A. READE, THE STORY OF LIFE ASSURANCE 30 (1903)).

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Halpérin describes a pamphlet he found in the Swiss Economic Archive called *Insurance and Religion: a Question of Political Economy.* It was dedicated to demonstrating that insurance was an honorable thing in the eyes of religion and to reassure people of the morality of insurance.[36] Halpérin writes that Abbé, who wrote the pamphlet, concluded by saying that insurance was a religious and social necessity.[37]

But Halpérin also discusses religion as a positive factor in the development of insurance. He describes the efforts of the theologians to show that the universe was not arbitrary or magical.[38] Halpérin notes that: the first statistical and demographic work was encouraged, indeed sometimes undertaken by the theologians.[39] Statistical regularity proved the errors of superstitions and the orderliness of the universe.[40]

Alexander Welsh, discussing the Religion of Life Insurance, wrote that "life insurance is the characteristic institution of a Christian society whose faith in immortality had decayed or is declining."[41] He suggested that "if

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The umbrella of the insurance advertisements may be compared to the sheltering cloak of Mary. *See* JAMES HALL, DICTIONARY OF SUBJECTS & SYMBOLS IN ART 325 (rev. 1974). The entry begins: "The disasters that befell medieval man, such as war and disease, especially the plague, were seen as the workings of divine judgment. He might mitigate them however by placing himself under the protection of a tutelary figure, a saint or, to even greater purpose the Virgin herself." *Id.* (thanks to Pamela Sheingorn for calling my attention to the sheltering cloak). Tom Baker, using a Melville short story, indicates that objections to life insurance on the theory that interference with divine providence could have a broader reach than insurance. In the Melville story it reached the issue of lightening rods. *See* Baker, *supra* note 29, at 255. The idea also occurred to others. An Amish ordnung (discipline) of 1865 is translated by Harold S. Bender this way: "decided not to . . . enroll our material possessions in companies (insurance?) or to put up lightning rods on our buildings..." Harold Bender, *Some Early American Amish Mennonite Disciplines*, 8 MENNONITE Q. REV. 90 (1934).

36. *See* HALPÉRIN, *supra* note 34, at 117.

37. *See id.* Halpérin dates this as early 19th century. Geoffrey Clark discusses similar arguments in 18th century England. *See generally* GEOFFREY CLARK, BETTING ON LIVES: THE CULTURE OF LIFE INSURANCE IN ENGLAND, 1695-1775 (1999). Since the Catholic Church was not opposed to gambling per se (but only when inappropriate), the opposition based on gambling may have been essentially Protestant. *See generally* LEO PFEFFER, CREEDS IN COMPETITION (1958). Gambling was historically associated with attempts to know the Divine will. The Amish, who often oppose insurance (see below), use lots to choose their bishops, *cf* certain biblical practice. *See, e.g.*, 1 *Chronicles* 24:5; *Acts* 1:26.

38. *See* HALPÉRIN, *supra* note 34, at 117.

39. *See id.*

40. *See id.* at 117-18.

41. ALEXANDER WELSH, *The Religion of Life Insurance, in* THE CHRISTIAN CENTURY 1541 (1963).

our belief in immortality had the original Christian force and literalness we would have no need for life insurance, [since] if we truly felt the next life to be more important than this, we would hold the same to be true for our heirs."[42] The institution of life insurance has "inherited and transformed the religious hope of immortality in an age that has lost religious assurance."[43]

Welsh found confirmation of his view in the rhetoric of the industry. The religious heritage survives in the everyday idiom of the insurance world: witness the calls to renew our "faith" in life insurance, the eagerness to "tell the story" of life insurance. And, he noted, a patriotic and biblical idiom is often heard in combination: "Our democracy was founded on spiritual foundations," says one agent, "we must help others help themselves by building their future upon the rock, not upon the shifting sands."[44]

A discussion by Miles Tracy, the work of a Professor of Business, views issues of insurance and religion from outside the framework of any specific religion. His work is addressed to something called "the insurance community" and considers the historical position of a number of religious groups on insurance.[45]

The Tracy article then moves to the modern situation and the argument that life insurance has itself has become a religion. There is also a discussion of the position of the Christian Scientists, who see the problem in terms of possible discrimination against Christian scientists (by the carriers) because the scientists rely on spiritual healing. (This material is a variation on such questions as whether Christian Science practitioners are engaged in the practice of medicine, can sue for fees as doctors etc.) There are additional comments on the Jehovah's Witnesses and the Mormons, and a concluding reference to non-Christian groups.

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42. *Id.* at 1542.

43. *Id.*

44. *Id.*

45. *See* Miles A. Tracy, *Insurance and Theology: The Background and the Issues, in* J. OF RISK & INS. 85 (1966). Tracy's comments on the early life insurance documents – that they are curiously silent on the theological implications of the plan – raise the question: what sort of theological discussion would we expect in such a document? Why would one "posit an elaborate theology" if one was acting on an existing and adequate theology? Tracy is looking for "discourses based on the scriptures" (Why? Why "scriptures"? And what groups are omitted from his mental map of religion?) Tracy draws on the piece from the Mennonite encyclopedia, (see *id.* at 85-87), reading it as describing a system of property insurance based on "the principle of sharing losses." *Id.* at 86.

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The Welsh articles evoked a response in 1965 by a representative of the insurance industry – Roger Hull, of New York Mutual. Hull argued in religious terms, including quotations from Dietrich Bonhoeffer, and concluding with a sermon preached in the 1880's by T. De Witt Talmadge:

> It is meanly selfish for you to be so absorbed in the heaven to which you are going that you forget what is to become of your wife and children after you are dead. if you could pay the premiums on a policy, and neglect then, it is a mean thing for you to go up to heaven while they go into the poorhouse.[46]

In short, Hull believed that the argument of the late nineteenth century in relation to the discussion was still useful in the mid-twentieth century.

But, of course, religion is not one thing. Rousas Rushdoony, for example, places the whole subject in the context of a society that has rejected the principles of restitution and therefore has forced responsible people to take out insurance as a second best solution to a serious problem. Rushdoony, a Christian conservative, wrote in 1970 that "The failure of a society to ground itself on restitution, or its departure from this principle, means a growing necessity for costly protection by means of *insurance*."[47] Insurance, as he saw it, was a kind of "self-restitution," since the insured is protecting himself against those "irresponsible people who will not make restitution," and from "the failure of the law to require restitution."[48]

The history of the Mennonites and insurance captures the essentials of the argument opposing insurance. An account in the Mennonite Encyclopedia explains that opposition to life insurance was originally very strong, with excommunication as the sanction. "Applicants for membership were required to surrender their insurance policies before being received."[49] This opposition covered all forms of insurance, but by the beginning of the twentieth century, "opposition to fire and auto accident insurance had greatly diminished."[50] Workmen's compensation "created

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46. Roger Hull, *Immortality Through Premiums? Rebuttal from the Life Insurance Center*, THE CHRISTIAN CENTURY, February 19, 1964, at 239 (quoting a sermon of T. DeWitt Talmadge).

47. ROUSAS JOHN RUSHDOONEY, THE INSTITUTES OF BIBLICAL LAW 227 (1973).

48. *Id.*

49. THE MENNONITE ENCYCLOPEDIA: A COMPREHENSIVE REFERENCE WORK ON THE ANABAPTIST MENNONITE MOVEMENT 343 (1957).

50. *Id.*

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serious problems for conservative Mennonites at first, but ultimately this was generally accepted."[51]

Eventually, even the absolute prohibition on life insurance was changed, with only certain parts of the denomination prohibiting it altogether. Finally "in the General Conference Mennonite Church, the Mennonite Brethren Church, and certain related groups, whatever minor opposition there once may have been has completely disappeared, although such opposition apparently never was very strong."[52]

The Mennonite opposition to insurance had several dimensions. They believed that "it reflects trust in man rather than in God";[53] and it meant becoming "'unequally yoked together with unbelievers'";[54] insurance was "equivalent to merchandising in human life";[55] it is putting a monetary price on human life, which is considered unscriptural since man is the "'temple of the Holy Ghost . . . .'"[56]

Further, many Mennonites "also objected to taking out life insurance because it was contrary to the spirit of genuine mutual aid and brotherhood"[57] and finally, "the corrupt practices of many earlier life insurance companies were often cited as objections to all life insurance."[58] The corrupt history of the industry "greatly fortified the theological arguments."[59]

This article in The Mennonite Encyclopedia then goes on to describe forms of mutual aid within the group. "A form of mutual brotherly aid insurance has developed among Mennonites in North American in recent decades in the form of death and burial and benefit associations, which are

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51. *Id.*
52. *Id.*
53. *Id.*
54. *Id.* at 344.
55. *Id.*
56. *Id.*
57. *Id.*
58. *Id.*
59. *Id.* One American court wrote in the late nineteenth century that: "Some companies, chartered by the legislature as insurance companies, were organized for the purpose of providing one or two of their officers, at head-quarters, with lucrative employment, – large compensation for light work, – not for the purpose of insuring property; for the payment of expenses, not of losses." Delancy v. Insurance Co., 52 N.H. 581 (N.H. 1873). It may be noted, however even this can be defined as an aspect of community of a particular social class. *See* ANTHONY F.C. WALLACE, ROCKDALE 49-50 (Norton 1980) (1972).

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in effect life insurance arrangements."[60] Nonetheless, the position is that these are substantially and significantly different from ordinary insurance. Five factors are listed: (1) the benefit payments are small, intended to cover only the cost of the burial,[61] or also medical bills attendant upon the last illness; (2) the system is entirely and truly mutual; (3) salary payments to officials are nonexistent or very low; (4) no agents' premiums are paid; (5) membership is limited to church members.[62]

* * *

There is a widely recognized disparity in response between issues of insurance as to property (fire, theft, maritime insurance) and issues of life insurance.[63] All insurance is not the same.[64] Rushdoony's emphasis on restitution—preceded in his *Institutes of Biblical Law* by an extensive discussion of restitution/restoration—allows us to reopen the question of why life insurance was different, sometimes opposed, even when other forms of insurance were accepted.

While we tend to assume a world with insurance,[65] we have, in the world of imagination and literary reference, another idea. It is precisely a world without insurance that is associated in the Western tradition with the story of catastrophic and inexplicable affliction represented by Job.

> 1 There was a man in the land of Uz, whose name was Job; and that man was blameless and upright, one who feared God, and turned away from evil. 2 There were born to him seven sons and three daughters. 3 He had seven thousand sheep, three thousand camels, five hundred yoke of oxen, and five hundred she-asses, and very many servants; so that this man was the greatest of all the people of the east . . . .[66]

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60. THE MENNONITE ENCYCLOPEDIA, *supra* note 49, at 344.

61. Life insurance may be conceived as burial insurance at times.

62. *See* THE MENNONITE ENCYCLOPEDIA, *supra* note 49, at 344.

63. *See, e.g.*, ZELIZER, *supra* note 22, at 123 (1979); *see generally* VIVIANA A. ZELIZER, THE SOCIAL MEANING OF MONEY (1997) (noting that all money is not the same).

64. *See* ZELIZER, *supra* note 22 (discussing the social meaning of money).

65. *See generally* Tom Baker, Insurance, Risk, and (the Social Construction of) Responsibility (unpublished manuscript, on file with the Insurance Law Center at the University of Connecticut School of Law) (noting that a world with insurance is usually assumed in the Western discussion).

66. *Job* 1:1-10 (Revised Standard).

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The story continues with a wager between God and Satan, in which Satan says: "Thou hast blessed the work of his hands, and his possessions have increased in the land. But put forth thy hand now, and touch all that he has, and he will curse thee to thy face."[67] And the LORD said to Satan, "Behold, all that he has is in your power; only upon himself do not put forth your hand."[68] Satan causes Job to lose everything he has; camels, servants, children.

The book of Job concerns itself with the problem of Job's suffering, and its lack of justification. Of interest here is not the major part of the text, but only the epilogue, the so-called happy ending.[69]

> And the LORD restored the fortunes of Job, when he had prayed for his friends; and the LORD gave Job twice as much as he had before. . . . And the LORD blessed the latter days of Job more than his beginning; and he had fourteen thousand sheep, six thousand camels, a thousand yoke of oxen, and a thousand she-asses. He had also seven sons and three daughters . . . .[70]

The restoration given to Job is provided by the same God who originally permitted/caused Job's suffering. But what if it had been provided by an insurance company? What if the first question for Job was not "Why Me?" or "Why should the Righteous Suffer?" but "Am I insured for This?" Of course, if Job had been insured, the afflictions could have included the insolvency of the Insurer.[71] But the idea that Job might have insured his wealth, or the lives of his children seems to change the story.

To the extent that it mitigates, insurance influences the meaning of human suffering in relation to certain events.[72] It is in that sense, like all

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67. *Job* 1:11.

68. *Job* 1:12.

69. *See* MARTIN COPENHAVER, *Risking a Happy Ending, in* CHRISTIAN CENTURY 923 (1994) "It is not difficult to see why many commentators have concluded that the epilogue comes from a different source and was simply tacked on. After the bold cadences of the poetry that has gone before, the epilogue is told in prose – and it seems, well, prosaic. It is the happily-ever-after ending of a fairy tale." *Id.*

70. *Job* 42:10 ff.

71. *See* TERENCE O'DONNELL, HISTORY OF LIFE INSURANCE: IN ITS FORMATIVE YEARS 751-52 (1936) (quoting William Penn who after an unsatisfactory experience wrote "Ensurers fail much." *Id.*).

72. If we compare the restoration of God, with an insurance ending, we get several issues. First, the insurance company may or may not pay, according to its reading of the contract. Second, it will not pay more than the loss (let alone double the loss), and in some

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other social reforms, which, when successful, have the effect of leaving us with the question of love and death in ideal conditions.

The story of Job concludes on a note of restoration, if not quite of the status quo ante, at least something quite close. Job has more money, no children, but the expectation of future children, presumably by way of substitution. As a commentator on Job wrote, modern values as to children are quite different from the ancient ones.[73] That there should have been changes on this point is no surprise. Compare modern western values with the tribal values described by Ruth Benedict as to tribe in which restitution – a new spouse for a murdered spouse – was considered an appropriate remedy.[74]

It seems possible that to the extent that insurance is restitutionary or restorative, it is aligned with a religious tradition that reaches the ultimate point in the idea of Messianic restoration. To the extent that it attempts to project future earnings (for example) insurance is more problematic.

The usual explanations hold that the hostility to life insurance has roots in concern with commodification of human life, that it reflects a lack of trust, a betting against God.[75] But, perhaps the idea of restitutionary remedies also has a role here. Certainly on this point we must first say something about the ending of Job, which involves more than restitution. Rushdoony reads Leviticus 5:14-16 as referring to "a case of sin where God was directly involved," in which case a fifth part was added to the restoration.[76] These are sins against God. But is this kind of statement a

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instances, the company may have subrogation rights under what is understood as an indemnity arrangement. Finally, it will pay because of the loss, not, for example, because Job has defended his friends.

73. *See* INTERPRETER'S BIBLE Vol. III 1196 (1954) (quoting A.S. PEAKE, THE CENTURY BIBLE (1904)); *see also* Cynthia Ozick, *The Impious Impatience of Job,* 67 AMERICAN SCHOLAR, Autumn 1998, at 15. Ozick seems to think that the children are also doubled. *See generally* ARCHIBALD MACLEISH, "J.B.": A PLAY IN VERSE (1976). Macleish attacks the idea that Job would start again. "Wife back! Balls! He wouldn't touch her. He wouldn't take her with a glove! After all that filth and blood and Fury to begin again. . . After life like his to take the seed up of a sad creation planting the hopeful world again – He can't!. . .he won't. . .he wouldn't touch her! And Mr. Zuss replies: "He does though." (Steven Wilf has called my attention to a medieval Jewish reading in which the original children were not dead, but have been taken to the wilderness. Messengers were misinformed so that they could report back to their death. These original children were subsequently retrieved and returned to Job.).

74. *See* RUTH BENEDICT, PATTERNS OF CULTURE 256 (1934).

75. *See* WILLIAM T. STANDEN, THE IDEAL PROTECTION 119 (1897).

76. RUSHDOONY, *supra* note 47, at 276 (not discussing Job).

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possible explanation for the double portion in Job?[77] Midrashic material contains a long description of Job's charity, including pledges to provide for widows and orphans if a sick husband should die.[78] The double portion, perhaps, balances an earlier account of generosity.

However, life insurance, as has been noted, is not really about restitution. It is not, as Jerry writes, focused on indemnification,[79] though it is sometimes described as having some component of indemnity.[80] Job does not receive lost profits.[81] It may be that here we have some sense of the answer to the question of why life insurance is different. It is not restitution, contrary to an assumption of economic theory, which considers an expectation interest as the equivalent of money in the bank. Further, life insurance, and the amount of insurance, is not – except at a psychological or rhetorical level – geared to a specific calculation about future support. It simply takes a number. Moreover, if life insurance is a projection of future support, it assumes that level of support through the individual life, which assumes a future and thus limits the Divine Plan.[82]

If there are problems specific to life insurance, there may also be positive features. A positive value, unique to life insurance, was said to be altruism. It is a transaction in which the insured receives nothing, except of course, the knowledge that the family's future was secure.[83] This private

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77. Is it, as Peake suggests through his citations, linked to a double portion for shame? (citing doubling in Isaiah 61:7 and Zachariah 9:12). *See* PEAKE, *supra* note 73, at 345.

78. *See* LOUIS GINZBERG, LEGENDS OF THE JEWS 230-31 (1983).

79. "Under the principle of indemnity, the insured's recovery should not exceed the loss. Life insurance, although it has some indemnity aspects (such as reimbursing the beneficiaries for the loss of income caused by the insured's death), is not indemnity insurance in the strictest sense. In most cases, no effort is made to place a value on the insured's life; an individual can purchase an unlimited amount of insurance on his or her own life." ROBERT JERRY II, UNDERSTANDING INSURANCE LAW 628 (1987); *see also* Spencer L. Kimball & Don A. Davis, *The Extension of Insurance Subrogation*, 60 MICH. L. REV. 841 (1962)

80. *See* STANDEN, *supra* note 75, at 70.

81. Unless that idea explains the doubling, i.e., doubling makes up for lost profits.

82. The Divine Plan is limited in that the worker might lose his position in the labor market at any time. Note that the Divine Plan can be seen as extending over generations. *See* C.S. LEWIS, THAT HIDEOUS STRENGTH 278 (1946) (referring to contraception as an attack on the Divine Plan).

83. Compare viatical transactions. A viatical settlement is an "act by a person who is terminally ill of cashing in a life insurance policy to pay for the necessary associated illness, medical expenses and final wishes." HARVEY W. RUBIN, BARRON'S DICTIONARY OF INSURANCE TERMS 512 (3d ed. 1995).

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altruism can be linked to a much larger community. Thus, in the writings of Josiah Royce, we find a stress on the point that "the greatest social power" of insurance "depends upon the fact that a man does not in general purchase an insurance policy merely for the transient creature of to-day called 'himself.'"[84] Rather, a "man purchases insurance for his 'beneficiary.'" The beneficiaries may include people or corporations of whose very existence he, the individual, is little aware. But his linkages with such beneficiaries may join him to the whole social order."[85]

Life insurance, perhaps all insurance, should be well-regarded for this reason. Yet a certain ambivalence may continue to be entertained about insurance, including life insurance, by quite mainstream religious groups. The Lutheran Encyclopedia article on insurance is positive along conventional lines, arguing for insurance as a way to protect loved ones. But it ends on a quite different note: "A warning: The Christian remains mindful of the fact that all forms of material security have their limitations and that they dare not become a form of idolatry. Ultimately the believer entrusts his material as well as his spiritual and eternal security to God."[86]

Harold Kusher's treatment of insurance in *When Bad Things Happen to Good People* begins with the position that insurance ultimately cannot compensate for the true, emotional, nonfinancial loss.[87] In short, financial compensation at its best is not enough. We are not indifferent between the thing or person (lost or injured) and the financial equivalent of what we have lost.

Another comment on insurance relates to the practice of the companies in discussing natural disasters as Acts of God. Kushner suggests that these are simply events in nature.[88] It is the human cooperation after the disaster that is the act of God.

It is not only the radical separatists, like the Amish who worry about certain tendencies which insurance might intensify; beyond this, there is a conception of insurance and its limitations, which is focused quite

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84. JOSIAH ROYCE, THE BASIC WRITINGS OF JOSIAH ROYCE 1136 (John J. McDermott, ed., 2d ed. 1969).

85. *Id.*

86. E.C. KNORR, *Insurance, in* ENCYCLOPEDIA OF THE LUTHERAN CHURCH, 1152 (1965).

87. *See generally* HAROLD S. KUSHNER, WHEN BAD THINGS HAPPEN TO GOOD PEOPLE (1981).

88. *See id.* at 59.

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differently, largely on political and communitarian issues. Part II turns to these questions.

II. POLITICAL DIMENSIONS AND DYSTOPIAN POSSIBILITIES

> It may seem unkind to a candidate to be rejected as a 'bad' life, but Insurance Companies are commercial undertakings, not charitable societies. If insurance were universal, Companies would probably be quite willing to abolish the medical examination and provide insurance protection for all ranks and conditions of men. As it is, they are obliged to discriminate between good and bad lives; and an Office is successful in proportion to the care with which it accepts lives. Let us drop the subject.[89]

Some aspects of the insurance enterprise can be viewed as dystopian. This section reviews several of these; It focuses on the exclusion of the uninsurable; the artificial nature of the community of the insured; the idea that insurance companies want people to buy insurance and also want not to pay claims and the related tendency of the insurance industry to focus on the darker more deceitful side of human nature.

At the heart of modern insurance there is a decision about inclusion and exclusion which cuts against the idea of mutual aid as understood by those groups which define themselves in terms other than insurability. For such groups, insurability is a consequence of inclusion in the group. Exclusion from the group results in withdrawal of mutual aid. Here, too, we may see the function of social control as described in some recent work.[90] To the extent that utopian goals are viewed as desirable, it becomes necessary to shape people so that they are within the average risk pool, people who avoid hazardous activity and whose behavior generates good health. It is only through coercion that they can be insurable.[91]

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89. ARTHUR READE, THE STORY OF LIFE INSURANCE 44 (1905).

90. *See,e.g.*, Pat O'Malley, *Imagining Insurance Risk: Thrift and Industrial Life Insurance in Britain*, 5 CONN. INS. L.J. 675 (1998).

91. *See* RICHARD TITMUSS, ESSAYS ON THE WELFARE STATE 66-67 (1959) ("The long-term and foreseeable dependencies of old age should be shouldered by progressive taxation just as the long-term dependencies of childhood are." *Id.*); *see also Tennessee Talks of Paring Plan for Uninsurables*, N.Y. TIMES, May 7, 1999 (discussing uninsurability in state context).

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Spencer Kimball noted as a feature of German insurance history that it referred to an "insured community" in an "almost mystical" term.[92] Yet there are ways in which the links between insurance and community, the community of the insured, are highly problematic. If it is a community, then it is one radically different from those which saw themselves as sharing beliefs or ethnicities and offering protection to those affiliated.[93]

In the context of commercial insurance, the insurability defined the group. Those who were uninsurable were excluded from the group because of their uninsurability. This was one of the reasons the Mennonites gave for their objections to insurance. Their objections to insurance were bolstered by a "powerful practical argument, namely, that the commercial insurance companies did not really help the needy, but sought only to protect the healthy and rejected as poor risks the weak and the ill who really needed protection."[94] The Mennonites considered it a practical, rather than religious argument. But it seems to have theoretical aspects if we say that it is the existence of the excluded which makes possible happiness of the others.[95]

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92. Spencer L. Kimball, *The Purpose of Insurance Regulation: A Preliminary Inquiry in the Theory of Insurance Law*, 45 MINN. L. REV. 471, 477 n.35 (1961).

93. Here, the risk is expulsion. *See* FREDERICK L. HOFFMAN, HISTORY OF THE PRUDENTIAL INSURANCE COMPANY OF AMERICA 7 (1900) (quoting Sidney Webb on fraternal insurance: "A member who has paid a whole life-time to the sick and superannuation funds may at any moment be expelled and forfeit all claims for reasons quite unconnected with his desire for insurance in old age. Against the decision of his fellow-members there is in no case any appeal; moreover, the scale of contributions and benefits may at any time be altered even to the extent of abolishing the benefits altogether; and such alterations do, in fact, even take place in spite of all the protests of the minorities of old members." *Id.*).

94. THE MENNONITE ENCYCLOPEDIA, *supra* note 49, at 344.

95. *See* WILLIAM JAMES, THE WILL TO BELIEVE 188 (1897) (". . .[I]f the hypothesis were offered us of a world in which Messrs. Fourier's and Bellamy's and Morris's utopias should all be outdone, and millions kept permanently happy on the one simple condition that a certain lost soul on the far-off edge of things should lead a life of lonely torture, what except a special and independent sort of emotion can it be which would make us immediate feel, even though an impulse arose within us to clutch at the happiness so offered, how hideous a thing would be its enjoyment when deliberately accepted as the fruit of such a bargain?" *Id.* at 188.). *See also* URSULA K. LE GUIN, *The Ones Who Walks Away From Omelas*, *in* THE WIND'S TWELVE QUARTERS 275 (1975) (described as "variations on a theme by William James." *Id.*).

Another version of the exclusions of insurance is suggested by Ulrich Beck, who, as previously noted, uses the term "risk" to mean controllable limited calculable and then insurable and risk and the word "threat" to refer to global meta threats. The line between the minor technical risk and the threat or hazard is, finally, established by the market,

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The image of insurance in connection to the social order is evident in general discussions of the function of the state. Thus, John Finnis notes that "political community exists partially (and sometimes primarily) as a kind of business arrangement between self-interested associates."[96] This, however, was "the kind of mutual insurance association or 'social contract' derided by Aristotle and all the classics for its meagerness as a form [or account] of community . . . ."[97]

In the current discussion, uncertainty – at least as experienced by some people – is the central theme of insurance. "Under the present capitalistic organization of society," Edward Woods wrote in 1928, "there are certain risks which every individual must face in everyday life, the untimely incidence of any one of which might transform him from a self-supporting producer in comfortable circumstances to-day into a dependent cripple or pauper to-morrow."[98] The emphasis is on the untimeliness of the risk as much as the risk itself. So that life insurance is linked to the idea of premature death of the wage earner, since the fact of death is certain. The reduction of the risks of life is linked to a story of the expansion of rights. The American version of this story is offered by Roosevelt.

"This Republic had its beginning and grew to its present strength, under the protection of certain inalienable political rights"[99] which more rights to life and liberty and as the nation grew, it became clear that "these political rights proved inadequate to assure us equality in the pursuit of happiness."[100] Finally Roosevelt said, "We have come to a clear realization of the fact that true individual freedom cannot exist without economic security and independence."[101] He quoted the language of an old English case "'Necessitous men are not free men.'"[102] People who are hungry and

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through the question of what will be insured by commercial insurance companies. *See* ULRICH BECK, RISK SOCIETY 103, 106 (Mark Ritter trans., 1992) (1986).

96. JOHN FINNIS, NATURAL LAW 149 (1991).

97. *Id.* Finnis quotes Aristotle to the effect that the *polis* was formed "not for the sake of life only but rather for the good life" . . . "it does not exist [merely] for the sake of trade and of business relations . . . any *polis* which is truly so called, and is not one merely in name, must devote itself to the aim of encouraging excellence [*arete*]." *Id.*

98. EDWARD A. WOODS, THE SOCIOLOGY OF LIFE INSURANCE 1 (1928).

99. Franklin D. Roosevelt, *State of the Union Message,* 90-1 Cong. Rec. 55, 57 (1944) *reprinted in* FRANK NEWMAN & DAVID WEISSBROT, INTERNATIONAL HUMAN RIGHTS 362 (1990) (quoting Vernon v. Bethell, 2 Eden 110, 113 (1762)).

100. *Id.*

101. *Id.*

102. *Id.*

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out of a job are the stuff of which dictatorships are made."[103] The risk here is unexpected loss of economic security. Again, uncertainty, as much as loss, is the theme.

Quite correctly, Roosevelt's message is included in a book on human rights, a field which has come to see the ideas of social security and industrial insurance in terms of fundamental rights. And certainly the emphasis on the issues of large scale risks is global. In Beck's usages these are not called risks at all, but rather threats or hazards.[104] They are, in a "risk" society, uninsurable threats, beyond risk, and in fact defined by their uninsurability by private insurance companies.

Insurance as protection and security is a powerful idea, visible at international and national levels and it can be also seen against the background of small communities, and the utopian discussion of the nation-state. When Bellamy described his program, invoking the great capitalist forms of his world of the corporation, the trust, adapting them to his utopian goals, he also included insurance: "...In effect the nation will then have become a universal insurance company for the purpose of assuring all its members against want, oppression, accident, or disability of whatever sort."[105]

While one convention distinguishes utopia from the real world, so that an acre in Middlesex is better than a principality in Utopia,[106] another sees that utopia is something to be achieved in the world. In the American setting, this approached a vision of progress which linked those Christian post millenialists and those who call themselves progressives or secular reformers. While certain real life proposals are called utopian—meaning that they are visionary, or unrealistic—that is a comment about the likelihood of success, not about the real context of the objectives. Utopian proposals are often directed at the world. The nineteenth century American utopias were of this type, communities in the world which provided models of the good, all but perfect life.

One part of that vision of the good life was often equality, and particularly equality of goods. Another was security, an idea which has a

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103. *Id.*

104. *See* BECK, *supra* note 95, at 47. As to globalization of risks (including new risk of extinction of human life altogether), Beck notes that when a class of societies can be nation states, risk societies, "communities of danger," must be international. *See id.*

105. EDWARD BELLAMY, EDWARD BELLAMY SPEAKS AGAIN 44 (1937).

106. *See* LORD MACAULAY, *Lord Bacon, in* CRITICAL, HISTORICAL, AND MISCELLANEOUS ESSAYS 460 (Cambridge, Sheldon & Co. 1860).

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clear relation to the idea of community. A community is for something, friendship, support, mutual aid. Thus Charles Nordhoff, describing the American utopian communities, said that he thought it important that these societies, had accumulated enough money to offer "a satisfactory provision for their own old age and disability, and for the education of their children or successors."[107]

The very idea of community has in it a link to risk, hazard, insecurity, and, in fact, everything we summarize in the words "After the Fall." It is caught in the utopian novel *Looking Backward*, in Bellamy's famous image of the human condition a coach on which some sat while others pulled the coach. The role of risk and accident is explicitly put on the description of the coach. "By the rule of the coach a man could leave his seat to whom he wished, but on the other hand there were many accidents by which it might at any time be wholly lost."[108] Then they would "help to drag the coach on which they had before ridden so pleasantly." The result was that "the apprehension that this might happen to them or their friends was a constant cloud upon the happiness of those who rode."[109]

There seems to be no risk in Eden, except the risk of expulsion. And this is true in some ways also of any mutual aid society. Such groups cannot eliminate death and disease but they offer help.[110] But they do not base their system on the idea of insurable (and then uninsurable) risks as presented by individual applicant and do not reject "bad" risks. A member is covered, while a member, at whatever level is generally available to members, regardless of the risk factors the individual may present.

Sumner and Keller noted that socialism was a way to deal with the aleatory element in life and this was no less true of Communitarianism.[111] And Summer and Keller saw that this was also true of the idea of

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107. CHARLES NORDHOFF, THE COMMUNISTIC SOCIETIES OF THE UNITED STATES 18 (1875).

108. EDWARD BELLAMY, LOOKING BACKWARD 7 (Robert C. Elliot ed., Houghton Mifflin Co. 1966) (1888). Bellamy's work was well known. *See* Aviam Soifer, *The Paradox of Paternalism and Laissez-Faire Constitutionalism: United States Supreme Court, 1888-1921*, 5 LAW & HIST. REV. 260 (1987) (discussing a reference by the United States Supreme Court to Bellamy).

109. BELLAMY, *supra* note 106, at 7.

110. *See generally* GEOFFREY CLARK, BETTING ON LIVES: THE CULTURE OF LIFE INSURANCE IN ENGLAND, 1695-1775 (1999).

111. *See* WILLIAM GRAHAM SUMNER & ALBERT GALLOWAY KELLER, THE SCIENCE OF SOCIETY 748 (4th ed. 1945).

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insurance.[112] The point is clear in the nineteenth century French statement which François Ewald uses as the motto of *L'Etat Providence*. The motto argues that "the system of our society is nothing other than insurance, insurance against weakness, insurance against unhappiness, insurance against ignorance."[113]

The area of international human rights stresses a global community, a world-space framework, in which the aspirations of the good life are worked out, maximally or minimally, in terms of certain western style rights e. g. participation in political regimes without discrimination on the basis, for example, of religion or gender. Here Utopian liberty goals are seen as extended to individuals regardless of their national affiliations. Some other human rights documents move also to the consideration of economic rights, or welfare rights may assume ideas of redistribution. The idea of material rights is sometimes conceived in terms of some "adequate" level of support, freedom from want. The conflict between this idea and religious liberty goals is parallel to a conflict in the area of women's equality rights. For example, some may want to reject social security and may refuse to participate in it. And of course for those associated with the green movement, there is something about a right to continued existence on the planet as something which might be thought of as a right.

The idea of insurance as compensation for losses resulting from various ascertainable risks can be viewed as building on utopian security goals.[114] The questions in their largest formulation involve the relation between freedom and security. In contract terms, the questions relate to the idea of solidarity and the nature of the commitments which individuals make to

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112. *See id.* at 749.

113. FRANÇOIS EWALD, L'ETAT PROVIDENCE 13 (1986) (quoting M. Le Baron de Beauverger, comment in legislative session, May 30, 1868).

114. Utopian goals might not include security, of course. The security/liberty issue is perennial. Note also that while at least certain kinds of communities in the United States did stress mutual responsibility and mutual aid, they were also sometimes interested in the utopian insurance. We find, for example, that the Rappites were unable to get fire insurance because they were considered a bad risk. They did however want it. *See* KARL ARNDT, GEORGE RAPP'S HARMONY SOCIETY (1785-1847) 507, 550 (1975). The Amana community, however, did not have insurance because it was cheaper to rebuild than to buy insurance protection. *See* BERTHA M.H. SHAMBAUGH, AMANA THAT WAS AND AMANA THAT IS 87 (1976).

Clearly, the Amish stance on social security and insurance is different, reflecting perhaps an intensity of concern at a theological level which other groups do not necessarily share. It should also be noted that the level of government activity confronting the Amish is quite different from that facing earlier separatist communities.

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each other, whether a commitment is to a global framework or to a legal system which recognizes individual insurance contracts.

The utopian idea has a clear connection to fraternal organizations as providers of insurance, as it does to the history of immigration and the attempts by social agencies to assist them. Both the insurance agent and the "friendly visitor"[115] (as well, one assumes, as the parish priest) visited the homes of the poor.[116]

But it is also linked to the history of these independent insurance companies that stressed service goals. A report from the Metropolitan Life Insurance Company in 1914 indicates that, for that enterprise at least, the Temple of Insurance image suggested by the architecture of its New York office had substance.[117] It was reflective of a program of activities, some directed to employees, some to policyholders, some to the general community, which went far beyond our idea of a relationship based on the contractual obligation to pay claims. The tone of the 1914 volume is optimistic, progressive, paternalistic.

But not all solidarity or associated ideas end with either religion or communitarianism. D.R. Jacques' formulations of 1849 relate to the expanded list of risks that insurance might cover, enlarged[118] but still finite, creating a contrast between insurance and Fourier and the socialists.[119] Jacques position, that one must begin with things as they are, is a clear statement of a reformist position: "if society needs something more effectual than the forms of civil government, and the guarantees of civil liberty" to secure the welfare of the masses, it also needs something more feasible than new theories of society.[120]

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115. *See* MARY WILCOX BROWN, THE DEVELOPMENT OF THRIFT 16 (1900) (discussing the "friendly visitor.").

116. *See* WALTER NICHOLS, *Fraternal Life Insurance, in* YALE READINGS ON INSURANCE 132 (Lester Zartman ed. 1909).

117. *See* METROPOLITAN LIFE INSURANCE COMPANY REPORT, ITS HISTORY, ITS PRESENT POSITION IN THE INSURANCE WORLD, ITS HOME OFFICE BUILDING AND ITS WORK CARRIED ON THEREIN 30 (1914).

118. *See* JOHN D. LONG, ETHICS, MORALITY, AND INSURANCE: A LONG-RANGE OUTLOOK 264 n.36 (1971) (referring to an expanded list of risks, including "bizarre" idea of divorce insurance).

119. D.R. Jacques, *Society on the Basis of Mutual Life Insurance,* 16 HUNT'S MERCHANTS' MAG. 152, 153 (1849) (discussed in Tom Baker, *On the Genealogy of Moral Hazard,* 75 TEX. L. REV. 237, 247 n.38 (1996)).

120. *Id.*

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Jacques' basic attack was on these new theories of society. He seems to be a social conservative. Jacques echoes a line for which we often cite DeToqueville. "The great and growing inclination to associated action which pervades society in this age, has been often remarked."[121] The associated action takes the form of partnerships, "incorporation, joint stock companies, lodges, and clubs. And of course "the principle of associated action" has also done a good deal for insurance.[122]

Jacques urges that these facts force us to consider this question "May not this plan, which has done so much in the form of insurance, do far more by means of insurance?" Insurance "does not pretend to diminish the aggregate of human misfortunes," Jacques said.[123] Rather, "it assumes that aggregate amount as a fixed fact." But it also assumes the larger aggregate of prosperity as equally certain."[124] Insurance "presents society a union for mutual aid, of the fortunate and unfortunate, where those only who need it receive aid, and those only who can afford it are put to expense."[125] Even then if it is true that suffering is undiminished and uncertainty continues to exist, still the aggregate of "human ingenuity and co-operation equalize the distribution of this fearful aggregate, and alleviate the terrors of uncertainty."[126]

Ewald has noted that as a society becomes secularized, the orientation of a speaker associated with the general social orientation here has less to do with God or morals and more to do with ethics. Thus, in discussing the current cautionary paradigm, he writes that

> The new paradigm of *safety* . . . bears witness to a deeply disturbed relationship to a science that is questioned less for the knowledge that it offers than for the doubts that it insinuates. Here, moral obligations take the shape of ethics, and the principle of responsibility is seen as a reflection of the new notion of *precaution*.[127]

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121. *Id.*
122. *Id.*
123. *Id.*
124. *Id.*
125. *Id.*
126. *Id.*
127. François Ewald, *The Return of the Crafty Genius: An Outline of a Philosophy of Precaution*, 6 CONN. INS. L.J. 47, 48 (1999). Ewald writes as to these that they are not those worlds which succeed each other (responsibility replaced by solidarity replaced by precaution) but are rather "three attitudes with regard to uncertainty, assessed and developed at three moments in time." *Id.* at 76.

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One idea is that the community created by actuarial insurance practices involves a distortion. Thus, Jonathan Simon has noted that "the shift toward actuarial practices alters the way we understand our status as subjects, both individual and group. Simon argues that "[b]y placing people in groups that have no experienced meaning for the members, and therefore lack the capacity to realize common goals or purposes, actuarial methods imply a particular view of individuals and their communities."[128] The clear risk, as Jonathan Simon perceives it is that people will understand themselves in terms of these representations "they may be stripped of a certain quality of belongingness to others that has long played a role in our culture."[129]

Insurance and an economic analysis can substitute one view of reality for another. Someone says "God is my insurer" and we call that person a "self-insurer." But is it really substitution? Is it more like saying that a violin is a piece of wood? Another example of the contrast is between what others call you, what you call yourself, and what you are.

To the extent that the insurance relationship is rooted in contract, it presents issues of commercialization and a potential flattening of human relationships similar to those debated in family law.[130] It is worth recalling that what is taken to be the first reference in an American law journal to the word "adhesion" is found in Patterson's article on life insurance,[131] published several years before Nathan Isaacs' well-known piece on adhesion contracts.[132] The contract emphasis resulted historically in an overreaching by insurance companies, followed by interventions by state authorities to protect the individual insured.[133] It is, in part, the contracts emphasis which makes possible the painful disparity between representations of insurance companies which relate to full security and

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128. Jonathan Simon, *The Ideological Effects of Actuarial Practices*, 22 L. & SOC'Y REV. 771, 774 (1988).

129. *Id.*

130. *See generally* CARL E. SCHNEIDER & MARGARET BRINIG, AN INVITATION TO FAMILY LAW: PRINCIPLES, PROCESS AND PERSPECTIVES (1995) (reviewing a family law discussion of contract and domestic relations).

131. *See* Edwin W. Patterson, *The Delivery of a Life-Insurance Policy*, 33 HARV. L. REV. 198, 222 (1919) ("Life-insurance contracts are contracts of 'adhesion.'" *Id.*).

132. *See* Nathan Isaacs, *The Standardizing of Contracts*, 27 YALE L.J. 34 (1917). That piece is treated as foundational in the contracts literature.

133. See the treatment of this question in FRIEDRICH KESSLER & GRANT GILMORE, et al, CONTRACTS: CASES AND MATERIALS 627-34 (3rd. ed. 1986).

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fact of coverage of certain risks, and even then only under certain circumstances in accordance with the insurance contract.[134]

The description Patterson offers of the life insurance purchase, a contractual transaction in which the buyer has no idea of what limits there are on what is being bought, remains important throughout the field, as it relates at least to consumers.

But an even more important point is that perhaps almost no one can understand the contract. This has implications for our judgment on the behavior of agents. "It is hard to accuse the agent of deliberate fraud,"[135] Lord Passfield (Sidney Webb) wrote. "He is perpetually driven – driven by the system itself, by the method by which he is paid, and by the ever-grinding pressure to replace lapses – to obtain a continual succession of new policies."[136] And "the people whom he has to canvass simply cannot understand the nature of the commodity that he is pressing them to purchase."[137] Finally, Lord Passfield asks, "[w]ho shall subsequently discover how much the agent actually said, how much he deliberately implied, and how much was honest misunderstanding that he suspected to exist, or was aware of, and merely neglected to dispel?"[138]

Even for professional buyers and sellers the insurance transaction is characterized, if not by gross disparity of bargaining power, at least by that willingness to put the details off until another day, which makes the "bargain," as in all standard form transactions, somewhat fictional. Then, too, there is the issue of the shifting "we" as used by the agent.

One answer suggests that this is not really a problem. Thus, it has been noted that perhaps "the greatest source of ethical concern for many agents and brokers is the feeling that they are caught in the middle between two parties who have conflicting interests."[139] The difficulty is that "on the one hand, an agent's primary responsibility is to serve the insurer."[140] But it is also the case that the agent is the consumer, to "owes, dedication, loyalty

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134. The legal perspective on insurance has for some time been reviewed in terms of the idea of contract. This contract optic is appropriate, whether we see that contract as one in which the risk holders have a stake in each other and have a contract with each other, or whether that contract is seen as a contract between individuals and insurance companies.

135. *Special Supplement on Industrial Insurance*, THE NEW STATESMEN, Mar.13, 1915, at 24.

136. *Id.*

137. *Id.*

138. *Id.*

139. ETHICS FOR THE INSURANCE PROFESSIONAL 19 (Rick Paszkiet ed., 2d ed.1996).

140. *Id.*

and service to the consumer."[141] "How can an agent reconcile this conflict? Actually, it is quite simple. By acting in the best interests of the insurer, the agent best serves the consumer."[142]

Ambrose Bierce thought that insurance is "[A]n ingenious modern game of chance in which the player is permitted to enjoy the comfortable conviction that he is beating the man who keeps the table."[143] The view of the writer of *The Devil's Dictionary* has resonances. One might compare the comments of Mark Twain, in *An inquiry about Insurance*,[144] which takes the form of a conversation with an insurance agent:

A man is told that a company has "issued over sixty thousand policies, forty-five of which have proved fatal and been paid for."[145] He responded that the presentation reveals a problem. "You appear to have it pretty much all your own way, you see. It is all very well for the lucky forty-five that have died 'and been paid for,' but how about the other fifty-nine thousand nine hundred and fifty-five?"[146] The bottom line is "You have got their money, haven't you? but somehow the lightning don't seem to strike them and they don't get any chance at you."[147]

This argument, one of the two which Rubinow identified as the basic arguments against insurance, has particular force in relation to profit making institutions. In pursuing his case for social insurance, Rubinow comments as to this point and as to the "moral hazard" argument, that one should assume for the sake of the discussion that they are true, and then go on to consider the benefits of insurance in terms of the security offered those who will, in fact, suffer losses.[148]

The idea of insurance carries a mixed message. On the one hand, one has the dictionary definitions of security and certainty (reinforced by the selling practices of the insurance companies themselves). On the other hand, the public image in which the insurance company signifies someone

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141. *Id.*

142. *Id.*

143. AMBROSE BIERCE, THE DEVILS DICTIONARY 63 (1993).

144. MARK TWAIN, *An Inquiry about Insurance, in* THE COMPLETE HUMOROUS SKETCHES AND TALES ON MARK TWAIN 78, 80 (Charles Neider ed., 1961).

145. *Id.*

146. *Id.*

147. *Id.*

148. *See* I.M. RUBINOW, SOCIAL INSURANCE 5 (1913); *see also* JOHN H. LANGBEIN AND BRUCE A. WOLK, PENSIONS AND EMPLOYEE BENEFITS 4 (1995) (noting that Bismarck's scheme was not properly a pension system since it began at age 65, beyond what was then the normal life expectancy).

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who will not pay a claim. The grim account of John Grisham's *The Rainmaker* reflects a common perception. It is not merely that there is a contractual argument in favor of the companies – that they have assumed only a particular responsibility under their contract – it is that they are rich, untrustworthy, insensitive and corrupt.[149]

We can, perhaps, assume that the reputation of the insurance industry is a response to something real, a defect in human nature. In his short story *Hunted Down*, Dickens wrote that "a Life Assurance Office is at all times exposed to be practised upon by the most crafty and cruel of the human race."[150] Even Bob and Margaret on Comedy Central are less than strictly honest in their approach to insurance. "When their home is burgled and it's time to fill out the insurance forms, they enthusiastically list elaborate electronics they never owned."[151]

But are these aspects of human nature, with which the companies must deal, manage or limit, or are they also a kind of resistance to the rationalizing tendencies of insurance?[152] Scott identified a number of leveling or flattening tendencies in early modern western society, from maps of land to permanent family names, to census and population counts.[153] Max Weber stressed the significance of double entry

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149. *See* THE RAINMAKER (Paramount Pictures 1998) (presenting a more hostile view of the insurance company than the book upon which the film is based).

150. Charles Dickens, *Hunted Down, in* VICTORIAN TALES OF MYSTERY AND DETECTION 48, 49 (Michael Cox ed., 1992).

151. THE GUARDIAN, July 10, 1998, at 72. On another possible link between insurance and social deviance, see J. OWEN STALTSON, MARKETING LIFE INSURANCE 660 (1942) (noting the suggestion that the beneficiary might sometimes be a "friend"); *cf* Tom Baker, *On the Genealogy of Moral Hazard,* 75 TEX. L. REV. 237, 252 (1996) (discussing Vanity Fair).

The skeptical view of the insurance contract is reflected in a discussion in a recent mystery. The character, himself an insurance agent once, says that the insurance contract is like other contracts, fine if you have a loss, understand what is covered, can pay the premiums. In short, it is Caveat Emptor. *See* MINETTE WALTERS, THE BREAKER 194-95 (1998).

152. Not all scholars focus on issues of resistance. Foucault's work, as has been noted by Said and Walzer, is disinterested in this issue. *See* MICHAEL WALZER, THE POLITICS OF MICHEL FOUCAULT, *in* FOUCAULT, A CRITICAL READER 54, 66 (David Louzrus Hoy ed. 1986); *see also* Edward W. Said, FOUCAULT AND THE IMAGINATION OF POWER, *in* FOUCAULT, A CRITICAL READER 151 (David Louzrus Hoy ed. 1986).

153. *See* JAMES C. SCOTT, SEEING LIKE A STATE 87-88 (1998).

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bookkeeping.[154] Should the actuarial methods of insurance be added to this list?

Associations with the idea of insurance are, then, sometimes negative and critical. One criticism is that insurance is, in fact, dystopian. The security is seen as illusion, and the community as either non-existent or involving definitions of the group which defeat true solidarity. Insurance is seen as less a community and more a business – and a big business at that.[155] The criticism advanced by the Mennonites is not fixed on a marginal point. It is not about a particular debate over a detail about premiums or coverage (how much time in the hospital for maternity stays, for example). It is not an argument that certain kinds of transactions are intrinsically immoral, while the main enterprise is appropriate. Rather, the critique is focused on the fundamental concept which underlines the enterprise: the distinction between insurability and uninsurability and the related ideas of insurable risk and uninsurable risk.[156]

Our ambivalence towards insurance is captured in the odd tone of an address by Mark Twain. When Mark Twain was associated with an insurance company, he gave a speech containing the following paragraph:

> I have seen an entire family lifted out of poverty and into affluence by the simple boon of a broken leg. I have had people come to me on crutches, with tears in their eyes, to bless this beneficent institution. In all my experience of life, I have seen nothing so seraphic as the look that comes into a freshly mutilated man's face when he feels

154. Weber had defined his project as considering religious ideas as a cause of certain economic forms. Weber's book engendered much discussion as to the characterization of particular religions and their particular links to capitalist forms. The controversy tended to concede the legitimacy of the basic inquiry concerning relations between religion and economic development. *See* Anthony Giddens, *Introduction* to THE PROTESTANT ETHIC AND THE SPIRIT OF CAPITALISM (Max Weber & Talcott Parsons trans., Routledge 1992).

155. *See generally* STALTSON, *supra* note 151.

156. Definitions from a dictionary of insurance suggest the major point: "underwriting: process of examining, accepting, or rejecting insurance risks, and classifying those selected, in order to charge the proper premium for each. The purpose of underwriting is to spread the risk among a pool of insureds in a manner that is equitable for the insureds and profitable for the insurer." BARRONS DICTIONARY OF INSURANCE TERMS 497 (3d ed. 1991). *See id.* at 414-15 (defining "risk management" and "risk selection"). "Insurability: circumstance in which an insurance company can issue life or health insurance to an applicant based on standards set by the company." *Id.* at 227.

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> in his vest pocket with his remaining hand and finds his accident ticket all right.[157]

The paragraph is unsettling. Presumably the problem is the juxtaposition of the idea of physical mutilation with the picture of a man beaming as he establishes that he is insured. Is this Mark Twain as Ambrose Bierce? But the company reprinted the paragraph in a pamphlet. Is that because there is something in this uncomfortable juxtaposition that is true? that finally, it is better to be insured than to be uninsured?

III. THE STORY OVER TIME

> **Smokey the Mayor**: In an early example of fire insurance, the first Lord mayor of London rules [in 1189] that all houses have to be equipped with a ladder and, during tinder-dry summers, a barrel of water by the front door.[158]

The opening section of Spencer Kimball's casebook on insurance makes a fundamental point about the various definitions of insurance. There is no single definition that will work for all contexts and purposes.[159] The contexts in which insurance operates and has operated are so varied, and the institution itself exists in so many forms, that a comprehensive definition is essentially impossible. Kimball moves from this rejection of a single definition to a list of the typical insurance coverages of middle class existence in this society, including of course the idea "at this time."

The need for historical work on insurance is as obvious now as it was when Kimball addressed the issue several decades ago, referring to the need for state by state inquiry in the American context.[160] William Vance,

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157. JUSTIN KAPLAN, MR. CLEMENS AND MARK TWAIN 303 (1966).

158. Stephen Mihm, *Once Upon a Time, Only Kings had Clothes; Milestones, Millstones as Design Marches On*, N.Y.TIMES, Dec. 30, 1999, at F1, Column 6.

159. *See generally* SPENCER KIMBALL, INSURANCE LAW (1942); *see generally* Lawrence Friedman, *Social Welfare Legislation: An Introduction*, 21 STAN. L. REV. 217 (1969) (discussing definitional problems in terms like "social legislation" or "social insurance").

160. *See* KIMBALL, *supra* note 159; *see also* LAWRENCE FRIEDMAN, CONTRACT LAW IN AMERICA 61-69 (1965) (discussing insurance law).

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in 1904, referred to 30,000 cases in "English print" on the subject of insurance.[161] And now?

Then, it is clear that religion has relevance to the story. But the accounts suggest certain methodological issues. To the extent that religious values are rooted in ancient texts or medieval interpretations, it is reasonable to ask whether these texts are to be understood as controlling in the same way over time and in all places. Perhaps, for example, the Canonist concern with usury in relation to insurance was not of particular importance in nineteenth century America. Perhaps it can more usefully be related to the problem in twentieth century Iran, where the Koranic injunctions against usurious contracts influence state law.[162] Issues of gambling, which in nineteenth century America are understood in terms of frivolity and general immortality, may or may not retain an older association with divination. Clark, for example, relates gambling to the issues of knowing God's will, as do materials on Islamic law.[163]

Further, the idea that insurance goes against God's providence is an idea which has different components. For some, it is thought to be something that averts injury, in which case the twelfth century precautions and safety devices are presumably vulnerable.[164] For others, insurance is about mitigation, averting the consequences of the injury. The argument, against insurance is for some, rebutted by a comparison to savings accounts, investment, umbrellas, as if the religious argument against life insurance assumed that the only appropriate religious stance is in effect, quietism and passivity as one simply accepts that happens.

Some of the links to religion are visible as links,[165] though their substance remains to be fully explored. What, for example, was the impulse behind the 1986 Connecticut Mutual study on societal religious values?[166] Would insurance companies have achieved their ideal condition when everyone could be covered by insurance because everyone was

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161. *See generally* William REYNOLDS VANCE, *Preface to* HANDBOOK ON THE LAW OF INSURANCE (1904).

162. *See generally* STEPHEN M. PASSAMANACK, INSURANCE IN RABBINIC LAW (1974) (discussing Canonist and Jewish law approaches).

163. *See generally* GEOFFREY CLARK, BETTING ON LIVES: THE CULTURE OF LIFE INSURANCE IN ENGLAND, 1695-1775 (1999).

164. *See supra*, Part III Motto.

165. *See e.g.*, WALTER B. WEARE, BLACK BUSINESS IN THE NEW SOUTH 87 (1973).

166. *See generally*, JOHN D. LONG, ETHICS, MORALITY, AND INSURANCE: A LONG-RANGE OUTLOOK (1971).

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subject only to average risks?[167] What drives "social control" efforts by private insurance companies aimed at those outside their "community of insured?" Some of this activity may be about making the world less risky for their insured. Is some motivated by the idea of making those outside the existing community insurance-worthy?[168]

As the earlier discussion of the Mennonites makes plain, some groups may refuse insurance.[169] The modern Amish distinguish sometimes between liability insurance and other kinds of insurance. In one such discussion stressing issues of liability insurance, (insurance sometimes justified as "for the other person"), the writer says: "If Jesus were here today, can we imagine him worrying about his earthly possessions to the degree that he would have some insurance plan in case he had a loss?"[170] The emphasis is on not worrying about the future unduly. Presumably it was right to worry some. In this discussion, insurance was on the wrong side of the line. It makes clear that the argument that insurance is the same as saving, or is simply another way of being careful and prudent does not answer the objection which is that some care is enough and other care is too much.[171] The issue of adaptations, when it arises at the national level, as in the case of Islamic states, may result in a variety of mechanisms to achieve the requisite objectives.[172] When it arises within a state which is not opposed to insurance in principle, it may either involve adaptations on

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167. The price of this might be high. Everyone average might mean everyone the same. But then mutual aid, among the utopians, e.g. Oneida, was joined to mutual criticism. *See* WEISBROD, *supra* note 13, at 96-7.

168. Insurance worthy, or insurable, as a way of fulfilling an unarticulated utopian-universalist goal and not merely by the desire to increase profits by increasing the number of buyers of insurance policies?

169. *See generally* PETER FERRARA, *The Amish and Social Security, in* THE AMISH AND THE STATE (Donald Kraybill ed. 1993) (presenting arguments of the Amish on insurance). Ideas of stewardship also have relevance here, since the position of the insured regarding property may not be the conventional one. Thus, in an Anabaptist discussion of dealing with what seems to be a delinquency issue, the question of responsibility to/for property is put in effect this way: What would God want his steward to do? *See* J. CRAIG HAAS, READINGS FROM MENNONITE WRITINGS NEW & OLD 228 (1992).

170. *See* Elmo Stoll, *Is Insurance Right or Wrong?*, FAMILY LIFE, April 1984, at 8-11.

171. *See id.*

172. *See* FRANK E. VOGEL & SAMUEL L. HAYES, ISLAMIC BANKING ISLAMIC LAW AND FINANCE: RELIGION, RISK AND RETURN 150-53 (1998).

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the religious side[173] and/or requests for exemption from public insurance programs.

If one tries to tell the history through time, one runs up against the serious definitional problem identified by Vance in his essay on the early history of insurance: shall we take the broad reimbursement ideas of the ancient trading societies as the start of insurance, or shall we restrict ourselves to a more modern understanding based on risk and risk spreading?[174] Shall we adopt for historical research the distinction offered by Ulrich Beck, between pre-industrial dangers, and "risk," defined now as the result of industrially-related decisions, so that risk is defined as "modern?"[175] Shall we follow the lead of Mary Douglas and assume that perceptions of risk are culturally specific,[176] or expand some suggestions in Giddens, that, as rooted in trust, they may also be individually specific?[177]

And if we decide to research insurance through a focus on the "modern" or "post-modern", where shall we begin? In what country? In what legal system? Under what ideological (including theological) frameworks?

Perhaps the question is not "what is insurance," as if it is a word with one meaning, but something more like: "how many meanings, and how large are the meanings, attached to the idea of insurance?[178] Spencer Kimball, in seeing clearly that the issue between the European and American perspectives on the subject had precisely to do with the issue of the involvement of government, saw also the tendency of the American

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173. For example, subjects of inquiry might include insurance in Islamic law and insurance in Jewish law.

174. WILLIAM REYNOLDS VANCE, *Early History of Insurance, in* ANGLO AMERICAN LEGAL ESSAYS 100 (1909).

175. *See* ULRICH BECK, RISK SOCIETY 21 (Mark Ritter trans., 1992) (1986).

176. *See generally* MARY DOUGLAS, PURITY AND DANGER: AN ANALYSIS OF THE CONCEPTS OF POLLUTION AND TABOO (1966).

177. *See* ANTHONY GIDDENS, THE CONSEQUENCES OF MODERNITY 92 (1990). Giddens' discussion of ontological insecurity and trust includes reference to R. D. Laing and Erickson.

178. This subject might be engaged comparatively. "The theoretical treatment of insurance in American economic literature differs from that in European, particularly German, literature. Many outstanding American writers consider insurance as only one of the numerous risk covering agencies and therefore give inadequate or primarily legalistic definitions of its functions. Elsewhere this point of view is not generally held; with Germany as its center of growth, insurance has developed as an independent discipline distinct from other fields of economics and as such has received separate and extensive treatment." ENCYCLOPAEDIA OF THE SOCIAL SCIENCES 95 (1937).

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professional discussion to focus on a narrow definition. He noted that in 1959, representatives of the industry could argue against the use of the word insurance for government pension plans.[179]

The question how is insurance distinguishable from investment or saving – is this self-insurance? – or from warranty[180] – becomes important because of the American (technical) approach to insurance. It is also important if we examine the rhetoric of insurance. Certain definitions may eliminate large issues, as when a short nineteenth-century discussion of the morality of life insurance says "life insurance is an investment of funds for the benefit of heirs, it is nothing more or less."[181]

If, we consider the seller's warranty on a product, we could easily think that the buyer was somehow insured against injury by the seller. But the transaction seems to omit the critical element in those definitions of the insurance transaction which stress risk by a group of people, all of whom might be injured unexpectedly in the same way. That a legal contract can be a foundation for formal communitarianism seems clear.[182] The basic American understanding of insurance is that it is a contract, and moreover, a contract with a commercial insurance company,[183] which also involves other people, and even creates a certain relationship between them to the extent that they are sharers of a common risk and must pay in one category.[184]

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179. *See* Spencer L. Kimball, *The Purpose of Insurance Regulation: A Preliminary Inquiry in the Theory of Insurance Law,* 45 MINN. L. REV. 471, 512-13 (1961).

180. Either one of which would reduce the injury from an unanticipated accident for the person injured.

181. Brewster, The Morality of Life Insurance, 22 HUNTS MERCHANT MAG. & COM. REV., Jan. 1850, at 117.

182. *See* CAROL WEISBROD, THE BOUNDARIES OF UTOPIA 75 (1980).

183. *See* THOMAS ERSKINE HOLLAND, THE ELEMENTS OF JURISPRUDENCE 200 (1880) (emphasizing contract in a description of insurance: "Insurance is a contract by which one party, in consideration of a premium, engages to indemnify another against a contingent loss, by making him a payment in compensation if, or when, the event shall happen by which the loss is to accrue." *Id.*). The company appears pervasively, e.g. "Adverse Selection: 'process in life insurance by which an applicant who is uninsurable, or is a greater than average risk, seeks to obtain a policy from a company at a standard premium rate. Life insurance companies carefully screen applicants for this reason, since their premiums are based on policyholders in average good health and in non-hazardous occupations.'" HARVEY W. RUBIN, BARRON'S DICTIONARY OF INSURANCE TERMS 17 (3d ed. 1995).

184. And again, "a contract of insurance is an agreement in which one party (the insurer), in exchange for a consideration provided by the other party (the insured), assumes the other party's risk and distributes it across a group of similarly situated persons, each of

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As noted, the history of insurance is going to be different in different countries. It should presumably be connected to the history of commerce, generally.[185]

For François Ewald, writing about France, a critical date is 1898, when the adoption of a French scheme of insurance for industrial accidents ushered in the modern age. Following an emphasis on assistance in the form of charity, France moved to a regime that Ewald describes in terms of solidarity: "The paradigm of *solidarity,* which corresponds to the welfare state, considerably extends the proportion of legal obligations."[186] These legal obligations tend to overlap moral obligations. Solidarity, as Ewald sees it, involves "a sort of general right to compensation when faced with any mishap of living."[187]

It is far from clear that this is a description of the United States. At the simplest level, the time frame in the United States would be different. In America, in 1901, relief from mining accidents was conceived within the context of private charity. A book on the Scofield Utah mine disaster, published for the benefit of widows and orphans, makes plain the private locus of social responsibility.[188]

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whose risk has been assumed in a similar transaction." ROBERT H. JERRY II, UNDERSTANDING INSURANCE LAW 17 (2d ed. 1996).

185. *See* JACOB VINER, THE ROLE OF PROVIDENCE IN THE SOCIAL ORDER: AN ESSAY IN INTELLECTUAL HISTORY (1972) (discussing religious objections to commerce in the ancient world). "Commerce by ships was itself an impious activity . . . an affront to providence, which intended the seas to be barriers to the contact of peoples. . . ." *Id.* at 34. He traces the development of pro-commerce position found in a religious form as late as 1894: "God made this world so that every nation in it has got to depend for something upon some other nation." *Id.* at 40.

186. François Ewald, *The Return of the Crafty Genius*, 6 CONN. INS. L.J. 47, 48 (1999).

187. *Id.* "It is contemporary with a scientific and technical utopia, where society would have the possibility of controlling itself, where knowledge would have an indeterminate control over power. In its philosophical foundations, it is inseparable from the imperative of prevention: prevention of illnesses (with Pasteur's discoveries), prevention of crimes (with the system of social defense), prevention of accidents (with the sciences of safety), prevention of poverty and social insecurity (with social insurances)." *Id.*

188. After the disaster, public officials sent condolences. See J.W. DILLEY, HISTORY OF THE SCOFIELD MINE DISASTER 204-05 (1901). A researcher looking for a commemorative song wrote that "sympathy and charity poured into stricken families." LA VERNE J. STALLINGS, *The Scofield Mine Disaster, in* WESTERN FOLKLORE 173 (1959). Even the expansion of the welfare state and social programs in the United States through the Great Society period would not result in a description of the sort that the European sociologists are taking as their point of reference. Lawrence Friedman's characterization of workman's

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While some discussion merges state and private insurance in a general idea of the "risk society," other discussions, and perhaps particularly American discussions, keep these elements separate.

Vance, for example, clearly distinguished the two in his treatment of the German efforts and their possible applicability to the American situation. "These experiments in Europe are being tried along the same lines as those pursued by the larger corporations" in the United States, Vance said. These experiments "may well be watched by us with great interest, with a view to their extension by corporate employers, and possibly to the ultimate adoption of such insurance as a governmental function."[189]

And Vance's introductory remarks make plain that insurance is, in his view, a theory which can be put into practice by any institution: "The student must observe that there is no reason why a contract of insurance shall not be made in any case where an actual loss may be suffered."[190] Vance indicated that whatever the contract may be called, or through whatever agencies it may be made, or whatever other incidents it may have associated with it, the agreement is still one of insurance, and subject to the rules of insurance law, if the requisite elements are present."[191]

Within the American materials, the stance of the Amish on the insurance issue[192] is almost as well known as its position on the familiar question of compulsory education. This results in a conversation on

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compensation as a "compromise system" makes the basic point. *See* LAWRENCE FRIEDMAN, HISTORY OF AMERICAN LAW 682 (2d ed. 1985).

On the theme of American exceptionalism, *compare* JAMES HARRINGTON BOYD, A TREATISE ON THE LAW OF COMPENSATION FOR INJURIES TO WORKMEN UNDER MODERN INDUSTRIAL STATUTES 6 (1913) ("Every civilized nation in Europe and many other nations in other parts of the world except the United States have discarded the old system of Employer's Liability based upon fault and substituted a system under which every industry bears the burden of relieving the distress caused by injuries to workers in any given industry practically without litigation.") *with* BARRY R. FURROW ET AL, HEALTH LAW 102 (1995) ("Unlike virtually every other industrialized nation, the United States has not, as of this writing, developed a program for making health care comprehensively available to its citizens.").

189. VANCE, *supra* note 161, at 25-26.

190. *Id.* at 24.

191. *Id.*

192. *See* Brian J. Glenn, Collective Precommitment Against Temptation: The Case of the Amish (1999) (unpublished manuscript, on file with the University of Connecticut School of Law Library) (permission to cite). *See also* THE AMISH AND THE STATE (Donald B. Kraybill, ed. 1993).

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insurance between the religious group and the representatives of the larger society through the courts.[193]

United States v. Lee held that an exemption for the Amish from the Social Security System was not constitutionally required.[194] The argument of the plaintiff in the case was built on an opposition to insurance on religious grounds, although as William Ball makes plain, the *Lee* case was not necessarily "an Amish case" in which a clear group position was at stake. "No Amish teachings has declared that the Amish religion forbade the payment of the employee's share of social security taxes."[195]

The opinion by Justice Burger reviews the District Court opinion: "the [district] court noted that the Amish believe it sinful not to provide for their own elderly and needy and therefore are religiously opposed to the national social security system."[196]

The district court also found that the Amish reject state insurance, as well as commercial insurance, because of their religious commitments. A critical point in the decision is that "the Amish religion not only prohibits the acceptance of social security benefits, but also bars all contributions by Amish to the social security system."[197]

A footnote in the Supreme Court opinion adds that, the Amish man complaining in *Lee* said that his scriptural basis for this belief was: "But if any provide not...for those of his own house, he hath denied the faith, and is worse than an infidel" (I Timothy 5:8.).[198] Justice Burger commented on the Amish position, beginning with the point that while the statute mandated contributions it did not compel the acceptance of benefits. Thus, "it would be possible for an Amish member, upon qualifying for social

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193. For rejection of an individual's claim to a religious exception based on his "Christian beliefs," *see* Bucklund v. Bd. of Comm'rs of King County Hosp. Dist. No. 2, 106 Wash. 2d 632, 633 (1986), *appeal dismissed,* 481 U.S. 1034 (1987) (upholding hospital's bylaws requiring doctors to carry professional liability insurance).

194. *See* United States v. Lee, 455 U.S. 252 (1982).

195. THE AMISH AND THE STATE 257 (Donald B. Kraybill ed. 1993). Ball, the attorney for the Amish in *Wisconsin v. Yoder*, 406 U.S. 205 (1972) in which the community won an exemption from two years of high school, suggests that Lee's position may not have represented the position of the judgment of the Amish bishops or a consensus of even his own Amish community. The Amish do not suggest that they themselves would necessarily find it impossible to contribute to social security without collecting it. Their stated concern in their legislative testimony was for ability of the next generation to resist temptation. *Id.*

196. *Lee*, 455 U.S. at 255.

197. *Id.*

198. *Id.* at 256 n.3. Note the direct invocation of a biblical authority, as against a discussion of authoritative interpretative material.

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security benefits, to receive and pass them along to an Amish fund having parallel objectives."[199] But Justice Burger commented "It is not for us to speculate whether this would ease or mitigate the perceived sin of participation."[200] Justice Burger was, in effect, suggesting the possible use by one Amish of the sort of accommodation that makes insurance possible for other groups.

In the United States the idea of progress suggested utopian goals rather than utopian achievements at the national level. It seems entirely possible that the aspiration of social insurance in America, from the New Deal forward, was not as wholehearted as those Ewald describes, and the belief in salvation through science not so completely pervasive. Ulrich Beck's description of a shift from a society of assumptions of knowability and certainty to one in which uncertainty has returned, may or may not describe America as a whole.[201]

There are other questions which might be explored comparatively. Ewald's description of the solidarity paradigm identified with the welfare state fits some countries in the world, but as suggested, the United States may not be among them. The language of solidarity is itself odd when used to describe American society. Insurance as solidarity is, in the United States, an idea which may reflect the historic connections between industrial insurance and the labor movement. It seems artificial with reference to the contemporary use of insurance by the middle class. (The class which is the subject of Kimball's list of various kinds of insurances, in his insurance casebook).[202] Insurance may seem less a matter of solidarity than a matter of class-status maintenance for individuals. The demand for *Total Justice* (the suggestive title of Lawrence Friedman's book), includes the demand for long and healthy life, and perfect and perfectly formulated infants and may thus reflect a continuing commitment to the scientific utopian model.[203] But we also see something else in Europe and also in America. Science and technology are widely understood as having incalculable side effects. The risk of becoming

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199. *Id.* at 261 n.12

200. *Id.*

201. *See generally* ULRICH BECK, *The Reinvention of Politics: Towards a Theory of Reflexive Modernization, in* REFLEXIVE MODERNIZATION: POLITICS, TRADITION AND AESTHETICS IN THE MODERN SOCIAL ORDER 1(1994).

202. *See* SPENCER KIMBALL, INSURANCE LAW xxv (1942).

203. *See generally* LAWRENCE FRIEDMAN, TOTAL JUSTICE (1985).

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uninsurable, through, for example, early detection of cancer, may be as great a risk for the middle class as the risk of unemployment or accident.

This awareness of the limits of science might be associated (and not only in America) with the irrationalities and failures of a world which we often call Kafkaesque. It is appropriate, therefore, to end this section with a reference to material by Franz Kafka when he was working as a clerk at the Accident Insurance Institute in Prague on precisely this sort of question. The annual report for the Institute is included by Max Brod in his biography of Kafka.[204]

Kafka was considering the "difference between square spindles and cylindrical spindles as it affects the technique for the prevention of accidents."[205] He described the machinery in some detail. "The cutters of the square spindle are connected by means of screws direct to the spindle and rotate with exposed cutting edges at speeds of 380 to 400 revolutions per minute. The dangers to the operator, presented by the large space between the cutter spindle and the surface of the table, are obvious."[206]

These spindles were used, Kafka explained, either because the danger was not recognized, which may incidentally have increased the danger, or with the knowledge of the presence of a permanent danger which could not be avoided.

> Although an extremely cautious operator could take care not to allow any joint of his fingers to project from the timber when guiding it over the cutter head, the main danger defied all caution. . . . Not only every precaution but also all protecting devices seemed to fail in the face of this danger, as they either proved to be totally inadequate or, whereas they reduced the danger on the one hand (automatic covering of the cutter slot by a

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204. *See* MAX BROD, FRANZ KAFKA: A BIOGRAPHY 82-83 (G. Humpreys Roberts & Richard Winston trans., Schocken Books 2d ed. 1960). Brod provides this account of the 1909 document: "The annual report of the accident institute for the year 1909 contains an article I give below which Kafka wrote as a clerk of the office. Naturally, Kafka is not mentioned by name in the report itself. But I remember exactly Kafka bringing me the annual report that year, and telling me this article was his work. His boss had corrected his draft, but Kafka's style can be seen unmistakably in passages here and there even in this technical work. The high official who was kind enough to see me also pointed out the passage, as well as another one in the annual report for 1910, and told me they were Franz Kafka's work." *Id.*

205. *Id.*

206. *Id.*

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> protecting slide, or by reducing the width of the cutter space), they increased it on the other by not allowing the chippings sufficient space to leave the machine, which resulted in choked cutter spaces and in injured fingers when the operator attempted to clear the slot of chippings.[207]

The idea that danger that is decreased on one side is increased on another side is an aspect of the description of the postmodern

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207. *Id.* at 83-84. Brod follows this with an outline of a working men's community which Kafka wrote at the end of his life: It was called the "Guild of Workmen Without Possessions." For Brod, at least, there seems to have been a relationship link between the impossibility of eliminating risk and the social or communitarian solution to the problem of the workers.

> *Duties.* – (1) To own or accept no money, no valuables. The following the only possessions allowed: the simplest clothing (details to be settled), materials necessary for work, books, food enough for one's own needs. Everything else belongs to the poor. (2) To earn one's keep only by work. To shrink from no work for which one has the strength without damage to one's health. Either to choose one's work oneself, or if that is not possible, to submit to the orders of the work committee, which is under the orders of the government. (3) To work for no other reward than one's keep (to be settled according to the district, for two days). (4) The most temperate life. To eat only what is absolutely necessary, for example, as minimum recompense, which is in a certain sense also maximum recompense; bread, water, dates. The food of the poorest, the lodgings of the poorest. (5) To treat the relationship with one's employer as one of trust, never to demand the intervention of a law court. Any work taken on to be finished under all circumstances, except when serious considerations of health prevent it.
>
> *Rights.* – (1) Maximum period of work, six hours; for manual labor, four to five. (2) In the case of illness, and when a man is too old to work, acceptance in a state home for old people, hospitals. The working life to be a matter of conscience and faith in one's fellow-man.
>
> Property a man [sic] brings with him to be given to the state for building hospitals and homes.
>
> For the present at least, exclusion of married men and women.
>
> Advice – heavy responsibility – to be given by the government.
>
> Where a man can help, in forsaken districts, workhouses, as teachers .
>
> . . .
>
> Limit 500 men.
>
> One year's novitiate. *Id.* at 84-85.

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understanding of risk. Here, too, Franz Kafka stands at the center of certain concerns of the contemporary world.

CONCLUSION

Presumably, Kafka believed in the utility of insurance. In general, he might have thought that it was better to have it than not to have it. The reservation which Kafka expressed is to the effect that the workers requested relief when they should demand it. "'How modest these men are,'" Brod recalls Kafka saying. "They come to us and beg. Instead of storming the institute and smashing it to little pieces, they come to us and beg."[208] The link between insurance, at least in the industrial insurance context, and the idea of social reform and moral obligation to one's fellows is clear.

Such linkages are presented again in the work of the philosopher Josiah Royce. At the time of the First World War, Royce published a book called *War and Insurance*, which he described as urging that "the cause of the world's peace would be aided if in the future the principle of insurance were gradually and progressively introduced into international business."[209] Royce noted that "[I]nsurance has already proved to be, in the modern life of individual nations, a cause of no little growth in social organization, in human solidarity, in reasonableness, and in peace."[210] Royce believed that the "best workings of the insurance principle have been, on the whole, its indirect workings. It has not only taught men, in manifold ways, both the best means and the wisdom of 'bearing one another's burdens,'[211] but it has also established many indirect, and for that very reason all the more potent, types of social linkage. . . ."[212]

We might also illustrate with the work of John Commons who visited the Amana Community and rejected what he saw there, and, in response to that form of religious communitarianism, developed his own program of

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208. *Id.* at 82.

209. ROYCE, *supra* note 84, at 1135.

210. *Id.*

211. *Galatians* 6:2; *cf* 6:5 "Everyone shall fear his own burden." Both are used as mottos in Levy and Wilson, with the suggestion that "burdens" in 6.2 means misfortune while in 6:5 it means liability. *See* HERMANN LEVY and ARNOLD WILSON, INDUSTRIAL ASSURANCE (1937).

212. ROYCE, *supra* note 84, at 1135.

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industrial economics, rooted, as he said, in debt rather than love.[213] In the figure of Commons, we can link labor history to utopian history, including labor organizations and workers industrial insurance.[214] If we can take a hint from the English history, we can connect the English friendly societies (early and somewhat covert forms of unionism, we are told)[215] and fraternal organizations as insurance enterprises. These groups, often ethnic and overlapping with Communitarian Utopias in stressing mutual aid, are rooted in communal affiliation. They are also a piece of the story of insurance and thinking about its link to visions of the ideal society.

This article has tried to offer an overview of some issues which might be explored in considering a social history of insurance. It has also, indirectly, suggested some of the materials, legal and non-legal, institutional and journalistic, which might be used in such exploration. Some of the perceptions offered are entirely impressionistic. Thus, Metropolitan Life at one time reminds one both of a vertical company town and of a utopian community. Perhaps the idealistic images (in language and photographs) are simply devices to sell insurance. But it seems more as though having insurance, which means being insurable, is a ticket to the good life. Insurance, on this reading, becomes one of the paths to utopia.[216]

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213. In his autobiography, John Commons wrote: "I became suspicious of Love as the basis of social reform. I visited the Amana Community of Christian Communists in Iowa. They distinguished rigidly between love of man and love of woman. I studied Mazzini, the great Italian leader of Christian Socialism fifty years before. He founded Christian Socialism on the Duties of Man, including duties to wife and family. Eventually, after many years, in working out my institutional economics, I made Duty and Debt, instead of Liberty and Love, the foundations of institutional economics." JOHN R. COMMONS, MYSELF: THE AUTOBIOGRAPHY OF JOHN R. COMMONS 51-52 (Univ. of Wisconsin Press 1964) (1934).

214. *See generally* JOHN R. COMMONS, HISTORY OF LABOUR IN THE UNITED STATES (1918).

215. *See* G.D.H. COLE & RAYMOND POSTGATE, THE COMMON PEOPLE 232 (1966).

216. *See generally* RICHARD RUSSO, THE RISK POOL (1998). *The Risk Pool* (called to my attention by Tom Baker) could be presented as a novel which describes the progress of a man who is a danger to himself and others ("People who hang around your father often require hospitalization;" *id.* at 33; who is "mired in the lowest depths of the risk pool;" *id.* at 23; and then, just before his death, is classified "eligible for insurance outside the risk pool." *Id.* at 470.).

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YELLOW PAGE ADS AS EVIDENCE OF WIDESPREAD OVERCHARGING BY THE PLAINTIFFS' PERSONAL INJURY BAR — AND A PROPOSED SOLUTION

Jeffrey O'Connell,[*] *Carlos M. Brown,*[**] *and Michael D. Smith*[***]

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INTRODUCTION

Huge fees recently extracted by plaintiff lawyers in the settlement of tobacco cases have focused attention on attorney's fees. But the problem of overly expensive–and expansive–contingent fees extends far beyond such blockbuster examples and reaches down to millions of fender benders, slips, falls, and indeed to all types of personal injury cases. Furthermore, Harvard University President, Law School Dean, and now Professor, Derek Bok, has focused on the problem of charging standard contingent fees–at least one-third of the recovery–in personal injury cases. According to Professor Bok:

> There is little bargaining over the terms of the contingent fee. Most plaintiffs do not know whether they have a strong case, and rare is the lawyer who will inform them (and agree to a lower percentage of the take) when they happen to have an extremely high probability of winning. In most instances, therefore, the contingent fee is a standard rate that seldom varies with the size of a

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likely settlement or the odds of prevailing in court.[1]

The contingent fee is the form of payment almost uniformly used in personal injury litigation, large and small. Attorneys will take a claimant's personal injury case on the basis that only if the case results in payment will the attorney be entitled to a percentage of the payment received. So if nothing is recovered the claimant will not be liable to pay for the lawyer's services. The system has been painted as the legal system's great social equalizer, characterized as the poor person's key to the courthouse.[2] It is heralded as the guardian of the average injured person because it allows those with few resources to take on anyone causing injury, including multimillion dollar corporations, in pursuit of his or her rights. Consumer advocates argue in turn that the contingent fee allows attorneys to be consumer watchdogs for public safety.

However, the question is often raised of whether the contingent fee arrangement by lawyers and their clients is a double-edged sword.[3] Normally, lawyers seldom take less than one-third of the recovery of any personal injury claim regardless of the amount of value added to the lawsuit by their services.[4] In many situations, the attorney may have to do no more than author a demand letter or make a phone call, all of which may take fifteen minutes to an hour, yet walk away with a windfall of thousands of dollars. Thus, the current contingent fee arrangement is seen by many as inefficient, wasteful, and unfair to the consumer. Only when substantial value is actually added to the claim should the attorney take such a substantial proportion of the award.

In effect, by basing its percentage on the entire value of the client's payment, regardless of (1) its inherent value and (2) the value added to the claim by the attorney, the plaintiffs' bar proceeds on the assumption that no claim has any value except that imparted by the attorney. Consider an

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1. DEREK BOK, THE COST OF TALENT: HOW EXECUTIVES AND PROFESSIONALS ARE PAID AND HOW IT AFFECTS AMERICA 140 (1993).

2. *See* Philip H. Corboy, *Contingent Fees: The Individual's Key to the Courthouse Door*, LITIG., Summer 1976 at 27, 28.

3. *See* PETER A. BELL & JEFFREY O'CONNELL, ACCIDENTAL JUSTICE 68-100, 109, 123, 176 (1997).

4. "[A] contingent fee of one-third of the amount recovered has become a general standard, at least in personal injury actions." 1 ROBERT L. ROSSI, ATTORNEY'S FEES § 2:9 at 112-13 (2d ed. 1995); *see also* Henry H. Drummonds, *The Law and Ethics of Percentage Contingent Fees in Oregon*, 72 OR. L. REV. 859, 863 (1993) ("Plaintiffs' lawyers typically charge from twenty-five percent to forty percent (exclusive of appeals) in their percentage [contingent fee arrangement] with clients; a one-third fee is most common.").

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analogous situation: the claim for reimbursement of a landowner whose property is condemned by the state. Could lawyers get away with charging for their services in the condemnation proceedings, one third of the value of the landowner's property as ultimately determined by settlement or litigation? Of course they could not. Indeed, in condemnation proceedings fees charged for the condemnee's lawyer are explicitly limited to a percentage of the value added by the lawyer, *e.g.*, a percentage of the amount by which the ultimate payment exceeds the amount offered by the condemnor.[5]

With this background, our research reports the results of a survey of twelve metropolitan area yellow pages to examine how personal injury lawyers advertise to indicate their fees. The survey especially focused on how the contingent fee was discussed or alluded to in these ads. The results show that uniformly, when lawyers' personal injury advertisements address fees, they do so in a general and vague manner without offering any truly informative details.

RESEARCH DESIGN

A. Purpose of Study

This article examines just what attorneys actually say in their advertisements, with a special emphasis on whether and how they discuss fee options and the amount of any contingent fee. We wanted to know, for example, if attorneys ever advertised a specific fee schedule for personal injury work, and if price competition was ever discussed in these ads.

In order to draw some general conclusions we have surveyed the Attorney/Lawyer section of the Yellow Pages of twelve metropolitan areas:[6] Chicago, Philadelphia, Atlanta, Denver, San Francisco, Richmond, Boston, Washington D.C., Seattle, Houston, Los Angeles, and New York (Manhattan). We conducted our survey by ascertaining "Yes or No" to the following questions under each advertisement examined.

Questions:

(1) Does the ad mention the fee?

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5. *See* LESTER BRICKMAN, MICHAEL J. HOROWITZ & JEFFREY O'CONNELL, RETHINKING CONTINGENCY FEES 57, n. 34 (1994).

6. The research for this paper was conducted in the Spring of 1997. Surveys were conducted of the yellow pages produced by the primary telephone company in all of the twelve metropolitan areas considered in this study. All the yellow pages were current as of the date of the survey.

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(2) Does the ad mention no fee unless recovery?
(3) Does the ad expressly mention contingent fee?
(4) Does the ad mention an hourly rate?
(5) Does the ad mention the percentage of contingent fee taken by the attorney?
(6) Does the ad mention the fee will beat the price of competition?
(7) Does the ad mention per job rate or flat fee?

In order to make the survey results reliable and consistent, we limited our inspections of advertisements to those ads which explicitly used one of the following terms in its copy: "injury," "accident," "malpractice," or "hurt." With regard to the contingent fee issue, we similarly required the explicit use of the term "contingent" in order to count as a "yes." With regard to the question of whether ads mentioned other terms such as "no fee, no recovery," "hourly rate," "flat fee," or "price competition," we were more liberal in including advertisements that generally conveyed such concepts. Generally, so long as an ad implied the concept, despite its exact language, we would count it as "yes."

B. Survey Results

We analyzed a total of 1,425 advertisements within the "Attorney" or "Lawyer" sections of the Yellow Pages which referred to a personal injury practice for twelve large cities in the United States. The results are presented in Chart I (in absolute numbers) and Chart II (in percentages as well).

Virtually none of the advertisements explicitly disclosed a policy of exacting a percentage of their client's recovery through a contingent fee. *See* Chart II, cell TOTAL/col.5. Overall, only 3.4% of the 1,425 ads openly state the use of a contingent fee. In fact, the personal injury ads placed in Richmond (Virginia), Atlanta, and Boston neglected to mention "contingent fees" at all. Conversely, the city of Denver was the most candid in its personal injury ads by mentioning "contingent fee" 17.4% of the time. Of the 1,425 ads, the mean total of those mentioning the term "fee" was 30.6%. The cities with the most ads that convey to potential clients any obligation of a "fee" were Chicago and Seattle, with 52% and 45%, respectively. Atlanta, however, with 161 ads, reported the lowest percentage of ads with only 6.8% mentioning an obligation to pay a fee. An overwhelming number of advertisements that referred to a fee for legal services in personal injury cases did so through the phrase, "No Fee, No Recovery." Each city was relatively consistent with a mean of 87.1% thus using the term "No Fee, No Recovery" when an ad referred to fees. Denver, Richmond, Chicago, and Philadelphia, however, served as outliers

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by using that phrase 57%, 64%, 97%, and 98% of the time respectively when an ad referred to fees.

In response to the questions regarding (1) hourly rates, (2) the specific percentage of the fee exacted, (3) a flat fee, and (4) price competition, the number of ads that mentioned those items were all much less than one percent of the total of 1,425 ads. These percentages are so small that there seems no need to include them on Chart II (listing percentages), since they would be zero or so close to zero as not to matter.

Only five advertisements of the 1,425 (.35%) mentioned an hourly rate. *See* Chart I, cell TOTAL/col. 5. Only seven ads (.49%) gave a specific percentage taken by the attorney as a contingent fee, which percentage averaged 30.6%. *See* Chart I, cell TOTAL/Col. 6. Only one ad (.07%) gave any indication that it would bargain with regard to fee for services provided. Finally, only six advertisements (.42%) made reference to a flat fee for personal injury services.

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CHART I – ***Phone Book Survey Result of How Personal Injury Attorneys Advertise***

Cities	Total Ads	# of ads which mention term "Fee"	# of ads which reference "No Fee, No Recovery"	# of ads which reference "contin-gent fee"	# of ads which reference "hourly rate"	# of ads which mention % of contingent fee taken by attorney	# of ads which reference "will beat price of competition"	# of ads which mention "flat fee"
Philadelphia	153	58	57	2	0	0	0	1
Chicago	75	39	38	2	0	0	0	0
Seattle	122	55	48	7	0	0	0	0
Richmond, VA	111	14	9	0	0	0	1	0
San Francisco	78	32	30	1	0	0	0	0
Atlanta	161	11	9	0	2	0	0	0
Boston	82	24	23	0	1	0	0	0
Washington, D.C.	137	47	41	9	1	1	0	0
Denver, CO	106	47	27	19	1	0	0	1
Los Angeles	116	43	41	1	0	0	0	4
Houston	179*	21	18	4	0	3	0	0
New York	105	46	40	4**	0	3***	0	0
TOTAL	1,425	437	381	49	5	7	1	6

* Twenty-seven of the Houston ads just state "Board Certified Specialist—Personal Injury Trial Law," in bold text.

** Twenty-four of the Manhattan ads mention in some variation: "We advance legal expenses which are payable at conclusion of case. Fee computed after deduction of expenses."

*** Three of the Manhattan ads say that they will take a percentage of the recovery but do not state what percentage they will take.

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7. Herbert M. Kritzer has conducted research in Wisconsin comparing the actual effective hourly rate of personal injury attorneys who charge fees based on contingent billing/fees and those that use flat fee or hourly rate billing. *See generally* Herbert M. Kritzer, *The Wages of Risk: The Returns of Contingent Fee Legal Practice*, 47 DEPAUL L. REV. 267 (1997). The results of his research suggest that though a small percentage of personal injury lawyers (5-10%) benefit by exacting contingent fees that earn them effective hourly rates above $1,000 per hour, the majority of personal injury attorneys billing on a contingent basis earn about what their counterparts earn who bill on an hourly basis. *See id.* at 291. Thus, his conclusion is that the contingent fee when considered in light of the majority of personal injury cases is not an unreasonable means by which to charge attorney's fees. *See id.* at 305. Rather, Kritzer argues that in light of the risk shifting that occurs with contingent fees and the benefit of giving more people access to the legal system, the contingent fee system is not only reasonable but serves an important public purpose. *See id.* at 307.

Though Kritzer concludes that the fee system operates reasonably, he goes on to suggest drastic changes in the form of greater competition, including from nonlawyers, and better information regarding fee options being made available to clients. *See* Jeffrey O'Connell, *Early Offers as Contingent Fee Reform*, 47 DEPAUL L. REV. 413-14 (1998). At any rate, in light of the Kritzer article, we conducted a survey of personal injury attorney yellow page ads in Wisconsin (i.e., in the 1996-97 edition for Madison). In the Madison survey, there were a total of 102 attorney ads that referenced personal injury work. Of the 102 ads, only thirty-three mentioned fee in any form. Of the thirty-three that did reference fee, twenty-six used the terms "no fee, no recovery." Only five of the thirty-three ads included the words "contingent fee." None mentioned the availability of an alternative to a contingent fee.

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CHART II

Cities	Total Ads	% of Ads which mention term "Fee"		% of ads which reference "No Fee No Recovery"		% of ads which mention term "fee" and reference "No Fee No Recovery"		% of ads which reference "contingent fee"	
Philadelphia	153	(58/153)	38%	(57/153)	37%	(57/58)	98%	(2/153)	1.3%
Chicago	75	(39/75)	52%	(38/75)	50%	(38/39)	97%	(2/75)	2.6%
Seattle	122	(55/122)	45%	(48/122)	39%	(48/55)	87%	(7/122)	5.7%
Richmond, VA	111	(14/111)	12%	(9/111)	8.1%	(9/14)	64%	(0/111)	0%
San Francisco	78	(32/78)	41%	(30/78)	38%	(30/32)	93%	(1/78)	1.2%
Atlanta	161	(11/161)	6.8%	(9/161)	5.5%	(9/11)	81%	(0/161)	0%
Boston	82	(24/82)	29%	(23/82)	28%	(23/24)	95%	(0/82)	0%
Washington, D.C.	137	(47/137)	34%	(41/137)	30%	(41/47)	87%	(9/137)	6.5%
Denver, CO	106	(47/106)	44%	(27/106)	25%	(27/47)	57%	(19/106)	17.9%
Los Angeles	116	(43/116)	37%	(41/116)	35%	(41/43)	95%	(1/116)	.8%
Houston	179*	(21/179)	11%	(18/179)	10%	(18/21)	85%	(4/179)	.2%
New York	105	(46/105)	44%	(40/105)	38%	(40/46)	86%	(4/105**)	3.8%
TOTAL	1,425	(437/1,425)	30.6%	(381/1425)	26.7%	(381/437)	87.1%	(49/1,425)	3.4%

* Twenty-seven of the Houston ads just state "Board Certified Specialist—Personal Injury Trial Law," in bold text.

** Twenty-four of the Manhattan ads mention in some variation: "We advance legal expenses which are payable at conclusion of case. Fee computed after deduction of expenses."

It should be noted here that a few jurisdictions (*e.g.*, Georgia and Washington) have mandated that if an ad mentions "no fee, no recovery," it must explain whether the percentage would be taken before or after litigation expenses had been deducted.

Because advertisements are the only way that the potential client is likely to become educated about the type and cost of legal services lawyers provide, this survey arguably presents a good gauge as to what lawyers actually offer.

Note that the laws in all jurisdictions surveyed allowed discussions of price in advertisements. Even so, it is not surprising that advertisements by professionals (including physicians) do not normally specifically cover fees to be charged. But what seems significant is that lawyers' personal injury ads do often raise the subject of fees so vaguely as to prevent the potential client from learning what the fee will actually be. Further, it is rare to find so much advertising anywhere concerning pricing that so thoroughly ignores the issue of competitive pricing.

It should also be noted that attorneys' personal injury ads are in stark contrast to auto insurers' and agents' yellow page ads, a quick perusal of which shows them replete with references to a willingness to underprice

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competitors' premiums. A further irony here is the insistence by the plaintiffs' personal injury bar and their allies that a "principal cause" of the high cost of auto insurance "has been concerted anti-auto competitive practices by insurers to raise prices . . . ."[8]

In sum, results of the survey reveal that the overwhelming majority of lawyers who advertise that they engage in personal injury litigation do not address at all the terms of their fees. Secondly, even those ads that do discuss fees overwhelmingly leave their discussion of the fee to the general and vague language of "no fee, no recovery" or, much more rarely, "contingent fee" without any specifics. Indeed, many of the ads gave at least the indirect impression through the phrase "no recovery, no fee" that only contingent fee arrangements would in fact be acceptable for personal injury work. Finally, we found only one advertisement which made even a vague reference to being open to bargaining over price.

This survey seems to confirm, then, (1) that as a practical matter the plaintiffs' personal injury bar uniformly charges contingent fees (since any other type of fee is so rarely mentioned), and (2) that there is little if any variation in at least the minimum contingent fee charged based either on the lawyer retained or the facts of the case (since any such variation is also so rarely mentioned).

All of the above is not to argue that bans on lawyer advertising, including those as to price, were necessarily something the United States Supreme Court should have outlawed.[9] In this regard, as Professor Paul Carrington of the Duke Law School has pointed out, "even simple price advertising by lawyers" might well be seen as threatening "to mislead because of the absence of . . . means to provide information about the relative quality . . . of this service that a lawyer seeks to sell."[10] But our point is that once bans on lawyer advertising have been lifted, the near uniform failure in the resultant flood of ads to mention price against a background of near uniform contingent fees of about one-third seems at the very least to point to overpricing. If so, what can be done about it?

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8. Albert B. Crenshaw, *No-Fault Car Insurance May Be Making Comeback*, WASH. POST, Feb. 9, 1997 at H1. For the proposition that there is price competition for auto insurance, *see* Joseph B. Treaster, *Auto Insurance is Now Cheaper in Many States*, N.Y. TIMES, April 15, 1998, at A5; Liz Pulliam, *Look Around*, L.A. TIMES, July 19, 1998, at D1, D8.

9. *See* Zauderer v. Office of Disciplinary Counsel, 471 U.S. 626 (1985); *In re* R.M.J., 455 U.S. 191 (1982); Bates v. State Bar of Ariz., 433 U.S. 350 (1977).

10. PAUL D. CARRINGTON, STEWARDS OF DEMOCRACY 167 (1999).

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This is not the place to exhaustively discuss a proposed solution already covered in the literature.[11] But briefly, Lester Brickman, Michael Horowitz and the senior author of this paper have proposed the following regimen which can be implemented by either statute or court rule:

(1) The proposal prohibits contingent fees being charged against settlement offers made before claimant retains counsel.[12]

(2) It provides that, except for non-cooperation from the claimant, defendant, in order to limit the size of the contingent fee, must make its settlement offer, if any, within sixty days from receipt of claimant's counsel's settlement demand.[13]

(3) It provides that if claimant accepts the offer, then his or her counsel's fees are capped at ten percent.[14]

(4) It requires claimant's settlement demand to include routinely discoverable information in order that defendant may evaluate the claim.[15]

(5) When making any offer covered by the proposal, defendant must disclose discoverable information in its possession on which it bases its offer in order that claimant may evaluate the offer.[16]

(6) If claimant rejects a settlement offer made pursuant to the proposal, claimant's counsel can charge a contingent fee only on recoveries in excess of the offer.[17]

(7) If no offer is made pursuant to the proposal, i.e., no early offer is made within sixty days of claimant's demand, any contingent fee contract is unaffected.[18]

Thus the proposal does not require the defendant to make an early offer and, if an offer is made, claimant need not accept it. The proposal therefore has no impact on a contingent fee if no offer is forthcoming or on amounts

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11. *See generally* Brickman et al., *supra* note 5; Michael Horowitz, *Making Ethics Real, Making Ethics Work: A Proposal for Contingent Fee Reform*, 44 EMORY L.J. 173 (1995); *see also id.* App. at 194 (the proposal plus extensive section-by-section commentary by Lester Brickman, Michael Horowitz, & Jeffrey O'Connell).

12. *See* Brickman et al., *supra* note 5, § 701 at 26. This provision expresses the basic concept of the proposal: that contingent fees may be charged only upon the fruits of value-adding labors.

13. *See id.* § 701, at 206.

14. *See id.* § 501(a), at 203.

15. *See id.* § 703, at 208-09.

16. *See id.* § 401, at 200-01.

17. *See id.* § 801, at 209.

18. *See id.* § 1002(b), at 211.

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above a rejected offer. For instance, if defendant offers $90,000 within sixty days of receiving a demand from claimant's counsel and claimant does not accept the offer but settles later for $100,000, claimant's counsel would be allowed ten percent of the $90,000, plus a third or more (depending on the contingent fee agreement) of $10,000, *i.e.*, the difference between the early offer and the final settlement. The proposal thereby discourages delays and rewards swift realistic settlement offers. If in the foregoing example, defendant immediately offers $90,000, such an offer provides claimant with $81,000 after deducting his or her attorney's ten percent fee. But if claimant has signed a standard 33 1/3% fee agreement and defendant doesn't make an early offer, it will cost defendant $121,500 to provide the same payout to claimant later in the course of litigation.[19] Nor does this higher amount include defendant's own attorney's fees and expenses which are likely to be much less with an early offer because early offers will likely be engendered by defendant's insurer's "in-house" claims department. Even if outside counsel are involved, their cost would be much less expensive compared to their participation in prolonged negotiation or pre-trial efforts.

It may be feared that defendants would game the system by making low offers designed to be rejected so as to reduce the rates of return for services by claimants' counsel in the instant and any future case, thereby lessening their incentives to take personal injury cases. Such a fear is the closest to a validly substantive one urged against the proposal. Note, though, that case-by-case "early offers" advantage only defendants who make realistic early offers. Cost savings in any given case do not benefit intractable defendants making niggardly tenders. Thus the self-interest of defendants should inhibit unfair gaming. Furthermore, the early offers proposal would seem to entail far fewer ethical hazards than under the present system which encourages (1) plaintiffs' counsel to overcharge, and, (2) defendants' counsel to harass the former with pre-trial maneuvers in order to lessen their return on any given case.

Even so, if it seems best, the proposal could be modified such that it becomes effective only when early offers are actually accepted. In other words, the proposal could provide that early offers become the basis on which contingent fees are computed only on offers not only made but

19. *See* Peter Passell, *Windfall Fees Under Assault In Windfall Cases*, N.Y. TIMES, Feb. 11, 1994, at A1.

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accepted, thus prompting only very realistic offers.[20] This change admittedly somewhat increases claimant counsels' incentives to reject early offers but would still leave things much better than under present practices.

CONCLUSION

This proposal is not a panacea. It makes no claim to solve all the problems of personal injury tort law. But it does offer a meaningful step toward a more ethical and efficient system of contingent fees (while also, not so incidentally, providing disincentives for the tactics often adopted by defendants to improperly avoid or delay paying claimants).[21] Such reforms are all the more important given the lack of information on fees currently being provided by claimants, a shortcoming amply documented by the survey of Yellow Pages undertaken by this study.[22]

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20. *See* O'Connell, *supra* note 7, at 418-19.

21. *See* Horowitz, *supra* note 11, at 185-86.

22. Even a casual listen or look at claimants' counsels' radio or TV ads confirms that no better information is provided therein than in the Yellow Pages.

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COMBATING DISCRIMINATORY INSURANCE PRACTICES: TITLE III OF THE AMERICANS WITH DISABILITIES ACT

*Jesse A. Langer**

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INTRODUCTION

Congress enacted The American with Disabilities Act of 1990 ("ADA")[1] to liberate disabled individuals and provide them with the means to participate in mainstream society. The ADA represents one of the most significant pieces of civil rights legislation since the Civil Rights Act of 1964 (Title VII).[2] The ADA's purpose, protecting disabled individuals, parallels that of Title VII, protecting individuals who are discriminated against on the basis of race, color, sex, religion, or national origin. Title III extends the prohibitions and requirements of the ADA to entities that constitute "public accommodations," such as restaurants and insurance companies, which often provide the means for disabled individuals to participate meaningfully in society.[3] Thus, eliminating discriminatory practices by those entities that provide goods and services to the public is paramount to the ADA's broad mandate against disability-based discrimination.

Though the ADA was passed with relative ease, application of the statute has proven both problematic and controversial. Determining the interplay between the ADA and the insurance industry has been especially difficult, despite the clearly stated purpose of the ADA to eliminate disability-based discrimination. The federal judiciary has narrowly construed the statute and provided disabled individuals with little basis from which to combat discriminatory insurance practices. Some circuit courts of appeal that have addressed Title III insurance claims have interpreted "public accommodation" to consist solely of physical structures and have also limited the scope of the provision to issues of physical or

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1. *See* Americans With Disabilities Act of 1990, 42 U.S.C. §§ 12101-12213 (1995).
2. *See* Civil Rights Act of 1964, § 701, *as amended* 42 U.S.C. § 2000(a) (1994).
3. *See* 42 U.S.C. § 12101(9). Congress determined that:

> The continuing existence of unfair and unnecessary discrimination and prejudice denies people with disabilities the opportunity to compete on an equal basis and to pursue those opportunities for which our free society is justifiably famous, and costs the United States billions of dollars in unnecessary expenses resulting from dependency and nonproductivity.

Id. The House Report emphasized the importance of "public accommodations" in removing disability-based discrimination. The Report asserts that: "It is critical to define public accommodations to include all places open to the public, not simply restaurants, hotels and places of entertainment . . . because discrimination against people with disabilities is not limited to specific categories of public accommodations." H.R. REP. NO. 101-485, pt. 2, at 35 (1990), *reprinted in* 1990 U.S.C.C.A.N. 303, 317.

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direct access to such structures.[4] Accordingly, the insurance industry enjoys comprehensive immunity from Title III claims.

This interpretation of Title III ignores the overarching purpose of the ADA—to dispel stereotypes and curb disability-based discrimination. Concluding that disabled individuals cannot state a legally cognizable claim against an insurance company is unsubstantiated by the plain meaning of the text and the accompanying legislative history of the ADA. "Public accommodation" should be construed liberally to include entities that interact with the public through mediums other than direct contact. In other words, the fact that an individual does not physically enter an insurance office and directly purchase an insurance policy should not exclude the insurer from Title III regulations. Additionally, Title III should be interpreted to reach the substantive elements of the insurance policy: the terms and conditions of coverage that unlawfully discriminate on the basis of disability should result in liability under Title III. Therefore, an insurance company that excludes certain individuals from coverage or provides unequal benefits, and cannot justify these conditions with actuarial data, violates Title III. This reading of the ADA is in accordance with congressional intent and does not contravene the McCarran-Ferguson Act.[5]

This Comment analyzes the current status of Title III claims raised in the insurance context. Does a limited interpretation of both the term "public accommodation" and the scope of Title V's "safe harbor" provision contradict the statutory language and purpose of the ADA? To unravel the ambiguity surrounding Title III, it is necessary to examine closely Title III and Title V and consider how the two provisions interact with one another.

Part I of this Comment provides an overview of the ADA. Part II outlines the judicial decisions that address the term "public accommodation" and suggests an expansive interpretation. Part III of this Comment analyzes Title III and concludes that the provision does reach the substantive elements of an insurance policy. To determine if one can raise a viable Title III claim against an insurance company, the role of the "safe harbor" provision must be defined. Part IV assesses the impact of Title V upon the insurance industry. This Comment concludes that Title III should

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4. *See, e.g.*, McNeil v. Time Ins. Co., No. 98-10585, 2000 WL 217500, at *6 (5th Cir. Feb. 24, 2000); Weyer v. Twentieth Century Fox Film Corp., 198 F.3d 1104, 1114 (9th Cir. 2000); Ford v. Schering-Plough Corp., 145 F.3d 601, 612 (3d Cir. 1998), *cert. denied*, 525 U.S. 1093 (1999); and Parker v. Metropolitan Life Ins. Co., 121 F.3d 1006, 1010 (6th Cir. 1997).

5. *See* 15 U.S.C. §§ 1011–1015 (1997).

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be construed to allow claims alleging discriminatory insurance practices and, therefore, uphold the ADA's purpose as an anti-discrimination statute.

I. OVERVIEW: THE PURPOSE OF THE ADA

The ultimate function of the ADA is to eradicate the pervasive barriers facing disabled individuals from participating as productive members of society. Congressional findings indicated that there are some forty-three million Americans suffering from one or more physical or mental disabilities.[6] The ADA was hailed as a significant step towards the liberation of disabled individuals from socially imposed segregation.[7] Congress described this isolation as comprehensive: disabled individuals experience discrimination "in such critical areas as employment, housing, public accommodations, education, transportation, communication, recreation, institutionalization, health services, voting, and access to public services."[8]

The ADA proclaims that disabled individuals are a "discrete and insular minority" deserving of equal opportunity to pursue their goals under the law.[9] Moreover, the statute asserts "that the nation's proper goals regarding individuals with disabilities are to assure equality of opportunity, full participation, independent living, and economic self-sufficiency for such individuals."[10] To accomplish these goals, the ADA consists of five sections pertaining to the following areas: employment (Title I),[11] public services (Title II),[12] public accommodations (Title III),[13]

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6. *See* 42 U.S.C. § 12101(a)(1).

7. The extent of the stigma attached to disabled individuals pervades all aspects of life. *See* H.R. REP. NO. 101-485, pt. 2, at 30. The Reports refer to the findings of the National Council on Disability, which explained that "[a] major obstacle to achieving societal goals of equal opportunity and full participation of individuals with disabilities is the problem of discrimination." *Id.* Accordingly, those that are disabled are consistently underprivileged and disadvantaged. *See id.* at 31.

8. 42 U.S.C. § 12101(a)(3).

9. *See id.* § 12101(a)(7).

10. *See id.* § 12101(a)(8).

11. *See id.* §§ 12111-12117. Title I generally prohibits discrimination by a "covered entity" against a qualified person with a disability with respect to "application procedures, the hiring, advancement, or discharge of employees, employee compensation, job training, and other terms, conditions, and privileges of employment." *Id.* § 12112(a).

12. *See id.* §§ 12131-65.

13. *See id.* §§ 12162-65.

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telecommunications (Title IV),[14] and miscellaneous provisions (Title V).[15]

Title III prohibits an entity that offers goods and services to the public from discriminating against individuals on the basis of disability.[16] These entities, or "public accommodations," cannot prevent individuals from "the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation by any person who owns, leases (or leases to), or operates a place of public accommodation."[17] Title III also provides a list[18] of private entities that are considered "public accommodations" under the ADA.[19] The provision's

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14. *See* 47 U.S.C. § 225 (1994) (amending the Communications Act of 1934).

15. *See* 42 U.S.C. §§ 12201-13.

16. *See id.* § 12181(6). The Department of Justice defines the term "private entity" as "any individual or entity other than a public entity." 28 C.F.R. pt. 36, app. B (1999). This usage of "entity" is incorporated into the definition of "public accommodation." *See id.*

17. 42 U.S.C. § 12182(a).

18. *See* 28 C.F.R. pt. 36, app. B. The list of categories is exhaustive. *See id.* Only a few examples are given and, therefore, other entities that clearly fall within each specific category, though not enumerated, are covered by the statute. *See id.*

19. *See* 42 U.S.C. § 12181(7)(A)-(L). Public accommodations include:

> (A) an inn, hotel, motel, or other place of lodging, except for an establishment located within a building that contains not more than five rooms for rent or hire and that is actually occupied by the proprietor of such an establishment as the residence of the proprietor;
> (B) a restaurant, bar, or other establishment serving food or drink;
> (C) a motion picture house, theater, concert hall, stadium, or other place of exhibition of entertainment;
> (D) an auditorium, convention center, lecture hall, or other place of public gathering;
> (E) a bakery, grocery store, clothing store, hardware store, shopping center, or other sales or rental establishment;
> (F) a laundromat, dry-cleaner, bank, barber shop, beauty shop, travel service, shoe repair service, funeral parlor, gas station, office of accountant or lawyer, pharmacy, *insurance office*, professional office of health care provider, hospital, or other service establishment;
> (G) a terminal, depot, or other station used for specified public transportation;
> (H) a museum, library, gallery, or other place of public display or collection;
> (I) a park, zoo, amusement park, or other place of recreation;
> (J) a nursery, elementary, secondary, undergraduate, or postgraduate private school, or other place of education;
> (K) a day care center, senior citizen center, homeless shelter, food bank, adoption agency, or other social service center establishment; and

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general anti-discrimination paragraph applies to the insurance industry because of the inclusion of "insurance office" in paragraph (F) of the list of "public accommodations."

Title III defines discrimination to include several essential aspects of access to the "full and equal enjoyment" of goods and services.[20] First, "public accommodations" cannot impose eligibility requirements that tend to bar individuals or any class of individuals who possess a disability.[21] Second, a covered entity must make reasonable accommodations necessary for disabled individuals to obtain goods and services unless such modifications would substantially modify its operations.[22] Additionally, a "public accommodation" must also take the necessary steps to avoid the exclusion of disabled individuals because of a failure to supply auxiliary services.[23] Finally, Title III adversely affects covered entities that neglect

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(L) a gymnasium, health spa, bowling alley, golf course, or other place of exercise or recreation.

Id. (emphasis added).

20. *See id.* § 12182(a).

21. *See id.* § 12182(b)(2)(A)(i). Paragraph (i) provides that
the imposition or application of eligibility criteria that screen out or tend to screen out an individual with a disability or any class of individuals with disabilities from fully and equally enjoying any goods, services, facilities, privileges, advantages, or accommodations, unless such criteria can be shown to be necessary for the provision of the goods, services, facilities, privileges, advantages, or accommodations being offered.

Id.

22. *See id.* § 12182(b)(2)(A)(ii). Paragraph (ii) describes discrimination as a failure to make reasonable accommodations in policies, practices, or procedures, when such modifications are necessary to afford such goods, services, facilities, privileges, advantages or accommodations to individuals with disabilities, unless the entity can demonstrate that making of such modifications would fundamentally alter the nature of such goods, services, facilities, privileges, advantages, or accommodations.

Id.

23. *See id.* § 12182(b)(2)(A)(iii). Paragraph (iii) provides that
a failure to take such steps as may be necessary to ensure that no individual with a disability is excluded, denied services, segregated or otherwise treated differently than other individuals because of the absence of auxiliary aids and services, unless the entity can demonstrate that taking such steps would fundamentally alter the nature of the good, service, facility, privilege, advantage, or accommodation being offered or would result in an undue burden.

Id.

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to remove architectural and communicative barriers that inhibit disabled individuals from obtaining and enjoying existing facilities.[24] The breadth of the specific anti-discrimination provisions, coupled with Title III's general prohibition against disability-based discrimination, help to illustrate the broad scope of the ADA.

Title III is also governed by the provisions delineated in Title V.[25] Title V consists of a series of miscellaneous provisions that apply to the preceding sections of the ADA. Paragraph (c) of Title V, referred to as the "safe harbor" provision, provides some guidelines concerning the impact of the ADA on the insurance industry and its practices.[26] First, the anti-discrimination provisions outlined in Title III are not to restrict insurance providers from partaking in underwriting and actuarial techniques that are consistent with state law.[27] Second, the protection offered to insurers

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24. *See id.* § 12182(b)(2)(A)(iv). Paragraph (iv) establishes discrimination as
> a failure to remove architectural barriers, and communication barriers that are structural in nature, in existing facilities, and transportation barriers in existing vehicles and rail passenger cars used by an establishment for transporting individuals (not including barriers that can only be removed through the retrofitting of vehicles or rail passenger cars by the installation of a hydraulic or other lift), where such removal is readily achievable.

Id.

25. *Id.* § 12201.

26. *See id.* § 12201(c). The paragraph provides:
> Subchapters I through III of this chapter and title IV of this Act shall not be construed to prohibit or restrict–
>
> (1) an insurer, hospital or medical service company, health maintenance organization, or any agent, or entity that administers benefit plans, or similar organizations from underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with State law; or
>
> (2) a person or organization covered by this chapter from establishing, sponsoring, observing or administering the terms of a bona fide benefit plan that are based on underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with State law; or
>
> (3) a person or organization covered by this chapter from establishing, sponsoring, observing or administering the terms of a bona fide benefit plan that is not subject to State laws that regulate insurance.
>
> Paragraphs (1), (2), and (3) shall not be used as a subterfuge to evade the purposes of subchapters I and III of this chapter.

Id. § 12201(c)(1)-(3).

27. *See id.*

cannot be implemented as a "subterfuge" to circumvent the purposes of the ADA.[28] Title V acknowledges that the insurance industry legitimately uses actuarial principles to assess risk and coverage limitations.[29] Accordingly, the ADA was not enacted to alter the way in which the insurance industry functions or the manner in which state law regulates insurance.[30] However, the inclusion of "insurance office" as one of the entities that exemplifies service establishments[31] and the "safe harbor" provision strongly suggest that the ADA specifically addressed the insurance industry. The question remains one of degree.

II. DEFINING "PUBLIC ACCOMMODATION"

The definition of "public accommodation" is essential in determining the ADA's impact on underwriting practices. A liberal interpretation of the term would most likely include entities that provide or administer insurance policies and, therefore, enable the ADA to regulate insurance practices.[32] When analyzing judicial interpretation of the term "public accommodation," it is important to consider two issues. First, does "public accommodation" refer solely to entities that provide goods and services directly from physical structures? Second, is the ADA only concerned with issues of physical access, or are the processes of distributing goods and services over mediums such as the internet and the telephone also subject to the ADA? The courts' approach to this issue has engendered confusion because the above two issues are often merged together.

Those courts that apply a narrow interpretation generally confine Title III to both physical structures and to situations where a covered entity bars disabled individuals from its premises.[33] Conversely, those jurisdictions construing Title III expansively refrain from imposing either restriction as a

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28. *See id.*

29. *See* H.R. REP. NO. 101-485, pt. 2, at 136 (1990), *reprinted in* 1990 U.S.C.C.A.N. 303, 419.

30. *See id.*

31. *See* 42 U.S.C. § 12181(7)(F).

32. Insurance often involves relationships that are more complicated than the typical market interaction. For example, employment insurance policies tend to be provided in the form of group policies and traditionally incorporate three parties: the policyholder, the insurer, and the employer. *See* ROBERT H. JERRY, II, UNDERSTANDING INSURANCE LAW 49 (1996). See *infra* note 109 for further discussion about group insurance policies. A strict interpretation of "public accommodation" fails to consider that entities that provide essential services to the public may do so in ways beyond a strict physical construction of the statute.

33. Part II.A discusses in detail the rationale supporting a narrow interpretation applied by some jurisdictions.

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requirement for a claimant's prima facie case.[34] This part discusses the competing interpretations of "public accommodation" and suggests that an expansive reading of Title III is the most reasonable interpretation in light of the ADA's broad mandate against discrimination.

A. Limiting "Public Accommodation" to Issues of Physicality and Locality

To determine the definition of "public accommodation" and the extent to which such an entity can be held accountable, courts have relied on several arguments of statutory construction. They argue that the statutory canon *noscitur a sociis*[35] renders a liberal construction of Title III incorrect.[36] The courts also contend that a conservative reading of Title III coincides with the interpretative guidelines proffered by the Department of Justice ("DOJ").[37]

In *Parker v. Metropolitan Life Insurance Co.*,[38] the Sixth Circuit, sitting en banc, determined that the plain meaning of the statutory language limited "public accommodations" to physical structures.[39] The court's

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34. *See infra* Part II.B.

35. Black's Law Dictionary defines *noscitur a sociis* as "it is known by its associates," as "a canon of construction holding that the meaning of an unclear word or phrase should be determined by the words immediately surrounding it." BLACK'S LAW DICTIONARY 1084 (7th ed. 1999).

36. *See infra* notes 53-63 and accompanying text.

37. *See* 28 C.F.R. pt. 36, app. B (1999).

38. 121 F.3d 1006 (6th Cir. 1997). The Western District Court of Tennessee determined that the plaintiff failed to state a claim under Title III because she was not actually denied access to the offices of the defendant insurance company. *See* Parker v. Metropolitan Life Ins. Co., 875 F. Supp. 1321, 1327 (W.D. Tenn. 1995). The Sixth Circuit, sitting as a three-judge panel, reversed the trial court and concluded that the plain meaning of the statute is not limited to physical structures. *See* Parker v. Metropolitan Life Ins. Co., 99 F.3d 181, 188-89 (6th Cir. 1996). The en banc decision followed the defendant's appeal.

39. The Fifth Circuit recently determined that "public accommodation" should be strictly construed to access to the goods and services offered by a covered entity. *See* McNeil v. Time Ins. Co., No. 98-10585, 2000 WL 217500, at *6 (5th Cir. Feb. 24, 2000). In *McNeil*, the court was asked to consider whether an insurance policy that provides limited treatment for AIDS violates Title III. *See id.* at *4. The court, relying on the interpretations offered by the Third and Sixth Circuits, affirmed the lower court's conclusion that Title III refers only to "physical use of the services of a public accommodation." *Id.* at *2. The D.C. Circuit has not rendered a decision concerning the scope of "public accommodation," but several district courts have addressed the issue and applied a restrictive interpretation. *See* Fitts v. Federal Nat'l Mortgage Ass'n, 44 F. Supp. 2d 317, 323 (D.D.C. 1999) (interpreting Title III to be limited to physical access); Fennell v. Aetna Life Ins. Co., 37 F. Supp. 2d 40, 44 (D.D.C. 1999) (limiting "public accommodation" to locality). *But see* Wai v. Allstate

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strict textual analysis of the ADA is limited. The court interpreted the list of "public accommodations" to include solely physical places from which goods and services are offered to society.[40] Specifically, section 12182(a) provides that "[n]o individual shall be discriminated against on the basis of disability in the full and equal enjoyment of goods . . . of any *place* of public accommodation."[41] The court referred to the DOJ's interpretation of "place."[42] The DOJ defines "place" to mean "a facility, operated by a private entity, whose operations affect commerce and fall within at least one of the twelve specified categories."[43] The term "facility" constitutes "all or any portion of buildings, structures, sites, complexes, equipment, rolling stock or other conveyances, roads, walks, passageways, parking lots, or other real or personal property, including the site where the building, property, structure, or equipment is located."[44] Relying on these definitions, the court determined that the scope of Title III applies solely to "facilities" or "places of public accommodations."[45]

The *Parker* court also concluded that the defendant insurance company was not a "public accommodation" because the nexus between the insurer and the employee was insufficient.[46] The public could not enter the office

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Ins. Co., No. 97-01551, 1999 U.S. Dist. LEXIS 16273, at *23 (D.D.C. Sept. 30, 1999) (extending the protection of Title III beyond physical entry).

40. *See Parker*, 121 F.3d at 1010. The court underscored the distinction between confining Title III to physical structures and limiting the provision to issues of physical access. *See id.* at 1011 n.3. Additionally, the majority rejected Justice Merritt's contention that the court renders a decision that also limits Title III to physical access. *See id.*

41. 42 U.S.C. § 12182(a) (1995) (emphasis added).

42. *See Parker*, 121 F.3d at 1011. The Sixth Circuit also presented this rationale in an earlier decision. *See* Stoutenborough v. National Football League, Inc., 59 F.3d 580, 583 (6th Cir. 1995). In *Stoutenborough*, the court determined that the broadcast of a "blacked-out" football game was not a "place of public accommodation." *See id.*

43. 28 C.F.R. pt. 36, app. B (1999).

44. *Id.*

45. There are several other courts that have also limited public accommodations to physical structures. *See* Fennel v. Aetna Life Ins. Co., 37 F. Supp. 2d 40, 44 (D.D.C. 1999); Brown v. 1995 Tenet Paraamerica Bicycle Challenge, 959 F. Supp. 496, 498 (N.D. Ill. 1997); Baker v. Hartford Life Ins. Co., No. 94 C 4416, 1995 U.S. Dist. LEXIS 14103, at *9 (E.D. Ill. Sept. 28, 1995); Pappas v. Bethesda Hosp. Ass'n, 861 F. Supp. 616 (E.D. Ohio 1994).

46. *See also* Lenox v. Healthwise of Kentucky, LTD., 149 F.3d 453, 456 (6th Cir. 1998) (reaffirming the *Parker* decision). This Comment does not specifically address Title III claims brought within the employment context, but the same issues concerning the definition of "public accommodation" and access are present. Other courts that have reached similar results include *Fitts v. Federal National Mortgage Ass'n*, 44 F. Supp. 2d 317, 323-24 (D.D.C. 1999) (holding that an employment benefits plan is not a "public

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of the defendant employer or insurance company and purchase the same policy that the plaintiff obtained.[47] Thus, the relationship between the benefits allegedly provided in an unlawful manner and the goods and services offered to the public were too tenuous to satisfy the definition of "public accommodation."[48] To support its contention that employers serve as an intervening force in the chain of causation, the court again referred to the DOJ guidelines: "[t]he Department intends for wholesale establishments to be covered . . . as places of public accommodation except in cases where they sell exclusively to other businesses and not to individuals . . . ."[49] Ultimately, the lack of nexus not only prevents a plaintiff from raising a successful discrimination claim, but also bars any Title III claim against an insurance company.

Judge Merritt strongly dissented on the grounds that the majority's decision contradicts the fundamental purpose of the ADA to eliminate discrimination.[50] Additionally, if insurers are not considered "public accommodations," then the limitations delineated in the "safe harbor" provision pertaining to entities that sponsor or administer insurance policies are superfluous.[51] In other words, Title V's inclusion of insurance is unnecessary because almost all potential plaintiffs would be prevented from raising a claim under a narrowly defined Title III. Finally, Judge Merritt relied on the legislative history of the ADA to buttress his arguments. The House Reports stipulate that insurance companies may continue to utilize underwriting techniques so long as the practices are supported by "sound actuarial data and not on speculation."[52] Accordingly,

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accommodation"); *Fennel*, 37 F. Supp. 2d at 44 (determining that Title III only applies to physical places and, therefore, does not reach an employment insurance policy); *Rome v. MTA/New York City Transit*, 97-CV-2945, 1997 U.S. Dist. LEXIS 23436, at *14 (E.D.N.Y. Nov. 18, 1997) (concluding that a Title III claim is inappropriate when involving an employer-provided plan because such policies do not constitute a place); *Leonard v. Israel Discount Bank*, 967 F. Supp. 802, 804 (S.D.N.Y. 1997), *vacated*, 199 F.3d 99 (2d Cir. 1999) (finding that Title III does not apply to employment-related insurance plans).

47. *See Parker*, 121 F.3d at 1011.

48. *See id.*

49. 28 C.F.R. pt. 36, app. B (1999).

50. *See Parker*, 121 F.3d at 1021 (Merritt, J., dissenting). Judge Merritt expounded, "[i]t boggles the mind to think that Congress would include only the few people who walk into an insurance office to buy health insurance but not the millions who get such insurance at work." *Id.*

51. *See id.* at 1020.

52. *Id.* at 1021. Judge Merritt alluded to the portion of the House Report discussing the role of Title V. *See also* H.R. REP. NO. 101-485, pt. 3, at 71 (1990), *reprinted in* 1990 U.S.C.C.A.N. 445, 494.

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an insurance company that administers a discriminatory insurance policy may be liable under Title III unless the terms and conditions are supported by accepted underwriting techniques.

The Third Circuit, in *Ford v. Schering-Plough Corp.*,[53] concluded that the proper interpretation of Title III limits the provision to direct access to physical structures. The *Ford* court considered whether an employee benefit plan improperly differentiated between mental and physical disabilities.[54] Before reaching the issue concerning the substantive terms of the policy, the court determined that the definition of "public accommodation" did not include the defendant insurance company. Statutory mechanics dictate that Title III should be confined to merely physical structures. The doctrine of *noscitur a sociis* states that ambiguous terms should be interpreted in the context of the accompanying words of the statute.[55] This approach attempts to limit the courts' ability to give undue breadth to statutes promulgated by Congress.[56] Interpreting the term "public accommodation" to include access to goods and services beyond that of physical entry unnecessarily expands the meaning of the text. Though the Third Circuit considered the text of the ADA, and the DOJ interpretative guidelines, the court failed to determine the plain meaning of the language.[57]

In *Weyer v. Twentieth Century Fox Film Corp.*,[58] the Ninth Circuit recently considered the scope of "public accommodation." The plaintiff participated in a long-term disability plan that provided different coverage for those suffering from mental conditions and those with physical disabilities.[59] In affirming the district court's grant of summary judgment

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53. 145 F.3d 601 (3d Cir. 1998), *cert. denied*, 525 U.S. 1093 (1999).

54. The plaintiff was an employee of the co-defendant Schering-Plough Corporation where she participated in a welfare benefit plan. *See id.* at 603. The plan provided different and unequal treatment for mental and physical disabilities favoring the latter. *See id.* at 604. Those suffering from physical disabilities were eligible for benefits up to the age of sixty-five whereas mental disabilities were only covered up to two years. *See id.* Subsequently, the plaintiff was diagnosed with a mental disability and brought a claim against her employer and the provider, Metropolitan Life Insurance Company. *See id.* The district court granted the defendant's motion to dismiss. *See id.*

55. *See Ford*, 145 F.3d at 614.

56. *See id.*

57. The court also neglected to examine the legislative history of the ADA. *See id.* at 613.

58. 198 F.3d 1104 (9th Cir. 2000).

59. *See id.* at 1107. The plaintiff obtained the policy through her employment with the defendant. *See id.* The policy provided benefits for mental disabilities for a period up to

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in favor of the defendant insurer, the court adopted the reasoning proffered by the Third and Sixth Circuits.[60] The court conceded that an "insurance office" is a "place of public accommodation."[61] This is not, however, a generous concession because "public accommodation" is interpreted to consist only of physical structures.[62] Additionally, to refute a more expansive interpretation, the court applied the doctrine of *noscitur a sociis* to the list of "public accommodations."[63] In other words, the plaintiff could not allege discrimination under Title III because the benefit plan did not constitute a physical place and, accordingly, was not a "public accommodation." Therefore, the cause of action alleged against the defendant insurance company failed to state a legally cognizable claim.

B. An Expansive Interpretation of Who Constitutes a "Public Accommodation"

While some courts interpret Title III narrowly to reach only physical structures and direct access, several jurisdictions have arrived at a contrary result extending the provision to include insurers as "public accommodations." There are four major arguments supporting the proposition that insurance providers are "public accommodations" pursuant to Title III. First, the list of "public accommodations" encompasses service establishments that do not necessitate physical access to obtain the offered good.[64] Second, courts view the expansive language of Title III's

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one year and those who were physically disabled were eligible for coverage until age sixty-five. *See id.*

60. It is interesting to note that a significant number of district courts within the Ninth Circuit, prior to the *Weyer* decision, employed a more expansive interpretation. *See* Dunlap v. Association of Bay Area Govt's, 996 F. Supp. 962, 965 (N.D. Cal 1998) (holding that an employer-sponsored plan is a "public accommodation"); Chabner v. United of Omaha Life Ins. Co., 994 F. Supp. 1185, 1192 (N.D. Cal. 1998) (concluding that Title III covers not only access to "public accommodations," but the substantive elements of goods such as insurance policies); Cloutier v. Prudential Ins. Co. of Am., 964 F. Supp. 299, 302 (N.D. Cal. 1997) (implementing a broad meaning of "public accommodation"); Shultz v. Helmet Youth Pony League, 943 F. Supp. 1222, 1225 (C.D. Cal. 1996) (holding that a limited interpretation of "public accommodation" would produce irrational results unintended by Congress); Kotev v. First Colony Life Ins. Co., 927 F. Supp. 1316, 1321-22 (C.D. Cal. 1996) (stating that the statutory language supports an expansive reading of Title III).

61. *See Weyer*, 198 F.3d at 1114.

62. *See id.*

63. *See id.*

64. Courts refer to the inclusion of "travel agent" as an example of service establishments that do not require physical entry to acquire its goods. *See* 42 U.S.C. § 12181(7)(F) (1995).

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substantive provisions as an indication that "public accommodation" involves more than just access to physical structures: the phrase "full and equal enjoyment of the goods and services . . . of any place of public accommodation"[65] suggests that "covered entities" include establishments that provide services over other mediums such as the telephone and the internet. Third, the use of the article "of" rather than "in" connotes a meaning extending beyond mere access to physical structures to other forms of access. Finally, because the ADA's legislative history indicates that Congress intended the ADA to serve as a broad prohibition against discrimination, immunizing the insurance industry from Title III claims would contradict the purpose of the ADA.

The First Circuit, in *Carparts Distribution Center, Inc. v. Automotive Wholesaler's Ass'n*,[66] concluded that the examples listed in the "service establishments" category suggest that physical entry by the public is not the defining characteristic of a "public accommodation."[67] The court rejected the trial court's determination that "public accommodations" are limited to physical structures and held that it erroneously dismissed the claim, in part, on the ground that Title III does not apply to the defendant insurer.[68] Therefore, insurance companies are "public accommodations" regardless of the method by which they sell their policies.[69] Though arguing that the plain meaning of the term "public accommodation" does not have to be limited to physical structures, the court conceded that the term is, at the very least, ambiguous.[70] Yet, a definition based upon physical entry would produce irrational results: one who enters an office to purchase a service is protected by the ADA, but if one receives the same service over the telephone they are not.[71] Title III does not make any clear reference to

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65. *Id.* § 12182(a).

66. 37 F.3d 12 (1st Cir. 1994).

67. *See id.* at 19.

68. *See id.* at 21. The court also remanded the case to the district court to reconsider the employment provisions of the ADA (Title I) because the trial court had determined that Automotive Wholesaler's Association of New England was not a "covered entity" under the ADA. *See id.* at 17-18.

69. *See id.*

70. *See id.*

71. *See id.* This decision applies equally to insurance policies provided within the employment context. Though the court did not expressly address the nexus issue later used by the Third, Sixth, and Ninth Circuits, the facts of the case involve an insurance policy sponsored by the employer. *See id. See also* Conners v. Maine Med. Ctr., 42 F. Supp. 2d 34, 46 (D. Me. 1999). In *Carparts*, the plaintiff was an employee of Carparts Distribution Center, that offered a self-funded medical plan through the co-defendant, Automotive Wholesaler's Association of New England. *See Carparts*, 37 F.3d at 19-20. The court's

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physical boundaries to support the district court's conclusion, nor does it indicate that the provision should be limited to physical access.[72]

The court also determined that an expansive interpretation of "public accommodation" could find support in the legislative history of the ADA.[73] The Reports explaining the application of Title III emphasize the importance of equal access to establishments offering public goods and services.[74] Congress proclaimed that the ADA was to serve "as a clear and comprehensive mandate for the elimination of discrimination against individuals with disabilities."[75] Accordingly, Congress intended disabled individuals to have equal access to the entire spectrum of goods and services made available to the public by private establishments.[76] Therefore, the ADA's broad purpose concerning discrimination requires a

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liberal interpretation of Title III also applies to insurance companies that administer employee-benefit plans. *See* Attar v. UNUM Life Ins. Co. of Am., No. 3-96-CV-0367-R, 1997 U.S. Dist. LEXIS 23254, at *39-*42 (N.D. Tex. July 19, 1997) (agreeing with the First Circuit in that a private entity that provides an insurance policy is a "public accommodation"). The benefits plan in *Carparts* was self-funded and could raise issues pertaining to the interplay between the ADA and the Employment Retirement Income Security Act ("ERISA"). *See* Nancy Lee Firak, *Threshold Barriers to Title I and Title III of the Americans with Disabilities Act: Discrimination Against Mental Illness in Long-Term Disability Benefits*, 12 J.L. & HEALTH 205, 215 (1998). ERISA, however, only addresses insurance plans that are funded by the employer itself and, therefore, policies purchased from insurance companies are untouched by the preemption clause and are regulated primarily by state law. *See* Ted Storer, *The Americans With Disabilities Act: Will the Insurance Field Change?*, 20 OHIO N.U. L. REV. 1031, 1041 (1994).

72. *See Carparts*, 37 F.3d at 20. Several courts have relied on *Carparts* to reject limitations concerning physical structures and physical access. *See, e.g.*, *Conners*, 42 F. Supp. 2d at 46; Doukas v. Metropolitan Life Ins. Co., 882 F. Supp. 1197 (D.N.H. 1995). There are several district courts that have considered the "public accommodations" issue and held that Title III extends beyond access. *See, e.g.*, Lewis v. Aetna Life Ins. Co., 982 F. Supp. 1158, 1165 (E.D. Va. 1997) (determining that Title III prohibits insurance providers from discriminating against disabled individuals whether they purchased the policy directly from the provider or through some other means); *Attar*, 1997 U.S. Dist. LEXIS 23254, at *41-*42 (holding that Title III is not limited to physical access to places of "public accommodation"); World Ins. Co. v. Branch, 966 F. Supp. 1203, 1207 (N.D. Ga. 1997) (concluding that the scope of Title III incorporates more than just physical access).

73. *See Carparts*, 37 F.3d at 19. *See also* Winslow v. IDS Life Ins. Co., 29 F. Supp. 2d 557, 562-63 (D. Minn. 1998); *Doukas*, 950 F. Supp. at 427.

74. *See Carparts*, 37 F.3d at 19. The court specifically discusses the implications of the Reports. *See* H.R. REP. NO. 101-485, pt. 2, at 24, 99 (1990), *reprinted in* 1990 U.S.C.C.A.N. 303, 305, 383. *See also* S. REP. NO. 101-116, at 3, 56 (1989).

75. 42 U.S.C. § 12101(b)(1) (1995).

76. *See Carparts*, 37 F.3d at 19.

liberal reading of the statute's language, otherwise, judicial application of the act would compromise the very *raison d'être* of the ADA.[77]

In *Doe v. Mutual of Omaha Insurance Co.*,[78] the plaintiffs brought suit against Mutual of Omaha alleging, *inter alia*, that their insurance policies improperly placed significant limits on benefits available to those suffering from AIDS or AIDS-related conditions (ARC) and, therefore, constituted discrimination in violation of Title III.[79] Judge Posner, writing for the court, relied primarily on textual analysis to justify including entities that provide goods or services in a manner that does not require the plaintiff to be actually present. The plain meaning of "full and equal enjoyment" dictates that a "public accommodation," whether in a physical or electronic space, cannot prevent disabled individuals from entering the facility and then from using that facility in any way available to an uninhibited individual.[80] According to Posner's interpretation, the defendant insurer may not escape Title III liability by claiming that it is not a "public accommodation" merely because the claimant did not physically purchase the policy at its office.[81]

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77. The court does concede that the debate concerning the definition of "public accommodation" is far from clear and questions whether there is any real distinction between access and the actual substance of the good or service being offered. *See id.*

78. 179 F.3d 557 (7th Cir. 1999), *cert. denied*, 120 S. Ct. 845 (2000). The plaintiff's insurance policies limited benefits associated with AIDS and ARC to a lifetime maximum of $100,000 or less. *See* Doe v. Mutual of Omaha Ins. Co., 999 F. Supp. 1188, 1190 (N.D. Ill. 1998), *rev'd*, 179 F.3d 557 (7th Cir. 1999), *cert. denied*, 120 S. Ct. 845 (2000). The amount of medical care available for other conditions was a lifetime maximum of one million dollars. *See id.*

79. *See Mutual of Omaha*, 999 F. Supp. at 1191. Plaintiffs also alleged that Mutual of Omaha's actions violated Section 364 of the Illinois Insurance Code. *See id.*

80. *See Mutual of Omaha*, 179 F.3d at 559. To illustrate his point, Judge Posner provided an example – the proprietor of a camera store can neither prevent a disabled individual from entering the store nor allow entry, but may refuse to sell his cameras on the same terms as other consumers. *See id.*

81. Several district courts in the Seventh Circuit arrived at a contrary conclusion. *See, e.g.*, Brown v. 1995 Tenet Paraamerica Bicycle Challenge, 959 F. Supp. 496, 498 (N.D. Ill. 1997) (holding that Title III only applies to physical structures); Erwin v. Northwestern Mut. Life Ins. Co., 999 F. Supp. 1227, 1233 (S.D. Ind. 1998) (concluding that a "public accommodation" consists of a physical space). *But see* Baker v. Hartford Life Ins. Co., No. 94-C-4416, 1995 U.S. Dist. LEXIS 14103, at *9 (N.D. Ill. Sept. 28, 1995) (interpreting Title III so that the plaintiff does not have to be physically present at the place of "public accommodation" to bring a viable cause of action).

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The Second Circuit, in *Pallozzi v. Allstate Life Insurance Co.*,[82] also concluded that the language of the ADA supports a more expansive reading of "public accommodation."[83] The *Pallozzi* court buttressed its inclusion of the defendant insurer as a "public accommodation" by setting forth a third textual explanation. Title III states that disability-based discrimination concerning the goods or services "*of* a place of public accommodation" is prohibited by the ADA.[84] The terms "of" and "in" are not synonymous and, furthermore, there is no indication within the text that the term "of" should be read to connote "in a place of public accommodation."[85] If Congress intended for Title III to deal solely with physical access to "public accommodations," then it could have simply stated "in a place of public accommodation" rather than "of a place of public accommodation."

The court also rejected the defendant insurer's argument that insurance policies do not qualify as goods or services "of a public accommodation." The list of "public accommodations" includes entities that offer goods or services customarily used outside the actual premises.[86] Accordingly, a narrow interpretation of "public accommodation" would not reach, for example, a bakery that declines to sell bread to a disabled individual.[87] The court concluded that this result would be contrary to the purpose of the ADA and, therefore, the text does not justify a limited reading of Title III.[88]

C. "Public Accommodation" Should Be Defined to Extend Beyond Both Physical Structures and Physical Access

A narrow interpretation of Title III is problematic for several reasons. Construing Title III to apply solely to locality and physical access ignores the plain meaning of the text and congressional intent. Additionally, the

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82. 198 F.3d 28 (2d Cir. 2000). The Second Circuit amended its original decision upon denial for rehearing.

83. Akin to the Seventh Circuit, several district courts in the Second Circuit concluded otherwise prior to the *Pallozzi* decision. *See* Rome v. MTA/New York City Transit, No. 97-CV-2945, 1997 U.S. Dist. LEXIS 23436, at *14-*15 (E.D.N.Y. Nov. 19, 1997) (holding that the plain language of the statue indicates that a "public accommodation" is a physical place); *see also* Leonard v. Israel Discount Bank, 967 F. Supp. 802, 804 (S.D.N.Y. 1997), *vacated*, 199 F.3d 99 (2d Cir. 1999) (arguing that Title III only applies to access to physical structures).

84. *See Pallozzi*, 198 F.3d at 33 (emphasis added).

85. *See id.*

86. *See id.*

87. *See id.*

88. *See id.* The court does not address the import of the legislative history or the DOJ guidelines because it finds the text determinative. *See id.*

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guidelines published by the DOJ are consistent with a more expansive reading of the ADA. Proponents of a narrow interpretation emphasize the inclusion of the term "place" in section 12182(a) to combat the otherwise broad language present in Title III.[89] The list of "public accommodations" arguably refers to physical entities and provides some support for a reading focusing on locality. Accordingly, a "public accommodation" is a physical structure, or at the very least, an entity from which the plaintiff must directly purchase the good or service.[90] This is a clever demonstration of statutory construction, but it is unsubstantiated by the statutory make-up of the ADA.

The language of Title III supports an expansive interpretation of "public accommodation." The "full and equal enjoyment" clause is an open-ended statement enabling the judiciary to consider an array of unlawful conduct that may fall within the parameters of Title III.[91] Specifically, section 12182(a) addresses conduct that effectively denies or limits the ability of disabled individuals to obtain goods offered by a "public accommodation," or practices that tend to segregate such individuals from society.[92] Congress further explained the far-reaching effect of Title III by enumerating several forms of discrimination that limit or exclude disabled individuals from participating in or purchasing goods and services from a "public accommodation."[93] Yet, even these provisions consist of expansive language. The chosen terminology may complicate the judiciary's ability to identify with precision which claims are legitimate under Title III, but the language does little to confine the reach of the ADA in terms of who or what constitutes a "public accommodation."[94]

The District Court of Maine, in *Conners v. Maine Medical Center*,[95] relied on the broad language present throughout Title III to conclude that the defendant insurance company was a "public accommodation."[96] Relying on the *Carparts* decision, the court refuted the import of the term "place," and opined that the list of "public accommodations" included

89. The paragraph reads in part, "No individual shall be discriminated against on the basis of disability in the full and equal enjoyment of the goods . . . of any *place* of public accommodation . . . ." 42 U.S.C. § 12182(a) (1995) (emphasis added).

90. *See supra* Part II.A.

91. *See* 42 U.S.C. § 12182(a).

92. *See id.* § 12182(b)(1)(A)(i)-(iii).

93. *See id.* § 12182(b)(2)(A)(i)-(v).

94. *See* Doukas v. Metropolitan Life Ins. Co., 950 F. Supp. 422, 425 (D.N.H. 1996).

95. 42 F. Supp. 2d 34 (D. Me. 1999).

96. *See id.* at 46. The court defers to the First Circuit's decision in *Carparts Distribution Center v. Automotive Wholesaler's Ass'n*. *See id.*; *see also supra* note 72.

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some entities, such as "travel agency," which demonstrate congressional intent to expand Title III beyond issues of locality and physical access.[97] However, as the *Parker* court determined, this argument is somewhat problematic considering that the majority of examples present in section 12181(7) do suggest an emphasis on locality.[98]

The *Parker* court misconstrues the meaning of the term "place" to refer to direct physical access. Section 12182(a) prohibits discrimination against disabled individuals in the "full and equal enjoyment" of goods and services "of any place of public accommodation."[99] Every "public accommodation" operates at some "place" or structure from which it interacts with the public. The entity may sell and advertise its products through a variety of mediums such as the internet, telephone, or direct physical transactions. The defining characteristic of a "public accommodation," therefore, is that the entity offers its goods and services to the public.[100] Moreover, the DOJ emphasizes that an entity constitutes a "public accommodation" if at least a portion of its business deals with the public.[101] Accordingly, the question concerning the "place of a public accommodation" is not whether goods and services are offered to consumers who enter the entity's facility, but whether the entity offers goods and services through any medium from its "place" to the public.

The contractual clause of the general anti-discrimination provision also counters the problem identified by the *Parker* court. Each of the enumerated forms of proscribed discrimination contain a clause stipulating that a "public accommodation" cannot do indirectly what it is prohibited from doing directly. In *Lewis v. Aetna Life Insurance Co.*,[102] the Eastern

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97. *See* Carparts Distribution Ctr. v. Automotive Wholesaler's Ass'n, 37 F.3d 12, 19 (1st Cir. 1994).

98. *See* Parker v. Metropolitan Life Ins. Co., 121 F.3d 1006, 1014 (6th Cir. 1997).

99. 42 U.S.C. § 12182(a) (1995).

100. Title III defines "public accommodation" as a private entity that affects commerce and also falls under one of the categories enumerated in section 12181(7). *See id.* § 12181(7).

101. The DOJ explains that a wholesale company is only a "public accommodation" if its operation, or part of its operation, deals with the public and not retailers. *See* 28 C.F.R. pt 36, app. B (1999). Accordingly, a wholesale company that grows produce and supplies it to entities that process its crops would not necessarily be a "public accommodation." *See id.* If the company, however, operates a road-side stand and sells its produce to the public, then those operations would be subject to Title III regulations. *See id.*

102. 982 F. Supp. 1158 (E.D. Va. 1997). In *Lewis*, the plaintiff was diagnosed with severe depression and received treatment for his condition. *See id.* at 1159. He was subsequently employed by the defendant and enrolled in the employee benefit plan. *See id.* When his conditioned worsened, the plaintiff began receiving benefits, but the plan only

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District Court of Virginia relied on the contractual clause to subject the insurance company to ADA requirements.[103] The court rejected the defendant insurer's argument that it was not a "public accommodation" because the employee did not purchase his benefit plan directly from the insurance company.[104] Title III stipulates that it is "discriminatory to subject an individual or a class of individuals on the basis of a disability or disabilities of such individual or class, directly *or through contractual, licensing, or other arrangements* to a denial of the opportunity . . . to participate in or benefit from the goods, services . . . or accommodations of an entity."[105] According to Title III, an insurer's status as a "public accommodation" remains unaffected by the fact that an intermediary party may exist between the insured and the insurer.[106] Thus, an entity that provides services to the public, through direct or indirect means, from its "place" constitutes a "public accommodation."

Under the *Lewis* court's interpretation of section 12182(b)(1)(A), an employer cannot serve as a vessel for the insurer to discriminate against disabled individuals. The House Reports state that the contractual clause pertains only to those individuals who are clients or customers of the "public accommodation."[107] The DOJ provides an illustration to explain the role of the contractual clause in the calculus of determining who constitutes a "public accommodation:" if an amusement park contracts with a food service company to operate its restaurants on the premises of the park, the amusement park is not liable for the discriminatory conduct of the food service company directed at individuals or entities not clients of the

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covered a twenty-four month period for mental disabilities. *See id.* at 1159-60. The plaintiff brought suit, alleging discrimination under Title III of the ADA. *See id.* at 1160.

103. *See id.* at 1163.

104. *See id.* at 1165. The court adopted the First Circuit's interpretation of "public accommodation" to extend beyond mere access to physical structures. *See id.* at 1164.

105. 42 U.S.C. § 12182(b)(A)(i) (emphasis added).

106. *See Lewis*, 982 F. Supp. at 1165.

107. *See* H.R. REP. No. 101-485, pt. 2, at 101-02 (1990), *reprinted in* 1990 U.S.C.C.A.N. 303, 384-85. The Report stipulates in relevant part:

> The intent of the contractual prohibitions of section 302(b)(1)(A)(ii)-(iii) is to prohibit a public accommodation from doing indirectly through a contractual relationship, what it may not do directly. Thus, the 'individual or class of individuals' referenced in section 302(b)(1)(A)(i)-(iii) has always been intended to refer to the clients and customers of the public accommodation that entered into a contractual arrangement.

Id.

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park.[108] Title III does not attach liability to a "public accommodation" merely because it is associated with an entity that discriminates against disabled individuals.[109] Therefore, the list of "public accommodations" does refer in part to physical entities, but Title III does not require direct service from the entity's physical location.

The ambiguous language of Title III necessitates consideration of the overarching purpose of the ADA. When a court attempts to clarify a textual ambiguity, it must first look to congressional intent because the "purpose of Congress is the ultimate touchstone."[110] Accordingly, courts should emphasize the expressed purpose of the ADA to determine the scope of Title III and the definition of "public accommodation." The existing debate among the courts indicates the ambiguity surrounding the definition of "public accommodation." The list of "public accommodations" is also unclear because one can construe the list to limit coverage to physical structures where the public has physical access.[111] Finally, the use of the term "place" produces some ambiguity as to how "public accommodation" should be interpreted. Yet, Congress explicitly stated that the ADA is "to provide a clear and comprehensive national mandate for the *elimination of discrimination* against individuals with disabilities . . . ."[112] The undisputed function of the ADA renders a narrow interpretation of Title III nonsensical. Therefore, reading Title III to apply only to physical structures, or only to entities that deal directly with the plaintiff, contradicts the plain meaning of the text and the statutory purpose of the ADA.

The purpose of the ADA also lends some clarity to the DOJ interpretative guidelines that several of the courts have opposed when limiting the scope of Title III. The DOJ reads the "full and equal

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108. *See* 28 C.F.R. pt. 36, app. B (1999).

109. An employee benefit plan differs from an ordinary contract between an individual insured and an insurance company in that the policy incorporates three parties. *See* JERRY, *supra* note 32, at 828. The tripartite contract usually consists of the insurer, the group representative, and the insureds. *See id.* Typically, group policies are formulated in the employment context and, therefore, the group representative tends to be the employer while the employees typically make up the policyholders. *See id.* The fundamental relationship exists between the insurer and the employees; thus, the employer merely serves as the intermediary between the two essential parties to the insurance contract. *See id.* at 829. Therefore, the employees are the clients or consumers of the insurance company and, accordingly, the insurer falls within the definition of "public accommodation."

110. Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 45 (1987).

111. *See* 42 U.S.C. § 12181(7) (1995).

112. *Id.* § 12101(b)(1) (emphasis added).

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enjoyment" clause expansively in accordance with congressional intent, though it makes a point in explaining that equal opportunity does not necessitate identical results.[113] Additionally, the scope of Title III is broad enough to include an entity that "owns, leases, leases to, or operates a place of public accommodation."[114] The DOJ stipulates that the entities themselves, not the "places" of the entities, that satisfy the definition of "public accommodation" are subject to the anti-discrimination provisions.[115] Therefore, the DOJ's interpretation of "public accommodation," and its explanation of the contractual clause, coincide with the language of Title III in supporting the inclusion of insurance companies.

III. DOES TITLE III COVER THE SUBSTANTIVE ELEMENTS OF INSURANCE POLICIES PROVIDED BY "PUBLIC ACCOMMODATIONS?"

The majority of jurisdictions presented with the question of whether the ADA possesses the authority to police insurance practices have concluded that Title III does not reach the nature of the goods and services proffered by "public accommodations."[116] An interpretation broadening the scope of the ADA to include the substantive elements of insurance policies raises questions concerning the accepted practices of the insurance industry and the purpose of the McCarran-Ferguson Act. Despite the ambiguity surrounding the ADA, and the variety of explanations proffered by the individual jurisdictions, the prevailing view immunizes the insurance industry from Title III claims.

Part II of this Comment concluded that insurance companies constitute "public accommodations." The question then becomes whether a claimant may raise a Title III claim alleging that the terms and conditions of the insurance policy discriminate on the basis of disability. Or is a disabled individual only entitled to assert a Title III claim if the insurance company refuses to provide coverage solely because of the individual's disability?

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113. *See* 28 C.F.R. pt. 36, app. B. The DOJ states that the "full and equal enjoyment" clause provides disabled individuals with the right to equal opportunity to obtain the same results as others, but this does not mean that the results will have an identical effect on both disabled and non-disabled individuals. *See id.*

114. *Id.*

115. *See id.*

116. This Comment critiques those courts that apply a limited interpretation of Title III. *See infra* Part III.B.

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A. Does the Language of Title III Indicate That Congress Intended the ADA to Regulate Insurance Practices?

The most prominent textual argument supporting a restrictive interpretation is the absence of substantive regulatory language. In determining that the content of an insurance policy is beyond the reach of Title III, the Seventh Circuit explained that the absence of such language is just too conspicuous and, therefore, Congress could not have intended for the ADA to reach the terms of insurance contracts.[117] Judge Posner argued that if Congress intended for the ADA to cover the content of insurance policies, then it most likely would have included some standards.[118] In other words, it is illogical for Congress to impose such a heavy burden on the federal judiciary without delineating some process the courts could apply.[119] The lack of guiding principles provided by Congress would require the courts to render decisions unsupported by any discernable legal standard and would increase the likelihood of judicial law-making.

Some courts focus on the "full and equal enjoyment" clause of Title III's anti-discrimination provision[120] when determining whether the ADA reaches underwriting practices. The clause dictates that the manner in which the products are offered by "public accommodations" is subject to the restrictions set forth in Title III. Once a court has determined that an insurance company is a "public accommodation," then that company is prohibited from refusing to sell its "goods and services," namely insurance policies, to disabled individuals on the basis that they are disabled.[121] The Second Circuit presented this argument within the context of a "simple

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117. *See* Doe v. Mutual of Omaha Ins. Co., 179 F.3d 557, 560 (7th Cir. 1999), *cert. denied*, 120 S. Ct. 845 (2000). Judge Evans provided a persuasive dissent arguing that the conduct of the defendant insurance company constituted discrimination prohibited by the ADA. *See id.* at 565 (Evans, J., dissenting). Judge Evans also disputed the majority's McCarran-Ferguson analysis in that the court overstated the impact of ADA regulations on state insurance law. *See id.* at 566.

118. *See id.* The court, in addressing whether the ADA should police underwriting techniques, opined that Congress would have spoken "more plainly" if it intended to regulate insurance practices that have historically and consistently been applied by the industry. *See id.*

119. *See id.* The Ninth Circuit also argued that if Congress intended for the ADA to cover the substantive elements of insurance policies, it would have provided a clear indication considering that the generally accepted marketing practices are to the contrary. *See* Weyer v. Twentieth Century Fox Film Corp., 198 F.3d 1104, 1116 (9th Cir. 2000).

120. *See* 42 U.S.C. § 12182(a) (1995).

121. *See* Pallozzi v. Allstate Life Ins. Co., 198 F.3d 28, 33 (2d Cir. 2000).

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discrimination" case.[122] "Simple discrimination" essentially prohibits a "public accommodation" from refusing to allow a disabled individual from entering its premises, either physically or by other means, and purchasing the goods offered, irrespective of the content of those goods.[123] In contrast, more complex forms of discrimination would involve the specific terms and benefits provided by an insurance policy allegedly biased against certain forms of disability. The question then becomes whether the ADA proscribes both forms of discrimination.[124] If this is not the case, then a "public accommodation" could refuse to sell products that are better suited for disabled individuals and not be subject to Title III so long as the disabled individual is afforded equal opportunity to purchase the items for sale.

The language of Title III has led some courts to conclude that the ADA prohibits any form of discrimination that may stem from the terms of an insurance policy. In *Doukas v. Metropolitan Life Insurance Co.*,[125] the district court held that the plain meaning of Title III extends the scope of the ADA to include the contents of an insurance policy.[126] The statute stipulates that "[i]t shall be discriminatory to provide an individual or class of individuals, on the basis of a disability . . . with a good, service, facility, privilege, advantage, or accommodation that is *different* or separate from that provided to other individuals . . . ."[127] The term "different" refers to the substance of the goods offered, rather than only access to the "public accommodation" and the products themselves.[128] Moreover, the breadth and diversity of the restrictions imposed by the "specific prohibition" paragraphs suggest that the statute is intended to extend beyond access issues to the content of goods such as insurance policies.[129] Thus, the

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122. *See generally id.*

123. Judge Posner describes a "public accommodation's" refusal to allow disabled individuals access to its goods as a simple prohibition on discrimination. *See Doe*, 179 F.3d at 564.

124. Accordingly, the *Pallozzi* decision leaves open the question of whether the terms and conditions of an insurance policy are subject to Title III. This Comment addresses this issue in more detail *infra* at Part III.B. and Part IV and answers the question in the affirmative.

125. 950 F. Supp. 422 (D.N.H. 1996).

126. *See id.* at 426. *See also* Lewis v. Aetna Life Ins. Co., 982 F. Supp. 1158, 1167-68 (E.D. Va. 1997).

127. 42 U.S.C. § 12182(b)(1)(A)(iii) (1995) (emphasis added).

128. *See Doukas*, 950 F. Supp. at 426.

129. *See id.* See notes 21-24 and accompanying text for a brief summary of the specific forms of discrimination prohibited by Title III.

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cumulative effect of these provisions has led courts to argue that the plain meaning of Title III incorporates regulatory authority over underwriting practices.

If the terms and conditions of insurance policies are subject to Title III restrictions, then what exactly is prohibited? Some courts have suggested that the prohibition against disability discrimination is not limited to those products that distinguish between disabled and non-disabled individuals.[130] Does Title III also reach insurance practices that are unsubstantiated by actuarial data? This Comment addresses the specific restrictions of the ADA on insurance practices in Part IV. Although these issues are not settled, Title III should be interpreted to cover the substantive elements of insurance policies.

B. Title III Should Be Construed to Reach the Terms and Conditions of Insurance Policies

Part II of this Comment argued that the definition of "public accommodation" includes entities that offer goods and services to the public through means other than direct physical access. The scope of Title III also extends to the nature of the goods and services offered by a "public accommodation." The general anti-discrimination provision incorporates not only the denial of participation, but also the degree to which a disabled individual may enjoy the goods and services offered by a "public accommodation."[131] Section 12182(b)(1)(A)(ii), for example, stipulates that no "public accommodation" shall offer disabled individuals goods and services that are unequal to those offered to non-disabled individuals.[132] Moreover, Title III prohibits a "public accommodation" from providing disabled individuals with a good or service "that is different or separate from that provided to other individuals, unless such action is necessary to

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130. For example, a Georgia district court determined that the ADA covers practices that discriminate between different kinds of disabilities. *See* World Ins. Co. v. Branch, 966 F. Supp. 1203, 1207 (N.D. Ga. 1997), *aff'd in part, vacated in part*, 156 F.3d 1142 (11th Cir. 1998).

131. *See* 42 U.S.C. § 12182(a).

132. *See id.* § 12182(b)(1)(A)(ii). The paragraph specifically states:

> It shall be discriminatory to afford an individual or class of individuals, on the basis of disability or disabilities of such individual or class, directly, or through contractual, licensing, or other such arrangements with the opportunity to participate in or benefit from a good, service, facility, privilege, advantage, or accommodation that is not equal to that afforded to other individuals.

Id.

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provide the individual or class of individuals with a good, service . . . or other opportunity that is as effective as that provided to others."[133] Accordingly, if an insurance company constitutes a "public accommodation," and the goods and services it provides consist of insurance policies, then those policies cannot discriminate against disabled individuals in any manner proscribed by Title III.[134]

Reading Title III so that it excludes the substantive elements of insurance policies would render much of the language superfluous. If Congress intended the "full and equal enjoyment" clause to refer only to degrees of access, and not to the content of the products offered, then it would be unnecessary for Congress to enumerate the distinctions between the types of benefits to be received by individuals.[135] Each paragraph lists the types of benefits that may be proffered by a "public accommodation" such as a "good, service, facility, privilege, advantage, or accommodation . . . ."[136] If Title III applies only to access to the goods and services, then the nature of the product offered by the "public accommodation" is not important. Additionally, if Title III includes the right to buy the product under the same conditions as a non-disabled individual, as expressed by Judge Posner in *Mutual of Omaha*, then it is also unnecessary to list the types of products offered by a "public accommodation."[137] The only relevant issue would be whether disabled individuals possess an equal opportunity to purchase the product.

To avoid this problem, Congress could have simply stated that a "public accommodation" shall not deny or refuse an individual access to its facilities because of that individual's actual or perceived disability. Moreover, if Congress were only concerned with issues of access, then it need not have distinguished unlawful conduct pertaining to architectural barriers from other forms of discrimination involving different or unequal benefits.[138] Congress indicated its intention to apply Title III in a broad manner by including a variety of prohibited discriminatory practices within the provision.[139] Therefore, courts should construe Title III expansively

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133. *Id.* § 12182(b)(1)(A)(iii). *See also Doukas*, 950 F. Supp. at 426.

134. *See* Pallozzi v. Allstate Life Ins., Co., 198 F.3d 28, 33 (2d Cir. 2000).

135. *See* 42 U.S.C. § 12182(b)(1)(A)(i)-(iii).

136. *Id.*

137. *See* Doe v. Mutual of Omaha Ins. Co., 179 F.3d 557, 562 (7th Cir. 1999), *cert. denied*, 120 S. Ct. 845 (2000) (concluding in part that "full and equal enjoyment includes the right to "buy on equal terms" as well as the right to enter a "public accommodation").

138. *See* 42 U.S.C. § 12182(b)(2)(A)(i)-(v).

139. *See id.*

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because it is generally recognized that statutes are not to be interpreted so that much of the language is left meaningless.[140]

The House Reports also clarify the anti-discrimination provision that prohibits a "public accommodation" from providing a disabled individual with products that are "different or separate" from those available to other individuals.[141] The Reports state that "[t]hese general provisions are patterned after the basic, general provisions that exist in other civil rights laws that prohibit discrimination on the basis of race, sex, religion or natural origin."[142] This language strongly indicates that Congress intended to apply section 12182(b)(1)(A)(2)(iii) to disability-based distinctions in a manner similar to that of other civil rights statutes. For example, in *Los Angeles Department of Water and Power v. Manhart*,[143] the United States Supreme Court concluded that Title VII prohibits an employer from using gender stereotypes to determine pension premiums, even if the generalizations are widely accepted as true.[144] Title VII is construed to include not only access to the contract, but also to the substantive treatment of the protected class by the covered entity.[145] Therefore, the inclusion of "different or separate" in Title III's general anti-discrimination provision incorporates access to the insurance policy itself and the nature of the terms and conditions of the contract. Accordingly, a "public accommodation" that provides a good or service that is different or unequal, based upon an individual's disability, may be liable under the ADA. Ultimately, Congress enacted the ADA, and proscribed several covered forms of discrimination, to "ensure that an opportunity for individuals with disabilities to participate in the goods or services is effective and meaningful."[146]

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140. *See* NORMAN J. SINGER, STATUTES AND STATUTORY CONSTRUCTION § 46:06, at 186 (6th ed. 2000).

141. *See* 42 U.S.C. § 12182(b)(1)(A)(2)(iii).

142. H.R. REP. NO. 101-485, pt. 2, at 103-04 (1990), *reprinted in* 1990 U.S.C.C.A.N. 303, 386-87.

143. 435 U.S. 702 (1978).

144. *See id.* at 710. The Court was asked to determine whether an employer could set annuity premium rates for an employee pension plan that was substantially based on gender. *See id.* at 707. The Court stated that Title VII applies to the context of employee group insurance. *See id.* at 710.

145. *See id.* at 710-11. Title VII specifically states that "It shall be an unlawful employment practice for an employer (1) 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 natural origin." 42 U.S.C. § 2000e-2(a)(1) (1994). This provision strongly implies that the substantive nature of the employer's conduct, not only mere access to employment opportunities, is covered under Title VII.

146. H.R. REP. NO. 101-485, pt. 2, at 105.

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To accomplish this goal, Congress also included several provisions to articulate some of the specific forms of discrimination that violate the ADA. Of particular importance to the insurance industry is the paragraph proscribing the imposition of eligibility criteria that actually or tends to bar disabled individuals from "fully and equally enjoying any goods, services, facilities, privileges, advantages, or accommodations . . . ."[147] The House Reports underscore the fact that the criteria used to prevent individuals from participating in society can take many forms.[148] Though the examples proffered by the Reports refer to the circumstances surrounding access, there is no language that limits this provision solely to access. To the contrary, the provision restates that eligibility criteria, governing access to the insurance contract and the benefits provided therein cannot prevent disabled individuals from "fully and equally enjoying any goods."[149] Thus, the clause encompasses the full array of goods, services and experiences that flow from a disabled individual's interaction with a "public accommodation." Finally, the ADA's statutory purpose, coupled with the absence of congressional intent to limit the scope of Title III, enables one to reasonably apply these provisions to the substantive elements of an insurance policy.

IV. THE ROLE OF TITLE V: IS THERE A "SAFE HARBOR" FOR INSURANCE COMPANIES?

Even if the courts interpret the language of Title III not to cover the substantive elements of an insurance policy, the "safe harbor" clause of Title V suggests that the ADA does reach insurance practices. Section 12201(c) protects insurance practices that are consistent with state law so long as the provider does not utilize this provision as a "subterfuge" to circumvent the purpose of the ADA. Many courts contend that the source

147. 42 U.S.C. § 12182(b)(2)(i) (1995). This provision is especially relevant to the insurance industry because insurance underwriting consists of mathematical statistics and other actuarial techniques that enable insurance companies to impose criteria for determining who should be covered by a particular policy. *See* ROBERT I. MEHR & EMERSON CAMMACK, PRINCIPLES OF INSURANCE 580-85 (1976).

148. *See* H.R. REP. NO. 101-485, pt. 2, at 105. The Report provides an example: if a pharmacy refuses to accept a check from a disabled individual to pay for prescription medicine unless the individual can provide a driver's license, then the store is not imposing a criterion that is disability-based. *See id.* Accordingly, this criterion violates the ADA because it tends to bar individuals from the goods and services of the "public accommodation." *See id.* The Report does state, however, that a "public accommodation" may implement neutral criteria if it is necessary for safe operation of the business. *See id.*

149. 42 U.S.C. § 12182(b)(2)(A)(i).

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of the ADA's authority to reach insurance practices stems from the "safe harbor" provision. Therefore, it is imperative to assess the import of Title V to insurance regulation and the possibility for claimants to raise discrimination claims under Title III. Specifically, does Title V support allegations of discrimination against insurance policies and, if so, to what degree? Furthermore, does an interpretation allowing Title III to regulate insurance practices infringe upon the limitations established by the McCarran-Ferguson Act?

A. Interpreting the "Safe Harbor" Provision and "Subterfuge"

The "safe harbor" provision of Title V states:

> Subchapters I through III of this chapter and Title IV shall not be construed to prohibit or restrict—
> (1) an insurer, hospital or medical service company, health maintenance organization, or any agent, or entity that administers benefit plans, or similar organizations from underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with State law; or
> (2) a person or organization covered by this chapter from establishing, sponsoring, observing or administering the terms of a bona fide benefit plan that are based on underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with State law; or
> (3) a person or organization covered by this chapter from establishing, sponsoring, observing or administering the terms of a bona fide benefit plan that is not subject to State laws that regulate insurance.
> Paragraphs (1), (2), and (3) shall not be used as subterfuge to evade the purposes of subchapters I and III of this chapter.[150]

1. Upholding State Law

Paragraphs (1) through (3) of the "safe harbor" provision provide the first element for determining whether an insurer is subject to Title III regulations. The first paragraph states that an insurer may use underwriting practices for health insurance, or other forms of insurance, so long as the

150. *Id.* § 12201(c).

contracts are consistent with state law.[151] The second provision allows entities, such as employers, that provide insurance policies to do so if the policies are based upon legitimate underwriting practices.[152] The final paragraph reaffirms that the Employment Retirement Income Security Act ("ERISA") governs self-insured plans not subject to state insurance laws.[153] Accordingly, the "safe harbor" provision only insulates those insurance policies that are either in accordance with state law or bona fide benefit plans.[154] The language of the "safe harbor" provision affords plaintiffs a cause of action if they can establish that the defendant insurer violated state law or failed to meet the requirements of a bona fide benefit plan.

The *Pallozzi* court examined the text of Title V and determined that Title III reaches underwriting practices to some extent. The court concluded that the absence of language clearly exempting the insurance industry reinforces the interpretation that Congress intended for the statute to reach insurance practices.[155] The Second Circuit emphasized the degree to which the language of the "safe harbor" provision suggests that insurance practices are subject to the ADA.[156] For example, Congress

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151. *See id.* § 12201(c)(1).

152. *See id.* § 12201(c)(2).

153. *See id.* § 12201(c)(3).

154. *See id.* § 12201(c)(1)-(3). The ADA does not specifically define bona fide benefit plan. The United States Supreme Court considered the term within the context of the Age Discrimination in Employment Act ("ADEA") and determined that a bona fide benefit plan is one that "exists and pays benefits." *See* United Air Lines v. McMann, 434 U.S. 192, 194 (1977). *See also* Public Employees Retirement Sys. v. Betts, 492 U.S. 158, 166 (1989) (reaffirming the *McMann* Court's definition of bona fide benefit plan according to the ADEA). Some courts have considered the question pertaining to bona fide benefit plans under the ADA and have adopted the ADEA definition. *See* Krauel v. Iowa Methodist Med. Ctr., 95 F.3d 674, 678 (8th Cir. 1996) (holding that the *Betts* Court definition of bona fide benefits plan applies to the ADA); Piquard v. City of E. Peoria, 887 F. Supp. 1106, 1120 (C.D. Ill. 1995). The Equal Employment Opportunity Commission ("EEOC") interpretative guidelines define bona fide benefit plan as a plan that "exists and pays benefits, and its terms have been accurately communicated to eligible employees[.]" *Interim Enforcement Guidance on Application of the ADA to Disability Based Distinctions in Employer Provided Health Insurance* (1993) (visited Mar. 29, 2000) <http://www.eeoc.gov/docs/health.tvt>.

155. *See* Pallozzi v. Allstate Life Ins. Co., 198 F.3d 28, 32 (2d Cir. 2000). The court states that insulating the insurance industry from all Title III claims would render the "safe harbor" provision superfluous and, therefore, contradict accepted statutory mechanics. *See id.* The *Winslow* court also construed the text of Title V to allow claims against insurance companies. *See* Winslow v. IDS Life Ins. Co., 29 F. Supp. 2d 557, 564 (D. Minn. 1998). The court held that the plaintiff must either demonstrate that the insurance policy is not a bona fide plan or not inconsistent with state law, or a "subterfuge." *See id.* at 564-65.

156. *See Pallozzi*, 198 F.3d at 32.

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would not have included an exemption for underwriting practices "based on or not inconsistent with State law" if it did not intend for the ADA to cover those policies that violate state law.[157] Congress would have had to provide unambiguous language to the contrary to eliminate the inclusive nature of Title V.[158] Moreover, if insurance companies were completely immune from Title III claims, then there would be no real need for the "safe harbor" provision.[159]

The Seventh Circuit, in *Mutual of Omaha*, refuted the plaintiffs' attempt to read into Title III the authority to regulate insurance policies and, moreover, that the exclusionary language of Title V was inapplicable to their case.[160] Judge Posner utilized an analogy to explain the court's decision. He described a statute promulgated to regulate the sale of "animals" where some disagreement remained over whether the act included fish.[161] If the legislature, however, provided a statutory provision excluding goldfish, then it would be clear that the statute also addressed the sale of fish.[162] In comparison, Title III regulates the behavior of "public accommodations" and provides a limiting provision, paragraph (c) of Title V, pertaining specifically to insurance practices. Therefore, plaintiffs would have to somehow prove that the "safe harbor" provision does not apply to insurance in their specific case.[163] The court referred to the ADA's legislative history to buttress its position: the Reports explain that a "public accommodation" violates the ADA when it denies equal access, but

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157. 42 U.S.C. § 12201(c)(1)-(3).

158. *See Pallozzi*, 198 F.3d at 32.

159. *See id.* The court recognized that the "safe harbor" clause does not render the insurance company completely susceptible to Title III claims and stated that the ADA enables the insurance industry to continue to classify, underwrite, and administer risk as it has traditionally done so long as it is in accordance with state law. *See id.* at n.2. *See also* Doukas v. Metropolitan Life Ins. Co., 950 F. Supp. 422, 428 (D.N.H. 1996).

160. *See* Doe v. Mutual of Omaha Ins. Co., 179 F.3d 557, 562 (7th Cir. 1999), *cert. denied*, 120 S. Ct. 845 (2000). *See also* McNeil v. Time Ins. Co., No. 98-10585, 2000 WL 217500, at *5 (5th Cir. Feb. 24, 2000); Weyer v. Twentieth Century Fox Film Corp., 198 F.3d 1104 (9th Cir. 2000); Ford v. Schering-Plough Corp., 145 F.3d 601 (3d Cir. 1998), *cert. denied*, 525 U.S. 1093 (1999); Parker v. Metropolitan Life Ins. Co., 121 F.3d 1006 (6th Cir. 1997); Leonard v. Israel Discount Bank, 967 F. Supp. 802, 805 (S.D.N.Y. 1997), *vacated*, 199 F.3d 99 (2d Cir. 1999).

161. *See Mutual of Omaha*, 179 F.3d at 562.

162. *See id.*

163. The plaintiffs argued that the "safe harbor" provision is superfluous if Title III does not cover insurance practices. *See id.* In response, the court stated that Title III does cover insurance, but only in cases of "simple discrimination" where equal access is denied to disabled individuals. *See id.* at 564.

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does not act unlawfully when an entity offers goods that are of unequal benefit to disabled individuals.[164]

The legislative history, however, supports the Second Circuit's interpretation of the "safe harbor" provision. The Reports go to great lengths to explain that the ADA does not "affect the way the insurance industry does business *in accordance with State laws and regulations under which it is regulated.*"[165] The Reports also demonstrate that Congress intended to "afford insurers and employers the same opportunities they would enjoy in the absence of this legislation to design and administer insurance products and benefit plans in a manner that is consistent with basic principles of insurance risk classification."[166] Ultimately, Congress included the "safe harbor" provision to ensure that the ADA was not utilized so that every insurance practice would be subject to Title III restrictions.[167]

The language of the "safe harbor" provision and the accompanying legislative history strongly suggest that underwriting practices are subject to Title III claims. The first three paragraphs essentially prohibit insurance policies that are not in accordance with state law. The legislative history also establishes that Congress did not intend all insurance practices to be scrutinized by the ADA, rather only those that violate the conditions set forth in the "safe harbor" clause. This demonstrates that underwriting practices are not completely insulated from any and all Title III claims.

2. "Subterfuge"

The second element of the "safe harbor" provision is the "subterfuge" clause. An insurer that utilizes the "safe harbor" provision to circumvent the purposes of the ADA is not shielded by Title V.[168] Therefore, an entity that provides a policy that is consistent with state law or is a bona fide benefit plan, but is used as a "subterfuge," may also violate Title III. The "subterfuge" clause is problematic because the ADA does not clearly define the term and the courts have struggled over its application.

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164. *See id.* at 562-63.

165. H.R. REP. NO. 101-485, pt. 2, at 136 (1990), *reprinted in* 1990 U.S.C.C.A.N. 303, 419 (emphasis added). *See also* S. REP. NO. 101-116, at 84 (1989).

166. H.R. REP. NO. 101-485, pt. 2, at 137-38.

167. *See id.* at 138. *See also* Doukas v. Metropolitan Life Ins. Co., 950 F. Supp. 422, 431-32 (D.N.H. 1996).

168. *See* 42 U.S.C. § 12201(c) (1995).

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Consequently, many courts have incorrectly adopted the definition of "subterfuge" set forth in *Public Employees Retirement System v. Betts*.[169]

In the *Ford* case, the Third Circuit focused on the "subterfuge" clause of Title V to explain why insurance practices are generally shielded from liability under the ADA. The court rejected the plaintiff's interpretation requiring the insurance company to prove that its policy did not constitute "subterfuge" by presenting actuarial data.[170] To determine the meaning of "subterfuge," the court looked to the United States Supreme Court's determination of the term as applied in the ADEA. In *Betts*, the Court defined "subterfuge" as "a scheme, plan, stratagem, or artifice of evasion."[171] This definition implies that an insurance company can only violate the "safe harbor" provision if it intentionally evades the purposes of the ADA. Determining that an insurer is not required to support its defense with actuarial evidence, and the difficulty inherent in establishing intent, has immunized the insurance industry from most Title III claims.

Congress, however, clearly rejects *Betts* when determining which insurance policies are subject to the ADA. The Reports state that "[the "safe harbor" provision] may not be used to evade the protections of . . . Title III pertaining to public accommodations beyond the terms of points (1), (2) and (3), *regardless of the date* an insurance plan or employer benefit plan was adopted."[172] This was clearly a response to the *Betts* decision that held that the contested employee benefit plan, adopted prior to the enactment of the ADEA, did not constitute a "subterfuge."[173] Accordingly, insurance plans existing prior to the promulgation of the ADA are subject to Title III restrictions.

The issue concerning intent, however, is far from settled. The courts are divided over whether "subterfuge" requires a showing of intent. Generally, plaintiffs contend that Congress rejected the ADEA definition of

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169. 492 U.S. 158 (1989).

170. *See* Ford v. Schering-Plough Corp., 145 F.3d 601, 611 (3d Cir. 1998), *cert. denied*, 525 U.S. 1093 (1999).

171. *Betts*, 492 U.S. at 167 (quoting United Air Lines, Inc. v. McMann, 434 U.S. 192, 203 (1977)).

172. H.R. REP. NO. 101-485, pt. 2, at 136 (1990), *reprinted in* 1990 U.S.C.C.A.N. 303, 419 (emphasis added). *See also* S. REP. NO. 101-116, at 85 (1989).

173. *See Betts*, 492 U.S. at 168. The ADEA proscribes discrimination "against any individual with respect to his compensation, terms, or condition or privileges of employment, because of such individual's age." 29 U.S.C. § 623(a) (1999). For more discussion concerning the impact of *Betts* on Title III standards, see Daniel A. Engel, *The ADA and Life, Health, and Disability Insurance: Where is the Liability?*, 33 TORT & INS. L.J. 227 (1997).

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"subterfuge" and, thus, there is no requirement to establish intent to discriminate. Conversely, defendant insurers typically assert that the *Betts* decision governs the ADA. The silence of the United States Supreme Court has only compounded the confusion among the courts in addressing Title III claims against insurance companies.

The legislative history supports an interpretation de-emphasizing intent. Congress states that an insurance company cannot limit coverage based upon classification of risk unless the policy is "related to actual or reasonably anticipated experience."[174] This passage indicates that the legislature contemplated objective criteria when formulating the "subterfuge" provision of Title V.[175] Thus, "subterfuge" does not solely refer to situations of disparate treatment, rather objective factors that tend to discriminate against disabled individuals may also constitute "subterfuge."[176]

There is evidence, however, that "subterfuge" should be interpreted to require intent. The Court applied the ordinary meaning of the term "subterfuge" when it decided *Betts*.[177] There is nothing in the legislative

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174. H.R. REP. NO. 101-485, pt. 2, at 137.

175. There is additional proof that Congress disapproved of an intent-based definition. Representative Edwards argued that

> [t]he term "subterfuge is used in the ADA simply to denote a means of evading the purposes of the ADA. It does not mean that there must be some malicious intent to evade the ADA on the part of the insurance company or other organization, nor does it mean that a plan is automatically shielded just because it was put into place before the ADA was passed.

136 CONG. REC. H4624 (daily ed. May 17, 1990) (statement of Rep. Edwards). Senator Kennedy also rejected the United States Supreme Court interpretation. Senator Kennedy stated that "[I]t is important to note that the term "subterfuge" as used in the ADA, should not be interpreted in the manner in which the Supreme Court interpreted the term in [*Betts*]." 136 CONG. REC. S9697 (daily ed. July 13, 1990) (statement of Sen. Kennedy).

176. Some courts have applied this interpretation of the statute. *See* Doukas v. Metropolitan Life Ins. Co., 950 F. Supp. 422, 431 (D.N.H. 1996) (concluding that the plaintiff is not required to demonstrate intent and the defendant insurer maintains the burden of rebutting the prima facie case with evidence of sound actuarial principles). *See also* Morgenthal v. American Tel. & Tel. Co., No. 97 CIV. 6443 DAB, 1999 WL 187055, at *3 (S.D.N.Y. Apr. 6, 1999) (determining that a motion to dismiss is premature especially when the defendant provides no explanation); Chabner v. United of Omaha Life Ins. Co., 994 F. Supp. 1185, 1193 (N.D. Cal. 1998) (determining that the plaintiff does not have to establish intent to discriminate); Cloutier v. Prudential Ins. Co. of Am., 964 F. Supp. 299 (N.D. Cal. 1997) (asserting that intent is not necessary to demonstrate "subterfuge" under the "safe harbor" provision).

177. *See Betts*, 492 U.S. at 167.

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history that explicitly states that an alternative usage of the word applies to the ADA. This becomes especially important considering that the ADA was passed shortly after the *Betts* decision and Congress was most likely aware of the ramifications of using the same language found in the ADEA. Coincidentally, many of the courts called upon to apply the "safe harbor" provision have implemented the definition of "subterfuge" provided by the United States Supreme Court.[178]

The legislative history indicates that Congress did not intend to apply the term "subterfuge" in the exact manner as the ADEA. The Reports expressly reject the *Betts* analysis suggesting that the ADA should only be applied prospectively and discuss the import of objective criteria to disability-based discrimination. Does this substantiate a complete deviation from ADEA jurisprudence concerning the definition of "subterfuge?" This is difficult to say considering the United States Supreme Court's silence thus far. Regardless of whether the courts construe the "safe harbor" provision to require the plaintiff to establish intent, the plaintiff is entitled to raise a Title III claim.

The "safe harbor" provision places underwriting practices within the purview of the ADA. Despite the confusing nature of the provision, Congress would have no need to include the paragraphs referring to state law, or the "subterfuge" provision, if it intended insurance practices to be immune from Title III claims. The legislative history strongly suggests that the above-mentioned interpretation is the most reasonable reading of the statute.

B. The Impact of the McCarran-Ferguson Act on the ADA

Many of the courts also claim that an expansive reading of the "safe harbor" provision and Title III violate the limitations imposed by the

178. *See* Parker v. Metropolitan Life Ins. Co., 121 F.3d 1006, 1014 n.7 (6th Cir. 1997). The court did not specifically address the "subterfuge" issue, but it intimated that requiring an insurance company to justify its action with sound actuarial data would be inconsistent with the Supreme Court's definition of "subterfuge" applied in the ADEA. *See also* Leonard v. Israel Discount Bank, 967 F. Supp. 802, 806 (S.D.N.Y. 1997), *vacated*, 199 F.3d 99 (2d Cir. 1999) (determining that Congress intended the term "subterfuge" to be the same in both the ADEA and the ADA). Some courts have come to the same conclusion within the context of Title I claims. *See* Krauel v. Iowa Methodist Med. Ctr., 95 F.3d 674, 678-79 (8th Cir. 1996) (holding that the legislative history does not conclusively reject the *Betts* definition of "subterfuge"); Modderno v. King, 82 F.3d 1059, 1064-65 (D.C. Cir. 1996) (determining that legislative history surrounding the ADA supports an intent-based definition); Piquard v. City of E. Peoria, 887 F. Supp. 1106, 1126 (C.D. Ill. 1995) (suggesting that "subterfuge" refers to intentional discrimination).

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McCarran-Ferguson Act. The McCarran-Ferguson Act establishes that state law is authoritative when dealing with matters of insurance.[179] Federal legislation must not be construed to supercede any state law that pertains to insurance unless that law "specifically relates to the business of insurance."[180] This section provides the current status of the United States Supreme Court's McCarran-Ferguson Act jurisprudence. Moreover, the recent decision rendered by the Second Circuit, in *Pallozzi*, correctly determined that an expansive interpretation of the ADA does not contravene the McCarran-Ferguson Act.

The United States Supreme Court interprets the McCarran-Ferguson Act's preemption clause narrowly.[181] The Court rejected an interpretation providing the states with exclusive authority to regulate the insurance industry unless a federal statute expressly and explicitly states otherwise.[182] This does not mean, however, that any federal legislation referring generally or tangentially to the insurance industry, and that avoids conflict with applicable state law, may be enacted by Congress.[183] The general rule is as follows: "When a federal law does not directly conflict with state regulation, and when application of the federal law would not frustrate any declared state policy or interfere with a State's administrative regime, the McCarran-Ferguson Act does not preclude its application."[184]

The United States Supreme Court, in *Barnett Bank v. Nelson*,[185] explained that the question whether a federal statute violates the McCarran-

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179. *See* 15 U.S.C. § 1012(a) (1997). The paragraph reads "[t]he business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation and taxation of such business." *Id.*

180. *Id.* § 1012(b). The section provides in relevant part:

> No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance.

Id.

181. *See* Humana, Inc. v. Forsyth, 525 U.S. 299, 310 (1999).

182. *See id.*

183. *See id.*

184. *Id.*

185. 517 U.S. 25 (1996). The Court considered whether a federal law permitting national banks to sell insurance policies conflicted with state law governing insurance practices. *See id.* at 27. The Court concluded that the federal statute was specifically related to insurance and, therefore, the McCarran-Ferguson Act's preemption clause does not apply. *See id.* at 28.

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Ferguson Act is one of congressional intent.[186] Moreover, most federal legislation does not provide explicit preemption language; thus, the courts must look to the federal statute's "'structure and purpose' or nonspecific statutory language" to determine preemptive intent.[187] Finally, and most importantly, the Court concluded that courts should presume textual and statutory intent in favor of federal legislation.[188] In other words, Congress did not intend the McCarran-Ferguson Act to provide the states with exclusive power over a particular area of national concern.[189]

The *Barnett* Court formulated a four step analytical framework to determine whether a federal act supercedes state law.[190] The first inquiry is whether the federal statute "relates" to insurance.[191] The next step instructs the court to determine if the statue "'specifically' relates to insurance 'explicitly, particularly, [or] definitively.'"[192] The court must then assess whether the statute specifically relates to the "business of insurance" in such a manner as to impact the fundamental relationship between insurer and insured.[193] Finally, the court must determine whether the proposed reading would contravene the very purpose of the McCarran-Ferguson Act.[194]

The application of the above-mentioned analytical framework led the *Pallozzi* court to conclude that the ADA does "specifically relate to the business of insurance" and, accordingly, does not violate the limitations imposed upon federal legislation by the McCarran-Ferguson Act.[195] This

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186. *See id.* at 30.
187. *Id.* at 31.
188. *See id.* at 33.
189. *See id.*
190. *See id.* at 38.
191. *See id.*
192. *Id.*
193. *See id.* at 39.
194. *See id.*
195. *See* Pallozzi v. Allstate Life Ins. Co., 198 F.3d 28, 35 (2d Cir. 2000). The court provides its own rendition of the "safe harbor" provision:

> (1) Because of the general preference expressed in McCarran-Ferguson's default rule that insurance matters be regulated by State authority, rather than by [the federal courts], we require a plaintiff seeking to prove a claim arising from underwriting decisions to show that the practice complained of is proscribed not only by this statute but also State law.
>
> (2) If, on the other hand, the insurer uses State law as a subterfuge to evade the purposes of this Act, that will also support a claim.

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determination, however, was made within the context of "simple discrimination" described by Judge Posner in *Mutual of Omaha*.[196] Nonetheless, Title III explicitly lists "insurance office" as one of the many enumerated public accommodations subject to the ADA.[197] Furthermore, Title V satisfies the second prong of the analysis because it specifically addresses the impact of the ADA upon the insurance industry.[198] These provisions do not tangentially affect the insurance industry; rather, the court determined that the ADA deals with "'matters . . . at the core of the McCarran-Ferguson Act's concerns such as 'the relation of insured to insurer and the spreading of risk.'"[199] Finally, the ADA's specific references to the insurance industry are not "inadvertent" and, therefore, the statute does not contravene state law protected under the McCarran-Ferguson Act.[200]

The *Pallozzi* court correctly determined that the preemption clause does not apply to the ADA. The ADA does "specifically relate to the business of insurance."[201] Title III lists "insurance office" as a "public accommodation."[202] Moreover, Title V explicitly refers to insurance and establishes parameters to the relationship between the ADA and the insurance industry.[203] Thus, there is no question that the ADA addresses the activities undertaken by insurance companies, rather than merely particular

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> (3) We set forth this separate provision (under the caption "INSURANCE") to make clear that our statute "specifically relates to the business of insurance" and therefore must be interpreted, notwithstanding McCarran-Ferguson, to regulate insurance practices.

Id.

196. In *Mutual of Omaha*, Judge Posner explained that if the McCarran-Ferguson Act does not shield insurance practices, and the ADA is fully applicable, then insurance companies will have to use the "safe harbor" provision to defend their policy terms and limits. *See* Doe v. Mutual of Omaha Ins. Co., 179 F.3d 557, 564 (7th Cir. 1999), *cert. denied*, 120 S. Ct. 845 (2000). The federal courts would then be in the position to regulate the insurance industry contrary to the principles delineated in the McCarran-Ferguson Act. *See id.*

197. *See* 42 U.S.C. § 12181(7)(F) (1995).

198. *See Pallozzi*, 198 F.3d at 34.

199. *Id.* (quoting *Barnett*, 517 U.S. at 39).

200. *See id.* at 35.

201. *Id.* at 34. The United States Supreme Court interprets the phrase "specifically relates to the business of insurance" broadly. *See Barnett*, 517 U.S. at 38. *See also* Hartford Fire Ins. Co. v. California, 509 U.S. 764, 781 (1993) (holding that "relates to the business of insurance" focuses on activity rather than entities).

202. *See* 42 U.S.C. § 12181(7)(F).

203. *See id.* § 12201(c)(1)-(3).

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actors of the industry.[204] Finally, the ADA does not contravene the fundamental concern of the McCarran-Ferguson Act: the McCarran-Ferguson Act was enacted to protect state law against "inadvertent federal intrusion" in the form of generalized statutory language.[205] The "safe harbor" provision specifically pertains to the impact of insurance practices on disabled individuals and, therefore, does not constitute a tangential or inadvertent interest in the insurance industry.[206]

The *Pallozzi* court did not allude to the statutory purpose of the ADA in justifying its conclusion. Nevertheless, the ADA's comprehensive mandate against discrimination satisfies the *Barnett* analytical framework. First, Congress enacted the ADA to assist disabled individuals in entering mainstream society by providing modes of relief against discriminatory practices.[207] Within this broad grant of authority, the legislature contemplated the effect of the ADA upon the insurance industry.[208] Second, the Reports state that Congress did not intend for the ADA to alter insurance practices conducted in conformity with state law.[209] This does not, however, absolve insurance companies of Title III liability.[210] Thus, the language and purpose of the ADA properly avoid the preemption clause of the McCarran-Ferguson Act.

The Seventh Circuit, however, concluded that the McCarran-Ferguson Act preempts the ADA's regulatory authority. The *Mutual of Omaha* court relied more on arguments of separation of powers than on the statutory analytical framework. The court explained that state regulation of insurance is comprehensive and, therefore, states are not indifferent to who administers their laws.[211] In other words, construing the McCarran-Ferguson Act to allow the ADA to regulate the content of insurance policies would force the federal judiciary to determine the validity of the defendant insurer's policy and interpret state law.[212] The court's

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204. The "safe harbor" provision includes several types of insurers such as a hospital and discusses the conduct that is proscribed by the ADA. *See id.*

205. *See Barnett*, 517 U.S. at 39.

206. *See* Pallozzi v. Allstate Life Ins. Co., 198 F.3d 28, 34 (2d Cir. 2000).

207. *See* H.R. REP. NO. 101-485, pt. 2, at 22-23 (1990), *reprinted in* 1990 U.S.C.C.A.N. 303, 303-04.

208. *See id.* at 136. *See also Pallozzi*, 198 F.3d at 34.

209. *See* H.R. REP. NO. 101-485, pt. 2, at 136. *See also* S. REP. NO. 101-116, at 84 (1989).

210. *See id. See also supra* Part IV.A.1.

211. *See* Doe v. Mutual of Omaha Ins. Co., 179 F.3d 557, 564 (7th Cir. 1999), *cert. denied*, 120 S. Ct. 845 (2000).

212. *See id.*

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apprehensions are well placed, but its determination is inapposite to United States Supreme Court precedent. Ultimately, federal law should not be preempted by state legislation unless such law directly conflicts with state regulation.[213]

In *Winslow v. IDS Insurance Co.*,[214] the District Court of Minnesota also concluded that interpreting the scope of the ADA to cover the content of insurance policies would not "impair or supersede" a state's administrative regime.[215] The court focused on the remedies available to claimants in determining that the McCarran-Ferguson Act does not preempt the ADA. Specifically, the ADA does not afford plaintiffs with the opportunity to seek excessive punitive damages.[216] Accordingly, potential claimants will not be deterred from alleging violations of state law because of the opportunity to bring a claim under Title III. State and federal laws that are "substantively identical but differ in penalty do not conflict with or displace each other."[217] Thus, the ADA does not impact state regulation in a manner proscribed by the McCarran-Ferguson Act.

CONCLUSION

The ADA was enacted by Congress to eradicate disability-based discrimination. These powerful biases and stereotypes inhibit disabled individuals from participating in daily activities. Insurance coverage is key to meaningful participation in society and, therefore, practices that limit coverage compound the problems facing disabled individuals. Accordingly, the ADA should be interpreted to allow Title III claims against insurance companies. Specifically, the statutory framework of the ADA supports a broad definition of "public accommodation," and regulation of the terms and conditions of insurance policies. Additionally, the combination of Title III and the "safe harbor" provision establish that the ADA specifically relates to the "business of insurance." Interpreting the "safe harbor" provision narrowly neither usurps the authority of state

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213. *See* Humana, Inc. v. Forsyth, 525 U.S. 299, 310 (1999).

214. 29 F. Supp. 2d 557 (D. Minn. 1998).

215. The plaintiff challenged the defendant insurance company's refusal to provide medical coverage for a dysthymia, a mental illness. *See id.* at 558. The question concerning the McCarran-Ferguson Act involves the interplay of the ADA and the Minnesota Statute section 72A.20 relating to insurance. *See id.* at 564.

216. *See* 42 U.S.C. § 12188(b)(4) (1995). The statute states in relevant part that the term "'monetary damages' and 'such other relief' does not include punitive damages." *Id.*

217. *Winslow*, 29 F. Supp. 2d at 564 (quoting NAACP v. American Family Mut. Ins. Co., 978 F.2d 287, 295 (7th Cir. 1992)).

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law nor triggers the preemption clause of the McCarran-Ferguson Act. Ultimately, this Comment only suggests that disabled individuals be afforded the opportunity to contest discriminatory insurance policies and, therefore, enable the ADA to function as Congress intended: as an anti-discrimination statute.

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THE VIATICAL SETTLEMENT INDUSTRY: THE REGULATORY SCHEME AND ITS IMPLICATIONS FOR THE FUTURE OF THE INDUSTRY

Ffiona M. Jones[*]

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INTRODUCTION

Consider the following scenario. Michael, a 38-year-old male, was diagnosed with HIV two years ago and now has full-blown AIDS. His doctors projected his life expectancy to be less than eighteen months. The debilitating nature of his illness forced him to quit his job several months ago, and Michael has no alternate source of income. Because he quit his job, Michael no longer qualifies for employer-provided health insurance. Consequently, he cannot afford to make his house or car payments, nor can he pay his overwhelming hospital bills.[1] Michael also wants to fulfill his lifelong dream of traveling around the world, and would like to leave some money to his family in order to ease funeral expenses once he dies.[2] Provided that Michael has a life insurance policy, he has the ideal solution to his economic hardships. He can obtain the money he desperately needs by selling his life insurance policy for a percentage of its face value, and can live his remaining months with relative peace of mind and financial security.

The transaction described above, the sale by a terminally ill person of his life insurance policy for a portion of its face value, is called a viatical settlement.[3] A life insurance policy is considered personal property, like a

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1. The National Association of People with AIDS conducted a study in 1992 and found that over 50% of people living with AIDS lived on less than $12,000 a year. *See* Miriam Albert, *The Future of Death Futures: Why Viatical Settlements Must Be Classified as Securities*, 19 PACE L. Rev. 345, 346 (1999). In another 1992 study, the American Medical Association found that from the time of infection to the time of death, AIDS patients incur roughly $119,000 in medical expenses. *See id.* (*citing* Clifford Carlsen, *AIDS Life Policy Purchaser Seeks New Life From IPO*, S.F. BUS. TIMES, Nov. 10, 1995, at 3).

2. This scenario is fictitious but is typical to the plight facing many individuals suffering from AIDS and other terminal illnesses.

3. The word "viatical" is derived from the Latin word "Viaticum" meaning "provisions given for a journey into the next world." 14 NEW CATHOLIC ENCYCLOPEDIA 637

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car, jewelry, or stocks and bonds, and is, thus, freely alienable.[4] A viatical settlement is simply explained. A terminally or chronically ill person (the viator) sells his life insurance policy to a viatical settlement company or an individual purchaser for the immediate lump-sum cash payment of a fraction of the policy's face value with no restriction on how the money can be spent.[5] In return, the viator appoints the purchaser as the beneficiary under the policy. The purchaser then assumes the premium payments and collects the death benefits once the viator dies.[6] The policy purchaser realizes a profit due to the difference between the policy's face value and the discounted settlement price paid, less certain administrative and transactional costs.[7] Because the return is fixed, the profit potential of a viatical settlement depends on the length of the investment or, in other words, on how long the purchaser must make premium payments.[8] If the viator dies before the predicated date or lives roughly as long as expected, the purchaser will realize a profit on his investment.[9] If the viator outlives

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(The Catholic University of America ed. 1967). *See also* Joseph M. Belth et al., *Viatical Transactions and the Growth of the Frightening Secondary Market For Life Insurance Policies,* 26 INS. F. 173 (1999). It is interesting to note that the term "viatical settlement" did not emerge simultaneously with the practice it is now used to denote. The term was coined by an editor of a magazine suffering from AIDS. *See id.* at 175.

4. *See* Jennifer Berner, *Beating The Grim Reaper, Or Just Confusing Him? Examining The Harmful Effects of Viatical Settlement Regulation*, 27 J. MARSHALL L. REV. 581, 591 (1994). Virtually any type of life insurance policy is a candidate for viatical settlement, including term, whole life, and universal life employer paid group policies.

5. *See* Protective Life Ins. Co. v. Sullivan, 89 F.3d 1, 2 (1st Cir. 1996) (per curiam); *see also* Berner, *supra* note 4, at 594. A purchaser will usually pay between 50 and 80% of the policy's face value depending on various factors discussed in Part IIB, *infra*. *See also* Amy Stone, *Easing the Economic Burdens of Terminal Illness*, BUS. WK., May 3, 1993, at 160. As there are no restrictions on how the funds received from a viatical settlement can be used, it can help pay for medical treatment, house or car payments, day-to-day living expenses, vacations, sharing with family and friends or charities.

6. *See* SEC v. Life Partners, Inc., 87 F.3d 536, 537 (D.C. Cir. 1996); *see also* Berner, *supra* note 4, at 582.

7. *See* Alexander D. Eremia, *Viatical Settlement and Accelerated Death Benefit Law: Helping Terminal, But Not Chronically Ill Patients*, 1 DEPAUL J. HEALTH CARE L. 773, 777 (1997).

8. *See id.*; *see also* Joy D. Kosiewicz, *Death for Sale: A Call to Regulate the Viatical Settlement Industry*, 48 CASE W. RES. 701, 701 (1998).

9. *See* Eremia, *supra* note 7, at 777.

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his life expectancy, as projected at the time of settlement, the purchaser makes less money and may in fact incur a net loss.[10]

The viatical settlement industry has experienced explosive growth over the past few years with many people profiting from these transactions. Viators receive the money they desperately need and investors and purchasers make money on the transactions. This Note focuses on the tremendous growth and change the industry has sustained in the past decade. It also explores the ways in which these developments have affected and will continue to affect the industry as a whole as well as its constituent parts, namely, the viators, purchasers and investors who participate in the transactions. More specifically, this Note will examine two issues that pose a formidable obstacle to the continued efficacy of the viatical settlement industry: fraud and certain provisions of viatical settlement regulation. Part I of this Note provides background on the viatical settlement industry and process with an emphasis on the increasing difficulty in predicting a viator's life expectancy when valuating a viator's policy. Part II examines viatical settlement regulation and the danger current regulatory schemes pose to investors and purchasers and suggests an alternative approach. Part III discusses the growing problem of fraudulent activity by viators in the policy application process and the ways fraud poses a substantial threat to the continued participation of investors and purchasers in the market. Part III also examines proposals aimed at combating fraud and concludes that each one fails to adequately address the concerns of purchasers.

I. BACKGROUND

A. Who May Purchase the Policy?

There are three types of viatical settlement companies: funding, brokerage and syndicate companies. Funding companies are institutionally financed, meaning collateralized bank loans and/or lines of credit constitute their primary source of funds.[11] They purchase the policies for themselves and assume the attendant portfolio risks.[12] Brokerage companies act as

10. *See id.*

11. *See About the Viatical Industry* (visited Jan. 16, 2000) <http://www.hivpositive.com/f-Money/13-Insurance/13-AVabout.html>.

12. *See id.*; *see also* GLORIA GRENING WOLK, CASH FOR THE FINAL DAYS: A FINANCIAL PLANNING GUIDE FOR THE TERMINALLY ILL AND THEIR ADVISORS 34 (1997).

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agents for the viators and pair them with potential purchasers.[13] Rather than charging the viators a fee for this service, brokers negotiate a commission that is paid by the company purchasing the policy.[14] The third type of purchaser, a syndicate company, is a species of a funding company that "syndicates" the sale of policies to pools of individual investors who then acquire fractionalized interests in a policy or a group of policies.[15] These companies focus attention on secondary markets and thus, shield themselves from many of the risks inherent in a viatical settlement transaction.[16] The syndicators receive a fee for setting up the sale and assume no portfolio risk.[17] By fractionalizing interests in a policy, syndicate companies allow investors to spread their risk and simultaneously hold interests in multiple policies.[18]

B. Factors Determining How Much the Viator Receives

Several factors determine the amount a purchaser will pay a viator for his policy. The single most important factor, however, is the projected life expectancy of the viator as determined by a physician.[19] Other factors include prevailing interest rates, premium obligations, credit-worthiness of the insurance carrier, and any outstanding loans against the policy.[20]

The majority of funding companies retain the policies as part of their investment portfolio but some resell the policies in the secondary market. *See id.*

13. *See* WOLK, *supra* note 12, at 22-23. The purchasers are usually funding companies, and brokers will typically shop the viator's policy among several funding companies in order to find the highest possible settlement price.

Brokerage companies tend to be favored by viators because they typically save the viator time and energy. When a viator contacts a broker the company requests and obtains all the insurance and medical information necessary for the transaction and makes copies for the funding companies.

14. *See id.*

15. *See About the Viatical Industry*, *supra* note 11.

16. *See* Kosiewicz, *supra* note 8, at 712.

17. *See id.*

18. *See id.* The Securities and Exchange Commission made an unsuccessful attempt to regulate the fractionalized market in 1996 and, to date, viatical settlement secondary markets have not been deemed securities by the courts. *See id.*

19. *See What is a Viatical Settlement* (visited Jan. 16, 2000) <http://www.MitchellViatical.com/whatis.html>; *see also Answers* (visited Jan. 16, 2000) <http://www.viaticus.net/page2.html>.

20. *See Answers*, *supra* note 19.

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Generally, a viator can expect to receive between fifty and eighty percent of the policy's face value.[21]

In some instances, the proceeds a viator receives from a viatical settlement may be tax-free. In 1996, Congress revised the tax code to exempt viatical settlement proceeds from gross income tax under certain circumstances.[22] If a viator has a projected life expectancy of twenty-four months or less, and meets other specified criteria, the federal government does not tax the proceeds from a viatical settlement as regular income.[23]

C. History of the Viatical Settlement Industry

In 1989, Rob Worley, then an insurance agent in New Mexico, heard a talk show program where a man dying of cancer discussed his dire need for cash to pay medical bills and his insurance company's refusal to buy back his life insurance policy.[24] Moved by this man's plight, Worley eventually started his own viatical settlement company.[25] Almost simultaneously, the aftermath of the AIDS pandemic of the 1980s created a group of individuals with similar financial obligations and the inability to satisfy them.[26] Though a fledgling industry in the late 1980s, it grew considerably in the 1990s in the wake of the proliferation of the AIDS virus.[27] By the end of 1989 there were three viatical settlement companies doing business

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21. *See What is a Viatical Settlement*, *supra* note 19. The National Association of Insurance Commissioners has established pricing guidelines for the purchase of viatical settlements which will be discussed in detail in Part II.B.

22. *See id.* In the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Congress created an incentive for entering viatical settlements by providing preferential tax treatment of the proceeds of a sale. As of January 1, 1996, the HIPAA excludes certain viatical settlements from gross income. More specifically, the HIPAA treats the proceeds of a viatical settlement as proceeds of a life insurance contract payable by reason of death, thereby excluding the proceeds received upon sale of the policy from the viator's gross income. *See* Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936 (codified in various sections of 29 U.S.C, 42 U.S.C., 18 U.S.C., 26 U.S.C.); *see also* Kosiewicz, *supra* note 8, at 710. The HIPAA also treats accelerated death benefits preferentially. *See* Eremia, *supra* note 7, at 774.

23. *See* Kosiewicz, *supra* note 8, at 710. For a more thorough examination of HIPAA and its effect on the viatical settlement industry, see Andrew Spurrier, *The Death of Death Futures? The Effects of the Health Insurance Portability and Accountability Act of 1996 on the Insurance and Viatical Settlement Industries*, 4 CONN. INS. L.J. 807 (1997/1998); *see also* Eremia, *supra* note 7, at 787-98.

24. *See About the Viatical Industry*, *supra* note 11.

25. *See id.*

26. *See* Berner, *supra* note 4, at 583.

27. *See id.* at 583-84.

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in the United States[28] and today there are over fifty.[29] According to the Viatical Association of America,[30] the face value of life insurance policies purchased by viatical settlement companies will reach roughly $1 billion in 1999.[31] In 2000, the figure is expected to top $4 billion.[32] This number is staggering, especially considering the how young the industry is, and the significant advances made in AIDS research and treatments during the past decade.

D. The Growing Unreliability of Life Expectancy Predictions

While AIDS victims comprised the majority of viators in the late 1980s and early 1990s, the industry has recently started to cater to those suffering from other terminal illnesses including cancer, arterio-lateral sclerosis ("Lou Gehrig's Disease"), cardiovascular illnesses, and the like.[33] This shift is due in part to the 1996 World AIDS Conference in Vancouver, Canada which confirmed a breakthrough in AIDS research and treatment that significantly increased the life expectancy of those with HIV and/or AIDS.[34] Though this was good news for AIDS patients, it was bad news for the viatical settlement industry. AIDS-afflicted viators once represented a sure bet guaranteeing significant returns because of the high probability of swift death. Successful treatment with protease inhibitors

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28. *See* Kosiewicz, *supra* note 8.

29. *See id.*

30. The Viatical and Life Settlements Association of America ("VAA") is a Washington, D.C. based non-profit trade association founded in 1994 that acts as a resource center, providing information and advice about viatical settlements. The VAA currently has roughly 42 members (as of May 19, 1999) consisting of viatical settlement companies, brokers, insurance agents, financial planners, escrow agents, medical consultants, investment counselors and other parties simply interested in the industry. For more information about the VAA, visit its website at http://www.viatical.org .

31. *See* <http://www.viatical.org/news/news990601.html> (visited Jan. 16, 2000) (managed by William Kelley; produced by Sartori Associates and Athene, Inc.). It is estimated that in 1989 insurance policies with a total face value of $5 million were viaticated and by 1990 that figure had grown to $40 million. *See* John F. Blake, *Unique Needs: Advising Terminally Ill Clients*, NAT'L L.J., Aug. 5, 1991, at 17; *see also* Daniel Eisenberg, *Making a Killing*, TIME, Nov. 29, 1999, at 112.

32. *See* Rod Schrader, *Viaticals Link Terminal Patients to Investors*, PUGET SOUND BUS. J., Sept. 29, 1997, at 18B.

33. *See, e.g.*, Kosiewicz, *supra* note 8, at 702; David W. Dunlap, *Recalculating Death Benefit Math*, N.Y. TIMES, July 30, 1996, at C1.

34. *See* Gail Diane Cox, *Growth Market in Death Future Spawns Suite: Sales of Life Insurance Policies at a Discount Draw Fraud Charges, SEC Action*, NAT'L L.J., May 26, 1997, at A9.

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significantly changed the life-expectancy tables and people with AIDS were no longer dying by the clock.[35] These longer life expectancies not only wreaked havoc on the actuarial tables on which viatical settlement discount rates are based, but also decreased the return for investors because of the additional premium payments not accounted for in the original valuation of the policy.[36]

Dignity Partners, Inc., a San Francisco based viatical settlement company, experienced a crippling drop in its stock price from $14.50 in early 1996 to just $1.38 after the Vancouver discoveries were revealed.[37] The financial distress of Dignity highlights the growing tension surrounding the viatical settlement industry's dependency on life expectancy predictions that, in light of medical advances, have become tenuous at best. Today, purchasing a policy from an AIDS patient is a

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35. The National Viatical Association reported that breakthroughs in AIDS research and treatment decreased the average yield on the purchase of a life insurance policy from around 20% to between 12 and 18%. *See id.*

36. *See* Eremia, *supra* note 7, at 786.

37. *See* <http://www.nettime.org/nettime.w3archive/199808/msg00097.html> (visited Jan. 16, 2000).

Dignity Partners has also been the subject of recent litigation. *See* Herceg v. Dignity Partners, Inc., 191 F.3d 1076 (9th Cir. 1999). A group of investors who purchased Dignity stock on the open market shortly after its initial public offering, but before news of the longer life expectancy of AIDS patients due to new treatments, filed a class action suit against the company alleging several violations of securities law. *See id.* at 1076. The plaintiffs claimed that Dignity knew of the longer life expectancy of AIDS patients before the information became public, but failed to disclose it in its registration statement filed prior to Dignity's initial public offering. *See id.* More specifically, the plaintiffs alleged that Dignity lied in its financial statements because it misrepresented the true worth of the business. *See id.* The plaintiffs claim that Dignity counted the potential proceeds from a policy as income as soon as the policy was purchased, rather than when it actually received the proceeds. *See id.* This accounting method concealed the fact that Dignity was not collecting and would not be collecting on these policies as fast as expected. *See id.*

The plaintiffs further alleged that as a result of the recent advances in AIDS research, and the fact that many of the viators with whom Dignity had contracted began to live longer than expected, Dignity saw its investments dwindling and decided to take the company public in order to recoup some of its losses. *See id.* at 1079.

After the district court dismissed the action on the ground that the initial class action representative lacked standing, and that the replacement representative was barred by the statute of limitations, the U.S. Court of Appeals for the Ninth Circuit reversed and remanded the case on August 27, 1999.

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dangerous venture that many purchasers and investors are unwilling to risk.[38]

Medical advances and treatments of other terminal illnesses have compounded the problems of viatical settlement companies. One faces extreme difficulty in determining with precision the life expectancy of any terminally or chronically ill person. The increased longevity of these viators has taken some of the profit out of viatical settlements and made the valuation of policies a guessing game as opposed to the stable calculation it once was when actuarial tables could be steadfastly relied upon.

The growing difficulty in predicting life expectancy creates problems for the viatical settlement industry as a whole since investors, whose money is needed by viatical settlement providers to fund the purchase of policies, are increasingly hesitant to invest in a market where the odds of a handsome return or even a net gain are bleak. Moreover, viatical settlement regulatory provisions fail to consider the precarious situation purchasers and investors face, and thereby exacerbate the disincentive for investors.

II. VIATICAL SETTLEMENT REGULATION

Viatical settlement regulation emerged in response to concerns over the possibility of abuses in the industry.[39] As the viatical settlement industry began to flourish in the late 1980s and early 1990s, states realized their inability to address issues that may arise in connection with the sale and purchase of a life insurance policy. Recognition of need for oversight or regulation in the industry forced states to explore the rules that should govern these transactions and attendant enforcement mechanisms. These inquiries revealed the inadequacies of existing laws regulating the ordinary

38. In February of 2000, research on a new class of AIDS drugs revealed that these new "entry inhibitor" drugs offer hope to those AIDS patients who are resistant to the original protease inhibitor drugs introduced at the Vancouver Conference. *See* David Brown, *New Class of AIDS Drugs Touted*, THE WASHINGTON POST, Feb. 3, 2000, at A06. This new class of drugs is promising to AIDS patients, but diminishes the appeal of AIDS patients as viatical settlement options. *See id.*

39. *See* Kosiewicz, *supra* note 8, at 703. Much of the concern over abuse stems from the unbalanced relationship between the viatical settlement purchaser, a large company with significant resources, and the viator, a desperate and vulnerable individual with no resources. *See id.*

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buyer-seller transaction in the context of a viatical settlement.[40] States therefore began enacting specific viatical settlement legislation and codifying these provisions in the insurance sections of their codes.[41]

In general, the provisions that govern viatical settlements establish requirements and procedures for buying and selling policies. It must be stressed that these regulations seek to protect sellers of insurance policies (viators) by ensuring that purchasers refrain from unfair practices or taking advantage of a viator's vulnerability, and do very little to protect the companies or individuals that purchase the policies and the investors that fund the purchase of the policies.[42]

A. The Viatical Settlement Model Act

In 1990, California became the first state to determine that state insurance law should govern the viatical settlement process.[43] Soon after, the National Association of Insurance Commissioners ("NAIC")[44] agreed and adopted the Viatical Settlements Model Act ("the Model Act")[45] in 1993 and the Viatical Settlements Model Regulation ("the Model Regulation")[46] in 1994. The Model Act and Model Regulation contain various provisions regulating the process of viatical settlement, only a few of which are within the scope of this article.

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40. *See id.* at 706; *see also* SEC v. Life Partners, Inc. & Pardo, 898 F. Supp. 14, 17 n.2 (D.D.C. 1995). Simple contract law, securities law, and the Uniform Commercial Code regulate most buyer-seller relationships but fail to encompass the intricacies of a viatical settlement transaction. *See id.*

41. *See* Kosiewicz, *supra* note 8, at 706.

42. *See* Berner, *supra* note 4, at 587; *see also* Eremia, *supra* note 7, at 779.

43. *See* CAL. INS. CODE §§ 101191.1-2 (Deering Supp. 1995).

44. The NAIC is an association comprised of the chief insurance regulatory officers of the 50 states, the District of Columbia, American Samoa, Puerto Rico and the Virgin Islands. *See* Malcolm E. Osborne, *Rapidly Developing Law on Viatical Settlements*, 31 WAKE FOREST L. REV. 471, 474 (1996) (citing KENNETH BLACK JR. & HAROLD D. SKIPPER, JR., LIFE INSURANCE 989-90 (12th ed. 1994)). Its primary objective is to develop model regulations addressing issues and problems in insurance law. *See id.*

45. *See* VIATICAL SETTLEMENTS MODEL ACT (National Ass'n of Ins. Comm'rs 1994), *reprinted in* 4 NATIONAL ASS'N OF INS. COMM'RS, MODEL LAWS, REGULATIONS AND GUIDELINES 697-1 – 697-18 (1995) (hereinafter MODEL ACT).

46. *See* VIATICAL SETTLEMENTS MODEL REGULATION (National Ass'n of Ins. Comm'rs 1994), *reprinted in* 4 NATIONAL ASS'N OF INS. COMM'RS, MODEL LAWS, REGULATIONS AND GUIDELINES 698-1 – 698-7 (1995) (hereinafter MODEL REGULATION).

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1. Licensing Requirements

The Model Act contains certain licensing requirements that a viatical settlement provider must satisfy before he can obtain a license from his state's Commissioner of insurance.[47] Section three of the Model Act requires that a company or individual desiring to enter the viatical settlement industry file an application and pay a fee with the commissioner. The Commissioner then investigates the applicant and issues a license if the following criteria are met:

(1) the applicant files a detailed plan of operation;
(2) the applicant is competent and trustworthy and intends to act in good faith; and
(3) the applicant has a good business reputation and has experience, training or education that has qualified him for the license.[48]

The Model Act further allows the commissioner to revoke any issued license if any one of the following five conditions occur:

(1) there was any misrepresentation in the license application;
(2) the licensee has been guilty of fraudulent or dishonest practices, is subject to a final administrative action or is otherwise shown to be untrustworthy or incompetent;
(3) the licensee demonstrates a pattern of unreasonable payments to policyowners;
(4) the licensee has been convicted of a felony or any misdemeanor of which criminal fraud is an element; or
(5) the licensee has violated any of the provisions of the Act.[49]

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47. Though the NAIC uses the term "Commissioner" it is meant to include any title of a state's chief insurance regulatory official. *See* Osborne, *supra* note 44, at 475.

48. MODEL ACT, *supra* note 45, § 2, at 697-2, 697-3; *see also* Osborne, *supra* note 44, at 475. At least one commentator has stated that licensing requirements limit the parties to whom a viator can sell his policy. *See* Berner, *supra* note 4, at 604-05. However, there is a consensus in the industry that such requirements impart credibility and accountability to viatical settlements. *See* Russel J. Herron, *Regulating Viatical Settlements: Is the Invisible Hand Picking the Pockets of the Terminally Ill?*, 28 U. MICH. J.L. REFORM 931, 945 (1995).

49. MODEL ACT, *supra* note 45, § 4, at 697-3. Section five of the Model Act requires that all viatical settlement contracts be filed with the Commissioner and that the Commissioner approve any such contracts. *See id.* § 5, at 697-3. A contract may be disapproved if it or any of its provisions, are "unreasonable, contrary to the interests of the

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2. Disclosure and Consent Requirements

Section eight of the Model Act requires full disclosure to the viator of alternatives to, and consequences of, the sale of his policy.[50] Some of the information that must be disclosed includes:

(1) alternatives to viatical settlements, including accelerated death benefits which may be offered by the viator's insurer;
(2) the possibility that some or all of the proceeds of the settlement may be taxable;
(3) the possibility that settlement proceeds may be subject to the claims of creditors;
(4) the fact that receipt of settlement funds may preclude a viator's eligibility for Medicaid or other government benefits or entitlements;
(5) the viators right to rescind a settlement contract within 30 days of the date it was executed or within 15 days after the receipt of the settlement funds, whichever is less; and
(6) the date on which the settlement funds will be made available to the viator, and the source of these funds.[51]

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public, or otherwise misleading or unfair to the policyholder." *Id.*; *see also* Osborne, *supra* note 44, at 476. Section six requires an annual statement to be filed with the Commissioner "containing such information as the Commissioner by rule may prescribe." MODEL ACT, *supra* note 45, § 6, at 697-4. Section seven allows the Commissioner to examine the viatical settlement provider after the license has been issued or while the license is pending, as well as demand the production of any books, records or other information with the exception of names and certain data that are deemed private and confidential. *See id.*

50. *See id.* § 8, at 697-4. The disclosure requirements must be met by the date the viatial settlement is signed by all parties. *See id.*

51. *Id.* Full disclosure to viators is particularly important because in some cases, viatication is not the best way for a viator to maximize the value of his policy. *See* Herron, *supra* note 48, at 940.

Accelerated Death Benefits is a rider to cash value or term life insurance that changes the way death benefits are paid. *See* WOLK, *supra* note 12, at 11-12. Basically, the rider allows a terminally ill insured to receive some or all of the death benefits that would normally be paid to beneficiaries. *See id.* at 12. While only some insurers offer the rider the payments can meet and sometimes exceed the proceeds an insured would receive from a viatical settlement. *See id.* Payments range from 50 to 100% of the death benefit but insurers offer the rider under limited circumstances. *See id.* For example, some insurers require that the rider be on the insured's policy *prior to* diagnosis or that the insured's life expectancy is six months or less. *See id.* at 14.

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Section nine contains a provision that requires the viatical settlement provider to obtain a written statement from a licensed attending physician that the viator is of "sound mind and under no constraint or undue influence."[52] Furthermore, the settlement provider must procure a witnessed document from the insured stating that the viator freely consents to the contract, understands the contract, acknowledges the catastrophic life threatening illness, has a full and complete understanding of the benefits of the life insurance policy, and releases his or her medical records.[53]

Most importantly, Section ten of the Model Act allows the Commissioner to set standards regarding reasonableness of payments under viatical settlement contracts.[54] This section is especially important because it allows the Commissioner to enact and regulate discount rates that determine the amount paid to a viator in exchange for the sale, assignment or transfer of his policy.[55] The significance of this provision for purchasers and investors is illuminated when examined in conjunction with a correlative provision of the Model Regulation. These provisions, taken together, reveal a startling obstacle to investor and purchaser enthusiasm for the viatical settlement industry.

B. The Viatical Settlements Model Regulation

After the Model Act's adoption in 1993, the NAIC began designing the Model Regulation which was eventually approved and adopted in 1994. As with the Model Act, the main thrust of the Model Regulation is viator protection. The provision seeks to protect viators whose delicate mental and physical conditions render them easy targets for unscrupulous purchasers. As alluded to above, the promulgation of minimum amounts to be paid to viators in exchange for their policies constitutes the most significant aspect of the Model Regulation. Section four of the Model Regulation weighs three factors in determining the minimum amount to be

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It is also important for the viator to consider that the proceeds he receives from a viatical settlement may disqualify him from receiving "needs-based" government benefits like Supplemental Security Income, food stamps, welfare and Medicaid. *See id.* at 28. In some circumstances, the loss of these benefits might be too harmful a consequence and the insured should consider alternatives to viatication. *See id.*

52. MODEL ACT, *supra* note 45, § 9, at 697-5.

53. *See id.*

54. *See id.* § 10, at 697-5.

55. *See id.*

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paid to viators: (1) the viator's life expectancy; (2) any outstanding loans received by the viator; and (3) the insurer's rating.[56] The following minimum discount rates are set forth in the Model Regulation: [57]

Life Expectancy	Minimum % of Insured's Policy's Face Value
Less than 6 months	80%
At least 6 but less than 12 months	70%
At least 12 but less than 18 months	65%
At least 18 months but less than 24 months	60%
24 months or more	50%

The percentage for each level of life expectancy can be reduced by five percent if the policy being viaticated was written by an insurer rated lower than the highest four categories in A.M. Best or a comparable rating by another agency.[58]

These minimum payouts constitute the most controversial element of viatical settlement regulation and much of the dispute centers around the substantial profits often realized by purchasers.[59] According to some early estimates, viatical settlement purchasers averaged roughly twenty percent profit on each transaction.[60] Such impressive profits prompted concern by many that purchasers were low-balling viators on settlement prices.[61] The NAIC, presumably in response to these concerns, included minimum discount rates in its Model Regulation.

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56. *See* MODEL REGULATION, *supra* note 46, § 4, at 698-2; *see also* Osborne, *supra* note 44, at 481. Generally, a viatical settlement purchaser will analyze a viator's entire medical history when determining life expectancy, but if the viator suffers from HIV or AIDS, the purchaser will also heavily consider the viators CD-4 cell count. *See* Herron, *supra* note 48, at 950. A persons CD-4 cell count determines his ability to resist infection and as AIDS progresses, the CD-4 count decreases dramatically. *See id.*

57. *See* MODEL REGULATION, *supra* note 46, § 4, at 698-2.

58. *See id.; see also* Herron, *supra* note 48, at 950. A.M. Best is an organization that analyzes and rates insurance companies based on their annual financial statement. *See id.* at 949.

59. *See id.* at 947.

60. *See id.*

61. *See id.*

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C. *Regulation of Viatical Settlements by States*

The Model Act and Model Regulation were intended, as their names suggest, to function as a prototype for state regulation of viatical settlements. At the time of this writing, twenty-seven states regulate the viatical settlement industry in some capacity and almost all of these states have adopted legislation that strongly parallels the Model provisions.[62] The general regulatory uniformity among states extends to licensing, disclosure, reporting and license revocation requirements, and the wording of their respective provisions mirrors the phrasing of the Model's.[63] The widespread acceptance of these provisions stems from a shared interest in

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62. The following states currently have regulations regarding viatical settlements: Arkansas, California, Connecticut, Delaware, Florida, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Michigan, Minnesota, Montana, New Mexico, New York, North Carolina, North Dakota, Oklahoma, Oregon, South Dakota, Texas, Vermont, Virginia, Washington, and Wisconsin. *See* NAIC Compendium of State Laws on Insurance Topics: Viatical Settlements (Living Benefits) (this compendium is updated monthly and is available from the NAIC).

Iowa and South Dakota have passed legislation relating to viatical settlements but the statutory provisions address the treatment of viatical settlements as securities and bring such settlements under the purview of each states Securities Division. *See* IOWA CODE ANN. §§ 502.102, 502.202 (West 1999); S.D. CODIFIED LAWS §§ 47-31A-401–47-31A-402 (Michie 1999).

63. *See* ARK. CODE ANN. §§ 28-81-501–28-81-512 (Michie 1987), Ark. Reg. 69; CAL. INS. CODE §§ 10113.1–10113.2 (West 2000); CONN. GEN. STAT. ANN. §§ 38a-465–38a-465m (West 1999); DEL. CODE ANN. tit. 18, §§ 7501-7511 (1999); FLA. STAT. ANN. §§ 626.991–626.993 (West 1999); 215 ILL. COMP. STAT. ANN. 158/1–158/99 (West 1999); IND. CODE ANN. §§ 27-8-19.8-1–27-8-19.8-25 (West 1999); 1999 KAN. SESS. LAWS 151; KY. REV. STAT. ANN. §§ 304.15–304.20, 304.15-700–304.15.725 (Banks-Baldwin 1998); LA. REV. STAT. ANN. §§ 22:201–22.210.1 (West 1999), LA. INS. ADMIN. CODE 58; ME. REV. STAT. ANN. tit. 24-A, §§ 6801-6814, tit. 32, §§ 10501–10504, 10607-A (West 1999); MICH. COMP. LAWS ANN. §§ 550.521–550.528 (West 1999); MINN. STAT. ANN. §§ 60A.961 – 974 (West 1999); MONT. CODE ANN. §§ 33-20-1301–33-20-1315, 33-18-203 (1999); N.M. STAT. ANN. §§ 59A-20-34–59A-20-36 (Michie 1999); N.Y. INS. LAW §§ 7801–7810 (McKinney 1999); N.C. GEN. STAT. § 58-58-42 (1998), N.C. ADMIN. CODE tit. 11, r. 12.1704 (Dec. 1999); N.D. CENT. CODE §§ 26.1-33.1-01–26.1-33.1-10 (1999); OKLA. STAT. ANN. tit. 36, §§ 4041-4052 (West 1999); OR. REV. STAT. §§ 744.319–744.358 (1999), OR. ADMIN. R. 836-014-0200–836-014-0330 (1998); TEX. INS. CODE ANN. art. 3.50-6A (West 1999); VT. STAT. ANN. tit. 8, §§ 3826–3834 (1999), VT. ADMIN R. 95-4 (2000); VA. CODE ANN. §§ 38.2-5700–38.2-5707 (Michie 1999), 14 VA. ADMIN. CODE 5-71-10– 5-71-100 (2000); WASH. REV. CODE ANN. §§ 48.102.005–48.102.901 (West 1999), WASH. ADMIN. CODE §§ 284-97-010–284-97-050 (2000); WIS. STAT. ANN. § 632.68 (West 1999).

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protecting viators and assuring that they make an informed choice when entering into a viatical settlement.[64]

There is less of a consensus among states with regard to minimum discount rates, the regulatory issue most significant to the resolution of the problem posed by this note. Of the twenty-seven states that regulate viatical settlements, nine specify minimum discount rates, nine authorize their insurance Commissioners to set discount rates at any time, and three explicitly forbid them.[65]

Though protection of viators motivated the regulations, policy sellers and buyers alike have attacked the minimum discount provisions contained in the Model Regulation as problematic.

1. Criticism by Sellers

At least one commentator has criticized the provision allowing insurance Commissioners to set minimum discount rates as an impediment to a viator's ability to obtain the highest possible price for his policy.[66] According to this argument, the existence of minimum discount rates diminishes the possibility of competitive pricing in the market and violates our legal system's preference for the free alienation of property.[67]

The focal point of the attack on minimum discount rates and licensing requirements is the general preference that American law places on the free alienation of property.[68] The supreme value we place on the ability to

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64. *See* Kosiewicz, *supra* note 8, at 702. Proponents of industry regulation maintain that such regulation equalizes the power imbalance inherent in a transaction between a vulnerable, financially strapped viator and a resource and asset-rich company. A transaction with such unequal bargaining power necessitates some form of regulation to ensure fairness. *See id.* The disclosure requirements are particularly vital to the protection of the viator due to the serious ramifications of selling one's policy, including potential preferential tax treatment and the possibility of no longer qualifying for various state and federal entitlement programs. *See id.* at 704.

65. The nine states with regulations that specify discount rates are: Arkansas, Louisiana, Minnesota, Oregon, North Carolina, Vermont, Virginia, Washington and Wisconsin. The nine states that authorize the insurance Commissioner to set discount rates are: California, Delaware, Illinois, Indiana, Kansas, Maine, Montana, New Mexico, and Oklahoma. The three states that explicitly forbid discount rates are: Connecticut, Florida, and Texas.

66. *See* Berner, *supra* note 4, at 587-89.

67. *See id.* at 591-92.

68. *See id.*; Stewart E. Sterk, *Restraints on Alienation of Human Capital*, 79 VA. L. REV. 383, 384-86 (1993); Guido Calabresi & A. Douglas Melamed, *Property Rules,*

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freely alienate our property stems from several fundamental beliefs. First, the principle of unfettered alienability certifies that property will go to those that want and value it most.[69] Second, an individual's right to freely alienate his property enhances his freedom to make those decisions that can heighten his quality of life.[70] Though American courts and law makers frown upon restraints on alienation of one's property, some exceptions have been recognized where major economic or public policy reasons exist for doing so.[71]

In addition to impeding a viator's ability to freely alienate his property, minimum discount rates also deny the viator the advantage of competitive pricing in the industry and, thus, often prevent him from receiving the highest possible amount for his policy. Critics argue that viatical companies have no incentive to increase their offers since each company offers similar, if not identical, prices and none wants to disturb the handsome profit these prices afford them and their investors.[72] The mandated

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Liability Rules, and Alienability: One View of the Cathedral, 85 HARV. L. REV. 1089, 1090 (1972).

69. *See* Sterk, *supra* note 68, at 383.

70. *See id.* at 382, 384. Sterk also raises a third point, that free alienability aids in controlling the market by driving the increase in the production of goods that buyers want and decreasing the production of those goods that buyers do not want. *See id.* at 383-84.

71. *See generally* Berner, *supra* note 4, at 592. Some examples of inalienabililty rules include restraints when the alienability of certain forms of property and in certain amounts lead to harmful monopolies which negatively impact the general public. *See* Sterk, *supra* note 68, at 387. For example, almost all states have statutes that proscribe transactions and contracts in order to prevent harm to the general public. *See, e.g.*, ALA. CODE § 8-10-1 (1993) (stating that forming or maintaining monopolies of businesses or industries is illegal); ALASKA STAT. § 45.50.562 (Michie 1992) (outlawing certain alliances and unions that restrain trade); N.Y. GEN. BUS. LAW 340 (McKinney 1993) (outlawing contracts restraining trade). *See generally* Berner, *supra* note 4, at 592.

Restraints on alienation also take on a moral character and militate against transactions such as selling oneself into slavery or prostitution. *See* Sterk, *supra* note 68, at 387. An example of how courts refuse to recognize such transactions is the fact that courts decline to enforce involuntary servitudes and rarely order specific performance of personal service contracts. *See, e.g.*, Woolley v. Embassy Suites, Inc., 278 Cal. Rptr. 719, 727 (Cal. Ct. App. 1991) (refusing to compel the specific performance of a personal service contract because it would violate the thirteenth amendment's protection against involuntary servitude).

72. *See* Berner, *supra* note 4, at 600.

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minimum prices often become the maximum prices offered by companies because this amount maximizes their profit and minimizes the risks.[73]

Some opponents of minimum discount rates assert that an abolishment of these rates would force viatical companies to be competitive and offer higher prices for policies. In turn, viators would receive the highest possible prices for their policies by guaranteeing that they would be bought by the company that values them most. While minimum discount rates, in theory, protect viators from seriously low and unfair offers, the opposite can often result. When viators shop for a company to purchase their policy, they invariably receive nearly identical offers from each company they approach. These discount rates afford the purchasers substantial profits on the transaction and deny the viator any meaningful choice.

2. Criticism by Buyers and Investors

While concern over the absence of competition on the seller side of life insurance policies is not misplaced, this author feels that the concerns echoed by the purchaser side of viatical transactions over minimum discount rates represents a far more serious and urgent problem.

When a viatical settlement company purchases a policy, or an investor invests his money with a viatical company, both parties undertake substantial risk. The profitability of a viatical transaction turns on the predictability of life expectancy, a variable that is largely unpredictable.[74] The unpredictability of a terminally or chronically ill viator's life expectancy has increased exponentially over the past decade due to advances made in the medical field. This unpredictability promises to become an even larger problem as medical science continues to develop new cures and treatments for conditions formerly deemed terminal or

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73. *See id.* at 600-01. When viatical settlement companies purchase policies they assume all future premium payments in addition to the regular overhead costs of entering the business, such as annual licensing fees and the costs of extensive record-keeping required by regulation. In addition, they also assume the risk that the viator will not "die on time" as any premium payment beyond the expected date of death eats into their profit margin, often very significantly. *See id.* As a result, companies have no incentive to make offers above and beyond the minimum discount rates mandated by regulation. Furthermore, with the risk that, on any day, a cure for AIDS may be found, viatical companies are even more reluctant to offer any price higher than that which is required by law.

74. *See* Eremia, *supra* note 7, at 783.

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chronic.[75] Medical research and treatments aside, predicting the life expectancy of an AIDS patient is very uncertain. Though CD-4 cell counts are fairly accurate predictors of a person's susceptibility to infections, many AIDS patients live for considerable periods of time with almost no CD-4 cells, and without acquiring any infection.[76] The uncertainty that surrounds life expectancy predictions is extremely problematic for purchasers and investors because a miscalculation could result in a major financial loss. Furthermore, purchasers and investors face another risk that the insurance carrier may become insolvent or might otherwise default on its death benefit obligation, resulting in a total loss on the investment.[77] Moreover, the original beneficiaries of a viaticated policy may challenge the transaction in court, resulting in costly litigation that detracts from the profitability of the transaction.[78] Regulatory authorities have largely ignored these risks incurred on the purchaser side of the transaction, despite the chilling effect they may have on the entire industry.

The attendant risks of a viatical transaction coupled with the mandated minimum discount rates set forth in some state legislation reveal an increasingly less attractive transaction. When a purchaser is forced to pay a minimum amount for a policy and, consequently, an investor is forced to contribute a correlative amount, the inherent risks in the transaction may counsel abstention altogether in order to avoid the possibility of sustaining a net loss due to the unexpected longevity of the viator, the chance that the insurer will default on its obligation, or the chance that the original beneficiaries will challenge the settlement in court.[79] Indeed, it seems that in many cases the mandated minimum discount rates are vastly disproportionate to the inherent risks in the transaction.[80] If the primary

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75. *See supra* notes 33-38 and accompanying text; *see also* Kosiewicz, *supra* note 8, at 703-04.

76. *See* Herron, *supra* note 48, at 951.

77. *See* Eremia, *supra* note 7, at 783.

78. *See id.*

79. *See* Kosiewicz, *supra* note 8, at 707.

80. *See* Eremia, *supra* note 7, at 783. It is interesting to note that the NAIC's legislative history reflects some early concerns over mandating minimum discount rates for settlement payouts. One such provision explains:

> A spokesperson for an association of people with AIDS expressed concern about minimum payouts. While wanting to assure that the association's members receive the highest payout for their policies, he said he did not feel mandating a minimum payment was an effective way. While seemingly well intended, regulating a

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incentive for purchasing and investing in life insurance policies is financial gain, and minimum discount rates pose a substantial threat to this goal, many investors and purchasers will hesitate to enter the industry. The loss of participants who purchase and put up capital to purchase policies is a blow the industry may not be able to sustain. If minimum discount rates frighten away enough purchasers and investors, the lifeblood of the industry will vanish and viators in desperate need of money will have no where to turn.

Mandatory rates also ignore the possibility that viators may want to sell their policies at rates below the statutory minimum. If a viator has a longer life expectancy, or his insurance carrier is not as reputable as those in the highest four A.M. Best categories, viatical settlement companies will likely turn him away out of fear of costly premium payments and the risk that the insurance writer may not be able to satisfy the claim for death benefits once the viator dies.[81] Rather than being permitted to make lower offers to account for certain risks, a viatical settlement purchaser will be forced to decline the transaction altogether if state law governing the transaction mandates minimum payouts. As a result, purchasers will not buy riskier policies and many insured's will be unable to viaticate their policies.[82] It seems that the regulations that were intended to help people live in relative comfort and dignity in their final days may actually prevent them from doing so.

To restate, the majority of states that regulate viatical settlements either explicitly mandate minimum discount rates or expressly authorize their Insurance Commissioners to create them at any time. These provisions

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> minimum payout could very well have the negative impact that it was intended to solve. He pointed out that viatical settlement companies take risks when buying a policy; risks related to time and to the rating of the underlying insurance company. He said the length of time that a viatical settlement company will hold the policy will naturally affect its carrying costs, since there is no way that an insured's exact longevity can be determined, particularly as more effective therapies are being developed that offer the promise of extended life for people with AIDS. He was also concerned that a minimum payout would greatly discourage, if not eliminate, the terminally ill person's option of selling a lower rated company's insurance policy.

MODEL ACT, *supra* note 45, §10, at 697-717.

81. *See supra* notes 45-46 and accompanying text.

82. *See* WOLK, *supra* note 12, at 66.

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may have detrimental effects on the industry if enough investors and purchasers abandon viatical settlements for more lucrative and secure investments.

The motivating factor behind viatical settlements is to allow insureds in desperate need of money to liquify a valuable and otherwise dormant asset. When the industry began to grow, and the need for regulatory oversight heightened, it appeared that the best way to accomplish this objective was to impose a regulatory scheme exclusively tailored to protecting viators. Today, with the benefit of a decade of experience to reflect on, it seems that some facets of the regulatory scheme actually work at cross purposes with viator's interests.

Rather than imposing a regulatory system that exclusively and vigorously safeguards viators, this author feels that the best way to protect viators is to protect purchasers and investors. After all, it is the continued participation of purchasers and investors upon which viator interests depend.

D. Recent Amendment to Model Regulation

Perhaps in response to concerns over a mass exodus of investors and purchasers from the industry, the NAIC in 1999 amended the Model Regulation to provide an alternative to minimum discount rates. This alternative allows viatical settlements to be judged by a reasonableness standard. Rather than promulgating definitive, fixed amounts, this new provision sets forth factors to determine reasonability and fairness of the payout. Among other factors left to the discretion of the states, the Commissioner may consider: (1) the life expectancy of the insured; (2) the rating of the insurance company that issued the policy; (3) the prevailing discount rates in the state; and (4) the prevailing discount rates in other states.[83]

1. Advantages of Reasonableness Standard

A reasonableness standard fulfills the regulatory goal of protecting viators, while simultaneously eliminating the numerous drawbacks of mandated minimum discount rates. The viator secures adequate protection from unscrupulous viatical settlement providers because the Commissioner

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83. *See* VIATICAL SETTLEMENTS MODEL REGULATION (National Ass'n of Ins. Comm'rs 1999), *reprinted in* 4 NATIONAL ASS'N OF INS. COMM'RS, MODEL LAWS, REGULATIONS AND GUIDELINES § 5, at 698-3 (1999).

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can review the settlement amount to determine if it is just and reasonable. Furthermore, this alternative also affords important protection to a previously marginalized group, purchasers and investors. Under a reasonableness standard, purchasers are not bound by mandated discount rates and can assess their risks and calculate a settlement offer that covers these risks yet still affords them a profit. This amendment represents one of the first efforts by the NAIC to protect purchasers and investors and presumably constitutes a recognition of the importance of these parties to the continued success of the industry. The NAIC, however, only promulgates model regulations for the states to consider when drafting their legislation. Therefore, it is important that states also recognize the importance of these parties when drafting or reevaluating their viatical settlement provisions.

In devising a regulatory scheme to govern viatical settlements, states must balance the diverse and often conflicting interests of all interested parties. While ensuring that viators receive reasonable settlement offers, states must simultaneously weigh the interests of purchasers and investors. If profit margins are too slim and risks too high, an inability to attract investors may force viatical settlement purchasers out of business.

The states that currently mandate or allow minimum discount rates should reevaluate their legislation and adopt a reasonableness standard in order to ensure the involvement of investors and the continued success of the viatical settlement industry in its humanitarian objective.

III. FRAUDULENT MISREPRESENTATIONS IN POLICY APPLICATIONS

Over the past decade, the viatical settlement industry has experienced remarkable growth, largely because viators and purchasers quickly realized the potential to make considerable sums of money. The potential for making a "killing," so to speak, has also created an incentive for industry participants to engage in fraudulent practices. This section addresses two types of fraud – fraud perpetrated against insurance companies by policy applicants and fraud perpetrated against both insurance companies and investors by viatical settlement purchasers.

Fraud has become common in the industry and has prompted some commentators to label viatical scams as one of the top ten financial cons in

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the country.[84] The prevalence of industry fraud serves as another disincentive for purchasers and investors to participate in viatical transactions and demands immediate attention if the industry is to continue to thrive.

A. Purchaser Fraud on Insurers and Investors

Some viatical settlement companies now recruit the old, young, sick, and healthy to purchase life insurance policies for the sole purpose of immediately buying them from the insured.[85] The insured, in return, receives a lump-sum payment for participating in the transaction.[86] The transfer of a newly issued policy is referred to as a "wet ink" transaction because the policy is transferred before the ink dries.[87] It is difficult to understand how a purchaser reaps a profit from a wet-ink transaction if the insured is young and healthy. The only imaginable scenario where a purchaser would realize a substantial return is if the applicant falsifies the health information provided to the insurance company in the application process, a practice called "cleansheeting."[88] Such actions constitute fraud that the insurance company will likely detect, particularly if the policy is large, and the insurance company will thereby reject the application.[89] However, it is inevitable that some misrepresentations escape detection.

Concern over fraudulent practices in the viatical settlement industry has recently heightened due to several highly publicized and egregious cases of "cleansheeting."[90]

1. Justus Viatical Group

Justus Viatical Group, a Florida viatical settlement company, was recently charged with selling fraudulently obtained wet ink policies.[91] Its

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84. This past May, the North American Securities Administrative Association noted the abundance of viatical settlement scams in recent years, and pegged such transactions as one of the country's top 10 cons. *See* Eisenberg, *supra* note 31.

85. *See* Jane Bryant Quinn, *The Lottery On Lives*, NEWSWEEK, March 15, 1999, at 55.

86. *See id.*

87. *See* Belth, *supra* note 3, at 175.

88. *See id.*

89. *See id.*

90. In response to an increase in the incidents of wet ink transactions and cleansheeting, the VAA, at its semi-annual spring meeting in May 1999, adopted a solid stance against the viatication of newly issued life insurance policies purchased with the express intent of immediately selling them. *See VAA News Release* (visited Jan. 16, 2000) <http://www.viatical.org/news.html>.

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vice president, Stephen Bendfelt, was indicted on charges of organized fraud, grand theft and insurance fraud.[92] Investigators from the Office of Statewide Prosecution and the State Insurance Commissioner probed complaints by various anonymous parties, and on January 7, 1999, the Florida Insurance Commissioner issued an order against Justus alleging several violations of state and federal law.[93] According to the order, Justus engaged in a "cleansheeting" scheme worth about $3 million between 1997 and 1998 and viaticated these cleansheeted policies to various investors.[94] The order further alleged that Justus made arrangements with policy applicants to purchase their policies before they were issued and encouraged applicants not to disclose terminal illnesses in order to assure acceptance of the application.[95] Justus was ordered to cease and desist from viaticating any more insurance policies in Florida and a hearing on the matter is currently pending.[96]

2. First American Fidelity Corporation

In another recent case of cleansheeting, a Dallas County Grand jury indicted Michael Davis and his viatical company, First American Fidelity Corp., on fraud and other charges.[97] According to court documents, Davis convinced several HIV-positive men to conceal their conditions and purchase multiple $50,000-$100,000 life insurance policies, which usually do not require a physical examination or blood test.[98] Davis is currently awaiting trial while his investors are holding roughly $10 million in life

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91. *See id.; see also* Quinn, *supra* note 85.

92. *See* Paula McMahon, *Viatical Executive Charged in Fraudulent Purchases; Inquiry Targets Pompano Firm,* SUN-SENTINEL (Fort Lauderdale), Oct. 27, 1999, at 1D.

93. *See* Belth, *supra* note 3, at 175.

94. *See id.* The order also alleged that Justus was not licensed to transact viatical business in Florida after its application to do so was denied in 1998 after "careful review of the biographical affidavits, investigative reports and on-site investigations." *Id.*

95. *See id.* The terminally ill applicants reportedly bought several policies without disclosing their terminal conditions. Because the policies they purchased were worth less than $100,000, they did not have to undergo physical exams or blood tests to confirm the information they provided. *See* McMahon, *supra* note 92.

96. *See* Belth, supranote 3, at 176. In another recent Florida controversy, a federal grand jury indicted Frederick Brandau and his company, Financial Federated Title & Trust, last summer for allegedly defrauding thousands of viatical settlement investors across the county in an intricate and sophisticated $115 million scheme. *See* Eisenberg, *supra* note 31.

97. *See* Eisenberg, *supra* note 31.

98. *See id.*

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insurance policies which will likely be worthless if the court finds these transactions fraudulent.[99]

3. Mutual Benefits Corporation

Another prominent case, *State v. Viatical Services, Inc.*,[100] has received significant media attention. Mutual Benefits Corp. ("Mutual") is a Florida-based viatical settlement company. On June 7, 1999, an investigator from the Insurance Fraud Division of the Department of Insurance ("Department") applied for a search warrant to search the premises of Mutual for various business, financial and other records revealing attempts by Mutual to conceal medical conditions of life insurance applicants and policyholders.[101] The warrant was based on the Department's review of certain of Mutual's files, twenty-two percent of which were missing disclosures of required information. The Department had already ascertained that sixteen files showed "obvious fraud in the application for life insurance by the insured, generally by the insured lying about his or her terminal illness when applying for the policy."[102] This discovery indicated a pervasive pattern of fraudulent practices by Mutual in the purchase and sale of its policies. The trial judge issued the warrant and at the time of this writing, the findings of the warrant have not yet been made public.

Cases such as these seem to be rampant, especially in states which conduct a high volume of viatical transactions. The Florida Department of Insurance noted in August of last year that at least five of the state's eight licensed viatical settlement companies were under scrutiny for allegations of cleansheeting.[103] When viatical settlement companies encourage terminally or chronically ill individuals to misrepresent their health in order to obtain policies, they often do so at the ignorance of their investors. When authorities discover this conduct, investors are left holding worthless policies and incur a total loss on their investment. Quite obviously, the possibility of such unconscionable conduct acts as a strong disincentive for investors to participate in the viatical settlement industry.

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99. *See id.*

100. 741 So. 2d 560 (Fla. 1999).

101. *See id.* at 561.

102. *Id.* This misrepresentation would be known to Mutual when it purchased the policy and sold it to an investor. *See id.*

103. *See* McMahon, *supra* note 92.

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B. Viator Fraud on Insurance Companies

Viatication allows viators access to immediate money if they have a life insurance policy to sell and, therefore, provides an incentive for terminally or chronically ill persons to fraudulently procure policies. When an insurer issues a policy based on fraudulent misrepresentations of the applicant's health, both purchasers and investors are left in a precarious situation.

1. *Protective Life Insurance Co. v. Sullivan*[104]

In a recent case, Dennis Sullivan misrepresented his HIV status on a policy application to Protective Life Insurance ("Protective"). Though Protective had the option of requiring a medical exam, including a blood test, it declined this option and issued Sullivan a policy worth $100,000 with a two year contestability period and an exception for fraud which would allow Protective to rescind the policy at any time, even beyond the expiration of two years.[105] Two years after the policy's issuance, Sullivan sold it to Dignity Viatical Settlement Partners L.P. and received $73,000.[106] Less than a year later, Protective challenged the policy, claiming that Sullivan fraudulently misrepresented his health in order to obtain the policy.[107] The court found that Massachusetts state law forbids fraud-based exceptions to incontestability clauses, notwithstanding language in the policy.[108] While stating that Sullivan's conduct was "deplorable and

104. 682 N.E.2d 624 (Mass. 1997).

105. *See id.* at 626-27. The policy stated: "[Protective Life] cannot bring any legal action to contest the validity of this policy after it has been in force two years except for failure to pay premiums unless fraud is involved." *Id.* Incontestability clauses limit the amount of time in which an insurance company can investigate fraud or other violations that may void the policy. *See* Albert, *supra* note 1, at 371. Basically, an insurance provider has a set period of time, typically two years, in which to uncover any abuses in the application process. *See id.* After the expiration of the contestability period, any fraudulent misrepresentations are considered to be erased and the insurer must pay on the policy when the insured dies. *See id.* at 371-72. There are a few exceptions to an incontestability clause that allow an insurer to deny payment beyond the two years. They typically include non-payment of premiums and violations of certain policy restrictions on military or naval service in wartime. *See id.*

106. *See Sullivan*, 682 N.E.2d at 627.

107. *See id.* at 624.

108. *See id.*

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deserved condemnation,"[109] the court declared that Protective could have discovered the fraud had it exercised reasonable diligence.

2. Ronald McDonald

In a similar case, an HIV-positive man, Ronald McDonald, received a two-year prison sentence in January of 2000 after being found guilty of lying about his health in order to purchase, and later sell, his life insurance policies.[110] McDonald enlisted the help of a Dallas life insurance agent to acquire three policy applications.[111] Allegedly, the insurance agent urged McDonald to leave the health questions blank so that he could fill them in himself and make McDonald appear to be perfectly healthy.[112] Two insurance companies, Illinois Mutual Life Insurance and American Amicable Life Insurance, issued McDonald policies with a total face value of $155,000.[113] Two weeks later, he sold the policies to a Florida viatical company.[114] In an interview last year, McDonald revealed that he knowingly permitted his agent to conceal his health in order to procure life insurance policies that he could later sell in order to provide for the future of his young son. McDonald was charged with two counts of mail fraud for mailing the two insurance applications and one count of wire fraud for transmitting a fraudulent application by computer modem.[115]

3. *Amex Life Assurance Company v. The Superior Court of Los Angeles County and Slome Capital Corp.*[116]

Another troubling case underscores the growing tension surrounding the prevalence of fraud in viatical settlement transactions. In *Amex*, Jose Morales knowingly failed to disclose his HIV status on a policy application to the insurance company. When Amex requested a medical examination, Morales intensified his fraud by sending his brother to take the exam in his place.[117] Although Morales' brother was four inches taller and thirty pounds heavier, Amex failed to notice the discrepancies and issued Morales

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109. *Id.* at 633.

110. *See* Paula Christian, *Man Who Lied About HIV Status Gets Prison Time,* NEWS & RECORD (Greensboro, N.C.), Jan. 25, 2000, at B1.

111. *See id.*

112. *See id.*

113. *See id.*

114. *See id.*

115. *See id.*

116. 930 P.2d 1264 (Cal. 1994).

117. *See id.* at 1266.

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a policy with a two-year incontestability period that prohibited Amex from challenging the policy, except for non-payment of premiums, after it had been in effect for two years.[118] Slightly more than two years after the issuance of the policy, Morales died of complications from AIDS. Just prior to his death, however, Morales viaticated his policy to Slome, a viatical settlement purchaser.[119] Before Amex paid Slome the death benefit on the policy, it learned that an imposter took Morales' medical exam and consequently denied payment. Relying on the incontestability clause, Slome sued Amex for breach of contract, insurance bad faith and equitable estoppel.[120] Amex attempted, unsuccessfully, to persuade the court that because Morales hired an imposter to take the medical exam, the policy does not insure Morales, but rather his brother, the person whose health information they relied upon.[121] The court rejected this view and held that even though Morales engaged in gross and willful fraud, Amex had to pay Slome. The court noted that the premiums on the policy had been paid past the two year contestability period and that "with minimal effort, Amex could have discovered the fraud at the outset."[122]

Though these cases involve viators who live beyond the two-year contestability period and, therefore, purchasers and investors realize a return on their investment, the growing frequency of this type of fraud casts a shadow over viatical transactions and taints the entire industry. Many of these cases, because of the egregiousness of the fraud involved, attract significant media attention and elicit criticism by opponents of the viatical settlement industry. Furthermore, when insurance companies challenge fraudulently obtained policies, which they usually do, the viatical settlement purchasers incur costly litigation expenses. These expenses detract from the profitability of the transaction and discourage investors from entering the industry. Another obvious disincentive for investors arises if, instead of the viator dying after the expiration of the contestability period, he dies during the two years within which the insurer can rescind the policy. In this scenario, the purchaser and investor would likely face a total loss on the transaction.

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118. *See id.* at 1265-66.

119. *See id.* at 1265.

120. *See id.*

121. *See id.* at 1266-67.

122. Superior Court v. Slome Capital Corp., 51 Cal. Rptr. 2d 354, 363 (Cal. App. 1996); *see also* Victoria Slind-Flor, *9th Circuit Gives Victory to Viaticals: Insurer to Pay in Case Where Imposter Took the Physical*, THE NAT'L. L.J., Mar. 10, 1997, at A6.

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C. *Current Regulation and Fraud*

The Model Act and the Model Regulation, after which states have modeled their viatical settlement regulation, have paternalistic overtones.[123] The provisions are intended to protect viators who may be in danger of coercive pressure and unfair settlement offers in their fragile emotional and physical states.

At one level, regulating the seller side of viatical settlements comports with common sense because in many situations viators need protection from unscrupulous purchasers. In such a young industry, where many people do not know or understand the ramifications of and alternative options to a viatical settlement, it is vital to require purchasers to disclose certain information and maintain a certain level of conduct. Furthermore, many viators desperately need money to pay medical expenses, car loans, mortgage payments and the like, and it is therefore essential that they receive all the information necessary to reach the most financially cogent decision. The current regulations governing viatical settlements seem to appropriately address these concerns and have thus far been quite successful.

As it is important to protect the seller side of viatical settlements, it is equally important to protect the purchaser side. The current regulations trivialize and largely ignore the growing problem of fraudulent practices in the industry that negatively affect the purchasers of, and investors in, life insurance policies. Both investors and purchasers have been the subject of fraud in the industry and the growing prevalence of such occurrences threatens the survival of the industry.

The current regulations fail to adequately safeguard against fraudulent practices. In order for viatical settlements to continue to meet the needs of desperate, financially strapped viators, the industry must take action to combat fraud.

D. *Proposed Solutions to Fraud*

Commentators have proposed several ways to combat the increasing incidents of fraud in obtaining and collecting on life insurance policies. Most of these suggestions promise only marginally effective results and fail to adequately address the problem of ensuring investor participation in the industry.

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123. *See* Berner, *supra* note 4, at 588.

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1. Lengthening or Eliminating Incontestability Clauses

Much of the concern surrounding fraud focuses on incontestability clauses in the policies.[124] Many in the insurance industry have suggested eliminating incontestability periods entirely or, at the very least, increasing the length of time during which insurers can investigate and uncover fraud.[125] While extending the contestability period on life insurance policies presents a relatively easy way to ferret out unprincipled viators, these periods serve an important function and should not be lengthened. Such clauses protect the insured and provide peace of mind by eliminating the possibility that the insured will pay premiums for years, only to have the insurance agency deny coverage.[126] Furthermore, two years gives an insurance company ample time to take the necessary steps to protect its interests. It seems only fair that if the insurer voluntarily enters into a relationship with an applicant and accepts premium payments, the insurer should have to pay out. While incontestability clauses may provide a dishonest policy applicant an avenue to secure payments of benefits, the public policy reasons for these clauses counsel against lengthening them.

Furthermore, legislation that either lengthened or eliminated contestability periods would ultimately hurt the viatical settlement industry. If an insurance company were allowed to deny payment of benefits after the death of the insured beyond the two-year period, the chance of the purchaser and investor incurring a new loss on the transaction increases substantially. This threat would drive investors away from the viatical industry and endanger viators who desperately need money but are unable to find buyers. Large amounts of cash constitute a crucial element of the viatication process, and few viatical companies have the resources to conduct business without the help of investors.

Another option includes passing legislation that would render a life insurance policy procured through cleansheeting or other fraudulent misrepresentations void. Such legislation would void the policy even beyond the contestability period. This proposed solution, creating an exception for fraud to incontestability clauses, would also discourage

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124. *See* Albert, *supra* note 1, at 371.

125. *See id.* at 372.

126. *See id.* at 373; *see also*, Katherine Cooper, *Liar's Power: The Effect of Incontestability Clauses After* Paul Revere Life Ins. Co. v. Haas, 1 CONN. INS. L.J. 225 (1995). Recall that fractionalization occurs when a viatical settlement purchaser syndicates the sale of policies to pools of investors who acquire fractionalized interests in the policies. *See* text accompanying notes 15-18.

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investors from entering the industry and would dry up the resources needed by viatical companies to conduct business.

2. SEC Act

Some commentators have proposed that classifying fractional interests in life insurance policies as securities represents the best way to decrease the incidents of fraud in viatical settlement transactions.[127] This classification would bring the industry under the control of securities law and would accord investors antifraud protections they currently lack.[128] The Securities and Exchange Commission ("SEC") attempted to accomplish this task and failed. In *SEC v. Life Partners, Inc.*,[129] the SEC attempted to bring viatical settlements under the purview of federal securities law by classifying them as investment contracts. If the law considered viatical settlements securities, investors could avail themselves of the protections and remedies contained in federal securities law.[130] Currently, investors have recourse only to common law fraud remedies.[131]

In *Life Partners*, the SEC accused Life Partners, Inc., a Texas viatical company, of violating federal securities law by selling unregistered securities in the form of fractionalized interests in viaticated life insurance policies. The SEC won at the district level, but the United States Court of Appeals for the District of Columbia Circuit, in a split decision, reversed. The Appeals Court applied the three-part *Howey* test to determine that a viatical settlement was not tantamount to the offering of a security.[132] In order to be classified as a security, an investment scheme must meet the following three criteria: (1) the expectation of profits arising from (2) a common enterprise that (3) depends on the efforts of others.[133] The

127. *See* Albert, *supra* note 1, at 363.

128. *See id.* at 382.

129. 898 F. Supp. 14 (D.C. Cir. 1995), *vacated,* 87 F.3d 536 (D.C. Cir. 1996), *and reh'g denied,* 102 F.3d 587 (D.C. Cir. 1996).

130. *See* Albert, *supra* note 1, at 382; *see also* Eremia, *supra* note 7, at 779.

131. *See* Albert, *supra* note 1, at 399. A few states have started to examine viatical legislation that regulates the fractionalization of life insurance policies by classifying such interests as securities. In 1998, Arizona passed a statute that broadened the definition of the term "security" to include viatical settlements. *See id.* at 381-83.

132. The *Howey* test is taken from the case of *SEC v. W.J. Howey*, 328 U.S. 293 (1946). Over the years, the *Howey* test has been distilled, but remains a fundamental tool of the courts in determining whether an investment method constitutes a security. *See* Albert, *supra* note 1, at 394-95.

133. *See Howey*, 328 U.S. at 293; *see* Albert, *supra* note 1, at 396-97.

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Appeals Court found that while viatical settlements satisfy the first two prongs of the *Howey* test, the profits anticipated by the investor are not derived from the efforts of others.[134] The SEC did not appeal the decision to the Supreme Court.

3. Better Screening by Insurers

Another suggestion is for insurance companies to subject policy applicants to heightened scrutiny and, perhaps, mandate blood tests for all policies.[135] Most insurance companies do not require blood tests for applicants seeking policies below a certain face value, typically $100,000 or less.[136] This tendency creates an incentive for applicants to falsify written information on low face value policies, knowing that a blood test will not reveal any misrepresentation. Perhaps insurance companies could consider requiring blood tests on policies of all sizes. This proposal undoubtedly carries with it increased administrative costs, but it dramatically decreases the odds of fraud and litigation fees attendant to contesting fraudulent policies. If insurance companies raised their own standards and implemented more meticulous screening procedures, they could avoid issuing policies to dishonest applicants. In one telling case discussed above, *Amex v. Superior Court,*[137] the insurance company that issued a policy to an applicant failed to notice that the individual who actually took the required medical exam was 4 inches taller and 30 pounds heavier than the representations in the initial application.[138] In cases such as this, where the policy applicant and hired imposter are obviously different, it seems astounding that the insurance company would miss the discrepancies. In other cases where the imposter resembles the applicant enough to evade notice, the insurance company could protect itself against such fraud by requiring positive identification.[139]

Though this solution seems logical in terms of its efficacy in decreasing the number of policies issued on falsified health information, it is unlikely that insurers will implement the suggested changes in their underwriting procedure. When issuing life insurance policies, insurers are

134. *See* Albert, *supra* note 1, at 402.

135. *See id.* at 376. Albert argues that although these procedures may be costly to insurers, they will prove to be cost efficient in the long run. *See id.*

136. *See supra* notes 122-23 and accompanying text.

137. *See supra* notes 116-22 and accompanying text.

138. *See Albert, supra* note 1, at 375; *see also* Christian, *supra* note 110, at 1265-66.

139. *See Albert*, *supra* note 1, at 376.

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aware of the possibility of fraud, and the possibility the insured may outlive the incontestability period. If they wanted, insurers could easily improve their screening procedures to ferret out dishonest applicants but they are unwilling to incur the associated administrative costs.

While all of these proposals address the problem of fraud, they approach the issue from a standpoint that discounts the effect on viatical settlement purchasers and investors. Lengthening or eliminating incontestability periods would advantage insurers by reducing the number of fraudulently obtained policies, but would increase the risk incurred by viatical settlement purchasers and investors. Similarly, enhanced screening by insurers in the underwriting process would decrease the number of policies issued to dishonest applicants, but fails to address the fact that when policies that slip through the cracks are viaticated, the purchasers and investors still incur substantial risk. Neither of these solutions aims to sustain the involvement of investors in the viatical settlement industry, but merely endeavors to shield insurers from fraudulent practices. Any solution to fraud must be sensitive to the critical position investors play in the market.

4. Mitigating the Risks of Fraud

Perhaps the best way to maintain investor participation in the market is to approach the problem of fraud from a standpoint that seeks not to eliminate it but to decrease the risk to investors resulting from it. One solution that is sensitive to the risks assumed by investors involves a provision of the amended Model Regulation. If states adopted the reasonableness standard as an alternative to mandated minimum discount rates, state Insurance Commissioners could incorporate, as one criterion of the reasonableness evaluation, the age of the policy. If the policy is still within its contestability period when it is being viaticated, the insurer can decrease the price accordingly. This solution would allow purchasers to incorporate into their settlement offer the risks associated with buying a "young" policy.

Admittedly, this suggestion only addresses one facet of the fraud problem, viators defrauding insurance companies, but it is a start. Attacking fraud has proven to be a very difficult task. Yet, however formidable this task may be, it is not insurmountable. In devising a regulatory scheme to combat fraud, it is vital that regulatory authorities consider all interests.

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CONCLUSION

After only ten years, the viatical settlement industry has experienced exponential growth. The face value of life insurance policies viaticated in 2000 is expected to top $4 billion.[140] Such rapid growth in the industry suggests that people have welcomed the prospect of using life insurance policies as a pre-death financial planning tool. Furthermore, the state and federal governments seem to have embraced the concept as well. The passing of legislation in almost thirty states and the various favorable viatical settlement tax provisions in the HIPAA suggest that our lawmakers also recognize the need for, and value in, such transactions.[141]

Lawmakers must recognize, however, that the complexion of the viatical settlement industry has changed and that this change requires a re-examination of the legislation pertaining to the industry. At its inception, the industry was a humanitarian enterprise exclusively tailored to help financially strapped AIDS patients and others suffering from life-threatening illnesses to obtain necessary funds.[142] With the realization that viatical settlements constitute a quick and relatively easy way to make money, for both the seller and purchaser sides, concerns have surfaced that never existed at the industry's inception. Now that viatical settlements have been in existence for over a decade, lawmakers should draw on the experience of the viatical industry and ask themselves whether the existing regulations have retained their effectiveness and relevancy.

Both the Model Act and the Model Regulation focus almost exclusively on protecting the seller side of the transaction at the expense of addressing the serious hazards on the purchaser side. Fraudulent activities have led to increasing incidents of investor victimization and demonstrate a need for protections currently absent in existing legislation. Moreover, minimum discount rates should be reexamined in order to attract the purchasers and investors that are so essential to the industry.

Investor money is the lifeblood of the viatical industry and without the participation of willing investors, the pool of purchasers will sharply decrease, leaving desperate viators with no options. The industry has had a tremendous positive impact on the lives of viators and action must be taken to assure the future of viatical settlements.

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140. *See supra* note 26 and accompanying text.

141. *See* <http://www.viatical.org/about_viatical_industry-0001.html> (visited Jan. 16, 2000).

142. *See supra* text accompanying notes 19-27.

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FROM THE JOURNALS: INSURANCE LAW ABSTRACTS

*Edited by Jeffrey E. Thomas**

AUTOMOBILE INSURANCE

Dragomir Cosanici, *Exclusionary Clauses in Automobile Insurance Policy: A Call for Federal Regulation*, 8 KAN. J.L. & PUB. POL'Y 191 (1999).

Cosanici addresses exclusionary clauses in automobile insurance policies that deal with inter-spousal immunity. Historically, there have been a number of justifications for inter-spousal immunity, including: (i) minimizing collusive or fraudulent claims; (ii) the unity-at-law doctrine, in which the rights of husbands and wives are merged into one unit; (iii) the canon of stare decisis; (iv) the notion that adequate legal remedies are available for the injured spouse in other forms; (v) the notion that inter-spousal torts would flood the courts with lawsuits with a burdensome number of matrimonial suits; (vi) the notion that tortfeasor spouses would benefit from their wrongdoing in community property states; and (vii) the belief that exclusionary clauses are not repugnant under states' public policies.

Most automobile policies include exclusionary clauses for the above-mentioned reasons. Cosanici argues that there should be a complete abolition of the inter-spousal immunity at the state level, because the automobile policy is no longer an exclusive contract between two parties. Third parties are often involved, such as children who depend on the daily income of their parents. In addition, the work productivity of the injured may fall victim to his or her inability to collect, resulting in serious consequences to the national economy. He argues that the daily hazards and perils of driving on roads with an increasing number of drivers mandate greater protection.

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Cosanici suggests that inter-spousal immunity exclusions can be abolished in three ways: (i) by case law in state courts; (ii) legislative action at the state level; or (iii) federal legislation at the national level, preempting state regulations. Cosanici concludes that the best way for abolishing inter-spousal immunity is by federally regulating all insurance contracts, which would ensure uniform procedures across the board.

The Honorable Jack Davies, *A No-Fault History*, 24 WM. MITCHELL L. REV. 839 (1998).

In this Article, Judge Davies describes no-fault automobile insurance legislation passed in Minnesota in 1974. He also discusses why other states have not passed no-fault legislation, and why efforts to pass no-fault legislation across the country have been largely abandoned.

Michael Fargione, Paul F. McEllistrem & Robert J. Hauer, Jr., *"Closeness to the Risk" in Uninsured and Underinsured Motorist Coverages in Minnesota*, 24 WM. MITCHELL L. REV. 945 (1998).

This Article analyzes the Minnesota Uninsured/Underinsured Motorist ("UM/UIM") statute and courts' application of it. The authors begin with a brief description of the historical background of the statute. In light of this background, they contend that courts' use of the "closeness of the risk" standard has been incorrect. They argue that the UM/UIM statute was intended to eliminate the "closeness of the risk" standard for UM/UIM coverage. The authors conclude that the Minnesota courts' misapplication of the "closeness to the risk" analysis has relieved insurers from complying with the terms of their policy.

Jeffrey A. Kelso & Matthew R. Drevlow, *When Does the Clock Start Ticking? A Primer on Statutory and Contractual Time Limitation Issues Involved in Uninsured and Underinsured Motorist Claims*, 47 DRAKE L. REV. 689 (1999).

This Article outlines the different ways in which legislatures, courts and insurers address the time limitations on claims arising out of uninsured/underinsured motorist coverage contracts. Although most courts agree that the contract statute of limitations applies, courts disagree about

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whether the limitation period commences on the date of the breach of contract, the date the insured settles with the tortfeasor, or the date of the accident. Because of this uncertainty, some insurers include a contractual limitations provision in their policies. Courts generally enforce these limitations, provided that the limitation period is reasonable and the provision is unambiguous. The authors suggest that an insured's tort action should toll both the statutory and contractual limitations provisions, which they contend will decrease the need for litigation while simultaneously limiting stale claims.

Helen M. Meyer & Paul K. Downes, *Entitlement to Benefits: Recurring Areas of Dispute*, 24 WM. MITCHELL L. REV. 1003 (1998).

Meyer and Downes examine the purposes of Minnesota's No-Fault Automobile Insurance Act and analyze the areas of dispute, including the duty to attend an independent medical examination and the effect of failing to do so, the use of a paper review, auditing bills, arbitrator bias and post-arbitration relief. Meyer and Downes consider whether the No-Fault Act has successfully created a system of small claims arbitration which has decreased both the expense and complexity of litigation, and assured prompt payment for medical treatment. They conclude that the Act is meeting many of its stated purposes, but there are recurring areas of dispute which serve to unnecessarily prolong disputes, create expensive litigation, and dissuade injured people from getting necessary and reasonable medical treatment.

Jeffrey O'Connell, et al., *Consumer Choice in the Minnesota Auto Insurance Market*, 24 WM. MITCHELL L. REV. 825 (1998).

This Article addresses the issue of whether Minnesota can find a compensation scheme for personal injury resulting from auto accidents that is free from the failures of traditional tort law, and also corrects the shortcomings of current no-fault laws. The Article begins by describing the shortcomings of both traditional tort liability and no-fault automobile laws. Specifically, the Article points out that traditional tort liability is inefficient and its costs are too high. However, no-fault laws are criticized for infringing upon the fundamental legal right to be paid for non-economic damages.

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The Article includes a study conducted by the RAND Corporation that compares personal injury protection insurance (no-fault) to traditional tort law (fault-based), as well as relevant data and trends about personal injury claims. The Article then describes a proposed reform called the "choice system." The choice system would allow individuals to stay in the current no-fault system ("stayers") or to switch to coverage that foregoes claims for noneconomic loss above Minnesota's threshold ("switchers"). Stayers would make a claim based on fault against their own insurers for noneconomic loss above Minnesota's threshold. Switchers could never sue or be sued for noneconomic loss and would only be allowed to claim in tort for economic loss in excess of their no-fault personal injury protection coverage. The Article describes in detail how this choice system would work and explains the interrelationship between stayers and switchers under the system. The Article concludes by discussing the potential cost savings of the choice plan, both in dollars and percentages.

Lawrence M. Rocheford & Mark D. Malloy, *Tort Thresholds, Auto Claim Behavior and Auto Choice Reform: Are Tort Thresholds Working?*, 24 WM. MITCHELL L. REV. 965 (1998).

This Article analyzes three issues relating to no-fault automobile insurance: (i) tort thresholds in the Minnesota No-Fault Insurance Act, (ii) empirical studies on auto claims and auto insurance, and (iii) the federal Auto Choice Reform Act of 1997.

The issue of tort thresholds is presented and explained from the perspective of a personal injury practitioner. The requirements for meeting the tort thresholds (minimum levels of damage required in order to pursue non-economic damages) are clearly defined. In addition, the finer points of pleading and proving the thresholds are discussed, along with appropriate defense strategies and tactics to defeat the claimed tort thresholds.

In their presentation of the empirical studies, the authors find that more people are making more claims for a wider variety of injuries than in the past. In addition, they find that the average economic losses and payments have increased dramatically in the past twenty years. Another interesting finding was a positive correlation between levels of attorney involvement and high insurance costs. Finally, the authors consider the overall efficacy of tort thresholds in relation to non-economic damages litigation.

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Joseph Sclafani, Note, *Stacking the Deck Against the Insurance Industry:* United States Fidelity and Guaranty Company v. Ferguson, *698 So. 2d 77 (Miss. 1997)*, 19 MISS. C. L. REV. 251 (1998).

This Note criticizes the Mississippi Supreme Court's decision in *United States Fidelity & Guaranty Co. v. Ferguson*, 698 So. 2d 77 (Miss. 1997), which allowed the stacking of uninsured motorist ("UM") coverages by declaring anti-stacking clauses void as against public policy. Sclafani first outlines the traditional arguments used in the case law prior to *Ferguson,* which allow stacking of UM coverages prior to *Ferguson* (i.e., stacking based on policy ambiguity, and stacking based on payment of multiple premiums). He then argues that the Mississippi Supreme Court abandoned these conventional theories in favor of the more radical approach of declaring anti-stacking clauses void as against public policy. Sclafani suggests that, based on market principles, *Ferguson* will have a negative impact on the availability UM coverage in Mississippi. Furthermore, he agrees with the concurrence in *Ferguson* that insurers should be required to obtain a separate waiver from the insured to prevent the stacking of UM coverages contained in a single policy.

Theodore J. Smetak, *Underinsured Motorist Coverage in Minnesota: Old Precedents in a New Era*, 24 WM. MITCHELL L. REV. 857 (1998).

This Article analyzes Minnesota's Uninsured Motorist ("UIM") and Underinsured Motorist ("UM") requirements. Smetak outlines the chronological development of the Minnesota UIM and UM rules, including the "Four Eras" of Minnesota's UIM with an explanation of how each iteration came to be and was eventually replaced. The author also discusses the actual determination of underinsured status and the variety of factors that can affect uninsured motorist coverage liability such as multiple parties/tortfeasors and vicarious liability. He also deals at some length with the "Family Auto Exclusion" and its effects.

The author then presents a summary of the requirements of making a UIM claim with an explanation of the *Nordstrom* rule and the *Smith* and *Clothier* requirements. In addition, he discusses the right of substitution for a UIM insurer and the rules for payment of UM/UIM claims.

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Mike Steenson, *Disability and Income Loss Benefits Under the Minnesota No-Fault Act*, 24 WM. MITCHELL L. REV. 1055 (1998).

This Article explores the right of an injured insured to receive disability and income loss benefits under the Minnesota No-Fault Automobile Insurance Act. It notes that the claimant has the burden of proving that the loss of present and future gross income flows directly from an inability to work. Steenson identifies difficulties in meeting this standard for self-employed persons and in those situations where the claim is based primarily on the prospect of future employment. He also considers the problems in calculating benefits when a plaintiff engages in substitute work or works two jobs but can only return to one. The author concludes that what is important is the claimant's loss as a result of the injury, including both gross income and the loss of tangible things of economic value.

Richard J. Thomas & Bryon G. Ascherman, *No-Fault Independent Medical Examinations: Purpose, Timing and Impact*, 24 WM. MITCHELL L. REV. 1045 (1998).

This Article addresses no-fault physical examinations in the context of Minnesota's No-Fault Automobile Insurance Act, their use by insurers and their impact on the no-fault system from a practitioner's standpoint. A tension is created by these examinations, and Thomas and Ascherman analyze this conflict by reviewing the fundamental underpinnings of the Act. Thomas and Ascherman conclude that physical examinations in the no-fault system serve a critical function both in theory and in practice.

Terry Trypin & Diana Lee, *An Analysis of the Minnesota Private Passenger Automobile No-Fault System*, 24 WM. MITCHELL L. REV. 1019 (1998).

This Article provides a description of state automobile insurance reparations systems, specifically analyzing the performance of Minnesota's no-fault law in the context of its effect on insurance claiming patterns. In addition, it compares the value to consumers of the reparations system and related insurance coverages in Minnesota with the value to consumers of the more modest, traditional financial responsibility and tort law system in Wisconsin. The Article also discusses public policy considerations

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relevant to strengthening the Minnesota No-Fault Automobile Insurance Act including the exclusive verbal tort threshold, managed medical care, and similar measures that have been examined or tried in other no-fault states. Lee and Trypin conclude that as long as a state's no-fault automobile insurance plan is a modified variety, where elements of the tort liability system remain intact, there will be multiple cost-drivers that affect the cost of insurance claims and, ultimately, the price of automobile insurance.

Rep. Bruce F. Vento, *A Federal Perspective on No-Fault Insurance Law*, 24 WM. MITCHELL L. REV. 849 (1998).

This is an Address by Rep. Bruce Vento to the No-Fault Automobile Insurance Law: Consumer Choice in Minnesota Auto Insurance Market Symposium. In his Address, he explains why Congress is unlikely to act on the pending congressional bill concerning no-fault insurance. He notes that the Federal government historically has had only limited involvement in the automobile insurance field, and suggests that any Federal action should use existing state laws as models for possible legislation. He concludes that, in light of the historical context, any changes on the federal level will likely be very incremental rather than sweeping.

Michael L. Weiner, *No-Fault Tort Thresholds: The Plaintiff's Perspective*, 24 WM. MITCHELL L. REV. 985 (1998).

This Article examines the no-fault thresholds found in the Minnesota No-Fault Act, MINN. STAT. § 65B.41 to § 65B.71 (1998). Weiner reviews the legislative history of the Act and analyzes the specific burdens and no-fault thresholds, including permanent disfigurement or injury, sixty days of disability, and the medical expense threshold. Weiner contends that analysis of these factors requires that one keep in mind that the very purpose of the Act is to deny an entire class of automobile accident victims certain damages, while at the same time allowing the seriously injured victim to recover all the traditional tort damages. Wiener concludes that the no-fault thresholds deny another class of victims recovery for non-economic detriment damages and that practicing attorneys must familiarize themselves with the intricacies of the Act.

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Thomas M. Jones & Jon D. Hurwitz, Comment, *An Introduction to Insurance Allocation Issues in Multiple-Trigger Cases*, 10 VILL. ENVTL. L.J. 25 (1999).

This Comment outlines the main concepts and theories pertaining to multiple-policy allocation of coverage in long-term environmental damage claims and toxic tort litigation. Two primary approaches are discussed: the horizontal policy exhaustion approach, whereby the full limit of each layer of coverage is used to indemnify the insured before requiring contribution from the subsequent insurer, and the less commonly used vertical policy exhaustion approach, or exhaustion by years.

Jones considers different methods of allocating indemnification obligations among multiple carriers, including joint and several liability, pro-ration by years, proration by years and limits and proration by exposure. Jones then considers various methods to allocate defense costs, including proration by years, proration by years and limits, and proration by equal shares. Finally, the concept of "orphan shares" is summarized, where courts have required apportionment to the insured, holding the policyholder responsible for gaps in coverage (considering it a sort of self-insurance).

Kurt C. Schultheis, Note, Sullins v. Allstate: *Lead Paint and the Growing Ambiguity of the Pollution Exclusion Clause*, 27 U. BALT. L. REV. 475 (1998).

This Note analyzes the Maryland case *Sullins v. Allstate Insurance Co.*, 667 A.2d 617 (Md. 1995), which found that lead paint was not a pollutant, and therefore that the pollution exclusion did not apply. The author notes that most courts have found that lead paint is not a pollutant, and have allowed extrinsic evidence to be used to help resolve ambiguity regarding the application of the pollution exclusion. If the ambiguity persists, the policy will usually be construed against the insurer. The author also outlines the evolution of the pollution exclusion, and then considers the analysis of that exclusion in the *Sullins* case. He concludes that a specific exclusion for lead paint litigation will be needed if insurers are going to avoid providing a defense in such litigation.

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Todd M. W. Turall, Comment, *If at First You Don't Succeed . . . Change the Facts?: New Hope for Insureds Seeking Defense and Indemnification from Insurance Companies for Environmental Cleanup Costs*, 6 WIS. ENVTL. L.J. 119 (1999).

This Comment discusses environmental cleanup costs, particularly the issue of who should pay for past harms. The Comprehensive Environmental Response, Compensation, and Liability Act ("CERCLA") is Congress's attempt at answering this question, by allocating cleanup costs to the party responsible for the contamination. Because of the high cost of cleanup, many businesses carry standard insurance policies to defray such costs, known as Comprehensive General Liability ("CGL") coverage. The purpose of CGL coverage is to avoid potentially enormous unforeseen financial burdens, such as those that might result from a contaminated site cleanup.

Turall's Comment focuses on two Wisconsin Supreme Court decisions, *General Casualty Co. v. Hills*, 561 N.W.2d 718 (Wisc. 1997), *aff'g* 548 N.W.2d 100 (Wis. Ct. App. 1996), and *Wisconsin Public Service Corp. v. Heritage Mutual Insurance Co.*, 561 N.W.2d 726 (Wisc. 1997), *aff'g* 548 N.W.2d 544 (Wisc. Ct. App. 1996), which held that the insurers were liable under the insureds' CGL policies. Prior to these two decisions, the leading case on this issue in Wisconsin was *City of Edgerton v. General Casualty Co.*, 517 N.W.2d 463 (Wisc. 1994), *aff'g in part, rev'g in part* 493 N.W.2d 768 (Wis. Ct. App. 1992), *cert. denied*, 514 U.S. 1017 (1995), which held that the insurer was not liable under the CGL policy. Turall provides an analysis of *Hills*, *Heritage* and *Edgerton*, and discusses how the court came to its decision in *Hills* and *Heritage*.

Edgerton dealt with a standard CGL policy, in which the insurer has the right and duty to defend any suit (not merely a claim) seeking damages. In a standard CGL policy, the insurer is obligated to defend the insured where the insured is named as a party in a lawsuit. The issues before the Wisconsin Supreme Court in *Edgerton* were (i) whether letters to the City and Edgerton Sand & Gravel triggered that duty to defend, and (ii) whether CERCLA response costs were covered by CGL policies. The court concluded that the insurer was not liable under the CGL policy, because the duty to defend is not triggered unless the suit seeks damages.

The *Hills* court differentiated between the duty to defend and the duty to indemnify, and concluded that the duty to defend is broader than the duty to indemnify. *Hills* dealt with the term "damages" in the CGL contract, and whether or not that term includes coverage for a claim which obligates Hill to pay monetary damages resulting from negligent property

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contamination that did not fit within some other exclusion contained in the policy. Distinguishing the facts in *Hills* from those in *Edgerton*, the court held that General Casualty did have a duty to defend Hills. These factual differences included the fact that (i) neither the EPA nor the DNR requested or directed Hills to incur remediation costs under CERCLA, as was requested by *Edgerton*; and (ii) the owned-property exclusion in CGL policies did not apply to *Hills*, whereas the exclusion likely applied to *Edgerton*. Therefore, in the *Hills* court's interpretation of *Edgerton*, the final disposition of the claim, whether or not it was covered by the insurance policy, would not have been affected by the Wisconsin Supreme Court's decision in *Edgerton*—coverage would have been denied appropriately under the owned-property exclusion. The court in *Heritage* simply stated that *Hills* was controlling, and therefore the claim was one for damages and *Heritage* was liable for the defense and indemnification of the insured.

Turall suggests that, because it appears that the differences between the results reached in *Edgerton* and the results the court reaches in *Hills* and *Heritage* are fact-specific, it is quite likely that a new definition for "damages" and a new "standard" for when an insurer will be liable for the defense of the insured will be forthcoming in the near future. He concludes that it is almost certain that CGL policies will somehow reflect these changes in the law, that premiums will probably rise, and that insurers will not fight so strenuously to deny a defense to their insureds.

HEALTH INSURANCE

Julia Anastasio, *Legislative Developments in the Regulation of Insurance Coverage: Will These New Regulations Benefit Women With Breast Cancer?*, 7 AM. U. J. GENDER SOC. POL'Y & L. 55 (1999).

This Article discusses legislative proposals to reduce the preemptive effect of the Employee Retirement Income Security Act ("ERISA"), and how such proposals could affect the availability of certain treatments for breast cancer. It addresses two specific current proposals in the House of Representatives, the Responsibility in Managed Care Act ("RMCA") and the Patient Access to Responsible Care Act ("PARCA").

The Article begins with a description of breast cancer treatment, and describes a new treatment using high dosage chemotherapy in conjunction with an autologous bone marrow transplant. Insurance companies have often denied coverage for these expensive treatments on the grounds that

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they are "experimental," "investigational," "not medically necessary," and/or "not medically accepted." Proponents of insurance coverage contend that this treatment offers breast cancer patients an encouraging and possibly life-saving treatment option. Opponents argue that the increased use of such unproven treatment programs is too costly and ultimately detrimental because they subject patients to unproven and risky procedures.

The author then discusses the impact of ERISA preemption on this debate. Preemption prevents insureds from using state law to hold insurance carriers accountable for their coverage determination. The proposed legislation would narrow the scope of preemption and would enable women to seek redress in state court under state law. Moreover, these women will have the opportunity to have their claims heard before a jury rather than a judge. Anastasio concludes that access to state courts and state law will improve the prospect of coverage for high dosage chemotherapy with autologous bone marrow transplant because state courts are more likely to find the exclusionary language ambiguous under state law.

Robert D. Hayes, Nancy G. Boyd & Kenneth W. Hollman, *What Attorneys Should Know About Long-Term Care Insurance*, 7 ELDER L.J. 1 (1999).

This Article describes the importance of Long Term Care ("LTC") insurance and the need for attorneys to be familiar with available policies. The authors note the aging trends of our population and the inevitable increase in demand for LTC services. They suggest that LTC insurance should become part of an attorney's financial planning advice, and go so far as to propose that failing to provide such advice may be considered malpractice. They contend that private insurance, Medicare, Medicaid, viatical settlements and reverse mortgages will often be insufficient to pay the expenses associated with LTC, resulting in the use of clients' personal wealth as a major source of LTC funding.

The Article identifies things to look for when choosing an LTC insurance policy. For example, the authors outline the different kinds of benefits available such as daily benefits, monthly benefits, and benefits paid on a reimbursement or indemnity basis. They prefer policies that allow payment for custodial and intermediate care, irrespective of whether or when skilled care is needed. Additionally, they suggest that potential purchasers should be aware of possible "pre-hospitalization requirements" and should seek policies that offer inflation protection. The Article

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explores the preexisting condition prohibitions, waiting time requirements prior to the payment of benefits, guaranteed renewability provisions, and maximum benefits payable.

The authors conclude that LTC planning has become essential for every American. Such planning can provide security for personal resources and peace of mind for the elderly, their families and their advocates.

Frank M. McClellan, *Is Managed Care Good for What Ails You? Ruminations on Race, Age and Class*, 44 VILL. L. REV. 227 (1999).

This Article looks at the differences between managed care insurance plans and fee for service plans and argues that society must have enough courage and sensitivity to acknowledge that race, ethnicity and class affect health and health care treatment. McClellan, relying on the experience of family members as well as medical studies, concludes that it is unclear which approach provides better quality of care. Managed care or fee for service plans may be good for some and bad for others. At the same time, McClellan argues that differences among individuals require a diversified health care system that will allow consumers and providers to make fundamental decisions about the delivery of health care.

McClellan contends that courts and legislators should take into account differences in race, age and other socioeconomic factors when evaluating the reasonableness and desirability of practices and policies adopted by managed care companies. He argues that only by taking these differences into account can society fashion a policy that both protects and enhances human dignity while allowing managed care to realize its tremendous potential to improve the availability of health care to the poor, the elderly and people of color.

McClellan concludes that society has a moral obligation to ensure that the health care delivery system provides maximum protection to the dignity of our parents and grandparents, just as it has a moral obligation to implement a financial plan that will prevent the floor of the health care system from crumbling. An efficient health care system that obliterates the worth and dignity of the elderly, while at the same time destroying the pride and respect of health care providers, may ultimately cost us much more than it is worth in terms of human dignity.

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Jill L. Schultz, Note, *The Impact of Title III of the Americans With Disabilities Act on Employer-Provided Insurance Plans: Is the Insurance Company Subject to Liability?*, 56 WASH. & LEE L. REV. 343 (1999).

This Note considers whether insurers can be subject to liability under the Americans with Disabilities Act ("ADA") for providing inadequate insurance coverage. Schultz considers three theories for possible liability under the ADA: (i) treating mental conditions differently than physical disabilities; (ii) excluding coverage for pre-existing conditions; and (iii) excluding coverage for certain ailments. She considers the application of these theories to health insurance and long-term disability insurance plans, and discusses whether insurance companies could be immune from liability under certain provisions of the ADA.

David M. Studdert, *Direct Contracts, Data Sharing and Employee Risk Selection: New Stakes for Patient Privacy in Tomorrow's Health Insurance Markets*, 25 AM. J.L. & MED. 233 (1999).

This Article considers the privacy implications of "direct contracts," which are agreements between employer/purchasers of health insurance and provider sponsored organizations ("PSOs"). The author describes how direct contracts came into existence, illustrates the impact of PSOs, and compares them to managed care organizations ("MCOs"). Studdert notes that PSOs must maintain a delicate balance between antitrust law and insurance regulation, as well as address some difficulties commonly encountered after assuming administrative duties currently handled by the MCOs.

Studdert next turns to consequences of the relationship between PSOs and employers. He identifies situations where information may be disclosed to employers. For example, physicians may provide information to employers for the purposes of determining employee suitability in returning to work. In addition, the relationship between employers and PSOs may create an opportunity and incentive for employers and physicians to engage in risk selection of employees/patients.

The author then briefly summarizes legal protections currently available that limit an employer's use of medical information, as well as bills under consideration. He notes that voluntary patient disclosures are proposed as part of quid pro quo approaches, and that seemingly "voluntary" disclosures may be subject to coercive forces.

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Studdert concludes by noting that PSOs offer a potential array of benefits but may share some common vulnerabilities with MCOs, namely, risk selection. He suggests three strategies to protect patient privacy, including increasing patient control in information transfers, increasing accountability at the procurer level by increasing prohibitions on accessing information, and restricting the use of patient information. Ultimately, however, Studdert suggests these strategies may be inadequate given the strong incentives to use that information.

INSURANCE - GENERAL

Eugene R. Anderson, John A. MacDonald, & James J. Fournier, *Fighting Insurance Company Fraud With RICO: The Supreme Court Clears the Way Under the McCarran-Ferguson Act*, 22 AM. J. TRIAL ADVOC. 267 (1998).

This Article discusses whether a suit claiming an insurer has violated the Racketeer Influenced Corrupt Organizations Act ("RICO") is precluded by the McCarran-Ferguson Act, which limits the application of federal law to insurance companies. The recent Supreme Court case *Humana, Inc. v. Forsyth*, 552 U.S. 994 (1997), held that RICO does not "invalidate, impair or supersede" state insurance law, and that as long as there is no conflict between RICO and state regulation, the McCarran-Ferguson Act does not prevent claimants from bringing RICO claims against insurers.

Anderson discusses the conflict that many courts have found between RICO and a state's unfair trade practices act. He points out that many of these acts were based on the Unfair Trade Practices Model Act, which left open the ability to hold insurance companies liable under non-insurance statutory and common-law remedies. Anderson contends that this shows that insurers should not be insulated from RICO liability. He concludes by encouraging claimants to consider the claim of RICO as further protection against insurance fraud.

Tamara S. Brandt, Comment, OMI Holdings v. Royal Insurance: *Applying the Minimum Contacts Test to Territory of Coverage Clauses*, 74 NOTRE DAME L. REV. 1311 (1999).

This Comment analyzes *OMI Holdings, Inc. v. Royal Insurance Co.*, 149 F.3d 1086 (10th Cir. 1998), which applies the minimum contacts test

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for personal jurisdiction to a non-domestic defendant. After summarizing the evolution of personal jurisdiction and the minimum contact test, Brandt concludes that the courts have developed a two-part test for jurisdiction over a foreign defendant: (i) minimum contacts, and (ii) reasonableness. She then considers *OMI Holdings* in light of this background. She finds that in considering reasonableness, the court considered the following factors: (a) the burden on the defendant to litigate in the forum; (b) the forum State's interest in adjudicating the dispute; (c) the plaintiff's interest in convenient and effective relief; (d) the interstate judicial system's interest in obtaining an efficient resolution; and (e) the shared interest of several states in furthering fundamental substantive social policies. The author also explains the territory of coverage clauses in insurance, and analyzes the interaction between such clauses and the minimum contacts test. She concludes that territory of coverage clauses indicate the geographical range of forums in which the insurer agrees to defend the insured.

Robert M. Horkovich, Adam A. Reeves & Peter J. Andrews, *Insurance Coverage for Employee Theft Losses: A Policyholder Primer on Commonly Litigated Issues*, 29 U. MEMPHIS L. REV. 363 (1999).

This Article outlines fundamental legal issues relating to fidelity insurance. It details policyholder responsibilities, such as providing both notice and proof of loss, and describes typical sources of litigation, including: (i) whether the loss was considered "direct" and thus covered; (ii) whether there was a dishonest or fraudulent act; and (iii) whether the person qualifies as a covered "employee" under the policy. The authors discuss the alter ego doctrine as it relates to a fidelity claim, finding that it will not always preclude recovery. They note that policyholders sometimes fail to provide timely notification of a loss. The authors assert that policyholders are entitled to maximize recovery after sustaining a loss at the hands of one of their employees.

Justin L. Jeter, Note, *Is* Universe Life Insurance Co. v. Giles *a Reasonable Alternative to the "No Reasonable Basis" Standard of Bad Faith Liability?*, 51 BAYLOR L. REV. 175 (1999).

This Note discusses the Texas case *Universe Life Insurance Co. v. Giles*, 950 S.W.2d 48 (Tex. 1997), and the impact of its "reasonably clear"

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standard on claims involving good faith and fair dealing. This standard imposes bad faith liability on an insurer for failing to cover a claim, or delaying payment of a claim "if the insurer knew or should have known that it was reasonably clear that the claim was covered." The Note compares this new standard to the previous standard of "no reasonable basis standard."

Jeter argues that the new standard does not clarify the definition of bad faith. He contends that the use of reasonableness standard will undermine the deterrent effect of the bad faith action, and will prevent the courts from adhering to the "no evidence" standard of review on appeal. The author concludes that only a clearer standard of liability that avoids a reasonableness inquiry will permit courts to make consistent decisions, thereby increasing the deterrent impact of the bad faith cause of action.

Sheri A. Mullikin, Note, *A Cost Analysis Approach to Determining the Reasonableness of Using Domestic Violence As an Insurance Classification*, 25 J. LEGIS. 195 (1999).

The author begins by describing insurance regulation and constitutional and statutory limitations on the use of certain data and characteristics in risk stratification. Mullikin then focuses on domestic violence and argues that there is no statistical proof that domestic violence correlates with an increased risk of loss. She further contends that domestic violence, like race, is uncontrollable and is not attributable to any conduct on the part of the insured, but instead is the result of a third party batterer.

The Note questions the continued use of risk classifications in general and suggests possible alternatives such as standardized marketing information. The author criticizes insurance company survey data purporting to show that consumers do not wish to subsidize insurance for victims of domestic violence. Additionally, the author argues that domestic violence classification may lead to underreporting of abuse and result in victims failing to seek medical attention, which may contribute to victims' unwillingness to leave abusive situations. Mullikin concludes that legislation should be passed preventing the use of domestic violence classification.

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Johnny Parker, *Replacement Cost Coverage: A Legal Primer*, 34 WAKE FOREST L. REV. 295 (1999).

This Article explains replacement cost coverage and explores the legal issues raised by such coverage. Parker begins by comparing replacement cost coverage to actual cash value coverage. He then analyzes several issues relating to replacement cost coverage, including when a claim must be reported, whether the proceeds must be used to rebuild, the meaning of "replacement," and when repair can be done instead of replacement. Parker also considers exceptions to the requirement to repair or replace in the case of impossibility or frustration, in the case of unconscionability, in the event of ambiguity, and where estoppel applies. He concludes that it is impossible to predict precisely how replacement cost coverage will be used because of the "human factor" that results in various interpretations and use of the coverage.

Christopher R. Rabley, *The Need for Liberalization of Barriers to Trade in Insurance to Promote Consumer Interests: Analysis of the Brazilian Reinsurance System As a Case Study*, 24 N.C. J. INT'L. & COM. REG. 633 (1999).

This Article presents an overview of the Brazilian reinsurance system, particularly, the Instituto de Resseguros de Brasil ("IRB"), in the context of trade liberalization after the 1995 World Trade Organization Financial Services Accord, and the 1997 World Trade Organization Financial Services Agreement. Rabley examines trade in financial services generally, and focuses on the efforts to privatize the IRB, Brazil's state-controlled monopolistic reinsurer. Central to the author's argument is the view that foreign investment by insurance companies is critical to the economic growth of developing nations.

Rabley contends that the positive effects of trade liberalization for Brazilian consumers achieved in the primary insurance sector are significantly diminished because of the lack of a corresponding removal of barriers to trade in reinsurance. He details direct and indirect negative effects of the IRB's reinsurance monopoly on consumers, and concludes that when negotiating for liberalization in insurance, WTO member states such as Brazil sometimes put the interests of insurance producers ahead of the welfare of insurance consumers.

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Thomas J. Schoenbaum, *Warranties in the Law of Marine Insurance: Some Suggestions for Reform of English and American Law*, 23 TUL. MAR. L. J. 267 (1999).

This Article explores both the similarities and differences between American and English law relative to marine insurance. Schoenbaum examines the law of warranty in marine insurance, specifically, the warranty of seaworthiness. The author offers some criticisms of English and American systems, in that the English system contains rigidities mainly resulting from consideration of the Marine Insurance Act ("MIA"). Schoenbaum credits the American system with containing some flexibility, but points out the serious inconsistencies existing within it. Among these inconsistencies is the extent to which some American courts will follow strict interpretation of the MIA, where other courts employ doctrines of flexibility.

Additionally, the Article examines other differences, such as the stricter English interpretation of warranties. The English system favors strict compliance with warranties as written, whereas the American system, at times, employs other interpretive strategies to avoid the full effect of the strict compliance compelled under the English system. When a breach does occur, English and American law treats them differently. Under English law, the rule of automatic discharge voids all coverage after a breach. American law merely suspends coverage, should a breach occur, and is unilaterally curable if the insured can remedy the breach. Lastly, there are differences when insurance covers a ship; under American law coverage begins immediately, while under English law, it begins upon commencement of the voyage.

The author concludes by noting that both systems would benefit from reforms. The English system, trapped in the past by the MIA, should be relaxed to adopt a more flexible approach. Meanwhile, the American system should eliminate the uncertainties currently in existence. The author suggests that a new restatement or codification would promote these changes.

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Karen M. Volkman, Comment, *The Limits of Coverage: Do Insurance Policies Obtained Through an Employer and Administered By Insurance Companies Fall Within the Scope of Title III of the Americans with Disabilities Act?*, 43 ST. LOUIS U. L.J. 249 (1999).

This Comment discusses whether Title III of the Americans with Disabilities Act ("ADA") can regulate insurance policies obtained through employers and administered by an insurance company. Title III expands the ADA and prohibits discrimination involving public accommodation. The author discusses in detail the ADA and the history of litigation surrounding this issue, finding a lack of agreement on this issue among the federal district courts. The author then considers the application of the ADA and Title III to insurance.

The author concludes that this issue will continue to confront the district courts until the legal standards can be clarified. The author suggests that Congress or the courts should provide this clarification, and encourages the adoption of a broad interpretation of the ADA and Title III to better protect the disabled.

INSURANCE REGULATION

Miriam R. Albert, *The Future of Death Futures: Why Viatical Settlements Must be Classified as Securities*, 19 PACE L. REV. 345 (1999).

This Article explores the delicate legal and ethical issues surrounding viatical settlements, and argues that they should be classified as securities. After describing the evolution of the viatical settlement industry, Albert suggests that they have become increasingly popular since their inception in the late 1980s, developing around AIDS and HIV-infected and other terminally ill life insurance policyholders. She also discusses the ethical issues that are raised by viatical settlements, including conflicts of interest, privacy and confidentiality of medical information, and fraud (perpetrated by insurance agents, viators, and viatical settlement firms).

Albert then argues that viatical settlements should be classified as securities and regulated under applicable statutory and case law. In particular, the author criticizes the District of Columbia Circuit Court of Appeals' decision in *Securities and Exchange Commission v. Life Partners, Inc.*, 87 F.3d 536 (D.C. Cir. 1996). She also comments on the SEC's continued efforts to subject viatical settlements to securities laws by describing developments after *Life Partners*. Albert concludes that

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regulation of viatical settlements as securities could help reduce the problems posed by what she argues should be a financially sound and socially beneficial industry.

Susan Randall, *Insurance Regulation in the United States: Regulatory Federalism and the National Association of Insurance Commissioners*, 26 FLA. ST. U. L. REV. 625 (1999).

This Article explores the feasibility of continued state control of insurance regulation, arguing that states are ill-equipped to deal with this increasingly complex, international industry. Randall begins by examining state regulation of insurance, including how regulation was developed. She then describes the function of the state insurance departments and commissioners, and the formation and constitution of the National Association of Insurance Commissioners ("NAIC").

Randall argues that the nature of insurance as a business, and the role of the NAIC, illustrate the need for centralization and uniformity in insurance regulation. She notes that the NAIC has recently attempted to improve regulation because of the high incidence of insurer insolvency and the threat of federal legislative involvement. However, she criticizes the NAIC's limited evaluation and investigation of insurers, and the NAIC's inability to compel states to participate in its programs. Randall explores the traditional federalist rationale for keeping regulation under state control, and argues that the NAIC essentially undercuts much of the "local control" argument for keeping insurance regulation under state control because its actions are not readily reviewable or modifiable by citizens. Additionally, Randall argues that a federal system of regulation is constitutionally permissible and would be cheaper and more uniform than individual state control.

Randall concludes by discussing the advantages and disadvantages of several reform options, including federal regulation, reform of state regulatory structures and state or federal delegation of power to the NAIC. Randall notes that the NAIC is closely identified with the insurance industry, and is unable to adequately perform some of the more complex functions that it currently undertakes.

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David A. Skeel, Jr., *The Market Revolution in Bank and Insurance Firm Governance: Its Logic and Limits*, 77 WASH. U. L.Q. 433 (1999).

This Article addresses the recent transformation within the financial services industry, and makes some predictions for the future of regulation. Skeel predicts that there will not be true convergence between financial and non-financial firm governance. He contends that corporate governance must be considered in light of the background of insolvency because of the complementary relationship between these two concepts.

Skeel explores both financial and non-financial firm governance. He argues that corporate governance has moved in an ex post direction, relying on market correctives such as takeovers and manager-driven insolvency regime. In contrast, financial intermediary governance reflects the opposite approach. Skeel finds that insurance insolvency regulation works on the assumption that managers should always be replaced. He contends that permitting managers to participate in insolvency decisions, at least in a limited way, could significantly improve the decisions of whether and when to initiate an insolvency proceeding.

Skeel concludes that market forces will inevitably contribute to a new round of bank and insurer failures, which he suggests will put significant pressure on existing insolvency options. In the insurance context, the pressures could justify going even further, even as far as establishing a Chapter 11-style reorganization option and including insurance insolvency in the Bankruptcy Code.

LIABILITY INSURANCE

Karon O. Bowdre, *Enhanced Obligation of Good Faith: A Mine Field of Unanswered Questions After* L & S Roofing Supply Co., 50 ALA. L. REV. 755 (1999).

This Article analyzes problems raised by the Alabama Supreme Court's adoption of the "enhanced good faith" approach to an insurance company defending its insured under a reservation of rights. The court adopted this rule in *L & S Roofing Supply Co. v. St. Paul Fire & Marine Insurance Co.*, 521 So. 2d 1298 (Ala. 1987), and thereby denied insureds the automatic right that exists in other jurisdictions to obtain independent counsel at the insurer's expense when the insurer offers to defend under a reservation of rights.

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Bowdre identifies a number of unanswered questions stemming from this approach, such as whether a new bad-faith cause of action has been created, what consequences should result from breach of this enhanced duty, what kind of conduct is required of defense counsel when handling confidential information from the insured that could affect coverage, and whether the reservation of rights affects the insured's obligation to cooperate with the insurer. She concludes that until the Alabama Supreme Court resolves these questions, the effectiveness of the enhanced obligation of good faith will rest on the shoulders of defense counsel, who should be careful to not put insurers' interests ahead of those of the insureds.

Justin A. Harris, Note, *Judicial Approaches to Stipulated Judgments, Assignments of Rights, and Covenants Not to Execute in Insurance Litigation*, 47 DRAKE L. REV. 853 (1999).

This Note describes and evaluates assignments by insureds in coverage disputes to third party plaintiffs in return for a covenant not to execute against the insureds' assets. It focuses primarily on the judicial approaches to such arrangements in Texas, Iowa and California.

Harris argues that courts should balance the interests of an insured who was wrongfully denied coverage with those of the insurer who is facing a potentially inflated judgment agreed to by the insured. When the insurer has breached its duty to defend, the balance should be struck in favor of the insured, who should have the right to settle with the plaintiff and assign her claims. On the other hand, the author contends that that the assignment should not be available where the insurer is providing a defense because in that case the risk of fraudulent and collusive agreements outweighs the justification for using the procedure.

Robert J. Newell, Travelers Insurance Co. v. Smith: *Arkansas Employers Are Exposed to Greater Liability*, 52 ARK. L. REV. 503 (1999).

This Article discusses an Arkansas case, *Travelers Insurance Co. v. Smith*, 947 S.W.2d 382 (Ark. 1997), in which the Arkansas Supreme Court held that a claim for emotional distress, with no preceding physical injury, existed outside the gamut of workers' compensation as the tort of outrage. Prior to *Travelers*, the Arkansas legislature had attempted to tighten up the Workers' Compensation Act by adopting Act 796, which was designed to limit the escalating costs of employers paying workers' compensation

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claims. Act 796 states that a mental injury is now compensable under the Workers' Compensation Act only if it is caused by a physical injury to the employee's body.

In *Travelers*, the legislature's goal of protecting employers has failed, and employers are now more vulnerable to an attack outside of the exclusivity defense of workers' compensation for claims of emotional injury. The Article discusses the facts and procedural history of the case, and then the historical development of the Arkansas Workers' Compensation Act. The next section deals with the exclusive remedy doctrine, in which the benefits that are provided to employees under the workers' compensation laws are obtained in exchange for employer immunity from most tort claims.

The author then applies the rationale of the court to the claim of sexual harassment, an emotional injury with no corresponding physical injury, and suggests that these claims can now be pursued outside of workers' compensation. He concludes that the previous cases involving sexual harassment and workers' compensation statutes must be reexamined in light of the *Travelers* case. If there is no remedy under the workers' compensation system, the claimant should not be barred from seeking a remedy outside of that system.

Craig Paulus, Comment, *Ethics 2000 and Insurance Defense Conflicts of Interest in Kentucky*, 87 KY. L.J. 1349 (1999).

Paulus discusses the project undertaken by the American Bar Association, *Ethics 2000*, which was developed to review and revise the Model Rules of Professional Responsibility. This Comment discusses how these revisions may or may not affect the ethics of insurance defense in Kentucky.

Paulus discusses Kentucky law regarding its treatment of the ethics of insurance defense. In Kentucky, the one fundamental principle guiding conduct is the rule that the insured is the client. The corollary of this rule is that the insurer is not the client. However, the Ethics 2000 Commission has considered incorporating the notion that the insurer should have more power to direct litigation, as drawn from Section 215 of the Restatement (Third) of the Law Governing Lawyers. The comment to Section 215 addresses the conflict of interest problem between the attorney, the insured and the insurer. For example, since the insurer is bearing the costs and possibly the ultimate liability in the litigation, the insurer has standing to assert a claim for professional negligence in the conduct of that litigation.

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However, where there is a conflict of interest, the attorney must act in the client's interest even under Section 215. This means that protecting confidential communications is of foremost importance, and choosing whether to spend more time and money conducting discovery is a tangential matter.

Paulus suggests that Kentucky should examine the results of the Ethics 2000 Project when the proposals are finalized, and consider updating the state's rules to further clarify the proper roles of the insured. In the meantime, the prudent Kentucky lawyer should follow the guiding principle of the insurance defense: the insured is the client.

Michael Sean Quinn, *Fortuity, Insurance, and Y2K*, 18 REV. LITIG. 581 (1999).

This Article discusses whether the principle of fortuity precludes insurance coverage for potentially costly Y2K claims. After giving several examples of potential Y2K catastrophes, Quinn explains the fortuity doctrine, including two variations—the loss doctrine and the loss-in-progress doctrine. He then applies these doctrines to Y2K claims. Some insurance companies have argued that the fortuity doctrine precludes coverage for Y2K injuries because the prospect of such damages was a certainty, not a risk. Quinn concludes that it is unlikely that the fortuity doctrine will bar Y2K claims except in the most extreme situations.

Jeffrey W. Stempel, *Domtar Baby: Misplaced Notions of Equitable Apportionment Create a Thicket of Potential Unfairness for Insurance Policyholders*, 25 WM. MITCHELL L. REV. 769 (1999).

This Article criticizes the Minnesota Supreme Court decision in *Domtar, Inc. v. Niagara Fire Insurance Co.*, 563 N.W.2d 724 (Minn. 1997), *aff'g* 552 N.W.2d 738 (Minn. Ct. App. 1996) ("*Domtar*") regarding apportionment of damages between multiple insurers. In *Domtar*, the policyholder, who had purchased more than $60 million of coverage, was ordered to assume more than three-fourths of a $2.8 million judgment, due to tort claims that triggered coverage in many different policy periods.

Stempel reviews both Minnesota and other precedent on insurance apportionment, as well as coverage allocation in general. He suggests that the *Domtar* court erred in several ways, including (i) misunderstanding the policy language "During The Policy Period;" (ii) misapplying the

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ambiguity principle of construction; and (iii) misconstruing the nature of liability insurance. He contends that this will cause an inequitable reduction in coverage, it will foster inequity among insurers, and it will promote inefficient and excessive litigation. Stempel also argues that allocation to the policyholder is particularly problematic, and concludes that the approach of *Domtar* will be unfair to policyholders and the insurance-purchasing public. He suggests that there is no good reason in contract law, equity, or public policy that justifies a reduction in the policyholder's coverage, because it is a victim of multi-year claims by third parties rather than more typical liability claims.

Jeffrey W. Stempel, *A Mixed Bag for Chicken Little: Analyzing Year 2000 Claims and Insurance Coverage*, 48 EMORY L.J. 169 (1999).

This Article addresses the likelihood of massive insurer liability for year 2000 ("Y2K") losses. After describing the Y2K problem and litigation to date, Stempel compares the Y2K liability to other "crises" in the insurance industry, such as coverage for asbestos and environmental contamination. He then examines the various types of insurance that could be implicated by the Y2K situation: Commercial Property Damage, Commercial General Liability, Directors and Officers Liability, Errors and Omissions/Professional Liability, Business Interruption Insurance, and Personal Lines Insurance.

Stempel analyzes the coverage available under such policies in light of various coverage issues, including fortuity, business risk, causation issues, categorization problems, investigation and underwriting issues, the indemnity/mitigation issue, enforceability of exclusions, and the development of Y2K insurance. Stempel concludes that overall the insurance industry is in a position of relative strength in dealing with the Y2K crisis.

Taylor C. Young, Comment, *Turning Back the Clock on the Millennium Bug: Trigger of Coverage for "Year 2000" Claims Under CGL Occurrence Policies*, 31 ARIZ. ST. L.J. 259 (1999).

This Comment discusses coverage for Y2K problems under Commercial General Liability ("CGL") policies. Young analyzes several specific provisions of such policies, and various coverage arguments that might be raised in connection with Y2K claims. For instance, he explores

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whether claims can meet the definition of "occurrence" and whether claims will be able to establish "bodily injury or property damage."

Young also considers whether damages might fall within the exclusion for "expected or intended harms." After considering these general provisions, Young turns to some specific Y2K exclusions. He suggests that the Insurance Service Office may have taken inconsistent views of these exclusions during the drafting process. Another problem he addresses is the trigger of coverage. He contends that characterization of Y2K damages as either sudden or progressive will be critical to determining the trigger of coverage.

LIFE INSURANCE

Christopher M. Keefer, Comment, *Bridging the Gap Between Life Insurer and Consumer in the Genetic Testing Era: The RF Proposal*, 74 IND. L.J. 1375 (1999).

This Comment addresses the implications of the Human Genome Project ("HGP") for the classification of insurance applicants, based on their genetic makeup. Insurers would like access to genetic information for risk classification, and assert that widespread fraud would result from withholding genetic information (from insurers), raising the premiums for all policyholders. Consumers, on the other hand, would like to limit insurers' access to genetic information to preserve their privacy, to give patients greater access to insurance, and to prevent discrimination against applicants. These debates have led to the enactment of state legislation. Keefer proposes federal intervention and the establishment of federal agency review for the regulation of genetic information.

Keefer begins with an introduction to genetics and genetic testing. He then discusses risk classification and its role in life insurance underwriting. Keefer suggests that developing and updating risk factors for each individual genetic disorder discovered is necessary to reduce the possibility that individuals at risk for genetic disease may withhold knowledge of their genetic risks from insurers. Such omissions may distort the underwriting process and lead to less accurate risk classification.

Keefer argues that developing risk factors for each genetic condition discovered by the HGP and incorporating those risk factors into insurance premiums would help alleviate the tension between insurers and consumers. The risk factors could be developed and approved by a federal agency such as the Department of Health and Human Services. Keefer

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identifies a list of criteria to be taken into consideration when developing risk factors. Government-approved risk factors for insurance premiums can bridge the gap between insurer and consumer by preventing invidious discrimination and improper anti-selection, while at the same time permitting more accurate risk classification.

Keefer concludes that Federal legislation is appropriate because the issue of genetic testing is of national importance. He contends that Federal legislation would provide broad consumer protection for health-based insurance and narrower protections for insurance, thereby providing financial security. It would also be more cost-effective than determining the proper role for genetic information through litigation in the aftermath of the HGP.

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RECENT CASE DEVELOPMENTS

*Jeffrey W. Stempel**

ABSENT EXPRESS AGREEMENT, INSURER NOT PERMITTED TO USE ARBITRATION AWARD AGAINST POLICYHOLDER; CGL POLICY MAY BE REQUIRED TO COVER CLAIMS FRAMED IN BREACH OF CONTRACT LANGUAGE RATHER THAN TORT LANGUAGE

Vandenberg v. Superior Court, 982 P.2d 229 (Cal. 1999).

The California Supreme Court dealt two blows to insurers, one by a unanimous vote in its recent *Vandenberg* decision. The court held: (1) absent express agreement in the arbitration clause, an insurer could not use an arbitration award unfavorable to the policyholder to gain "offensive" collateral estoppel against the policyholder in a subsequent coverage dispute; and (2) despite the general admonition that liability insurance covers tort claims rather than contract claims, a commercial general liability ("CGL") policy does not necessarily bar coverage for claims against the policyholder that are framed as breach of contract claims. *See Vandenberg*, 982 P.2d at 234.

Policyholder Vandenberg operated an automobile sales and servicing facility from 1958 to 1988 on land leased from Eugene and Kathryn Boyd. *See id.* In 1988, Vandenberg discontinued the business and the land was again possessed by the Boyds. *See id.* Subsequently, the Boyds discovered pollution damage on the land and sued Vandenberg, alleging that Vandenberg's installation and operation of waste oil storage tanks on the land created the pollution. *See id.* at 235. For the years in question,

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Vandenberg was insured by several companies through standard CGL insurance. *See id.* One insurer, USF&G, agreed to defend. *See id.* As part of a complex settlement arrangement, the pollution damage to the land was remediated (with USF&G footing much of the bill, at least as an initial matter). *See id.* The Boyds and Vandenberg arbitrated between themselves issues relating to whether Vandenberg's oil waste activity constituted a breach of the lease. *See id.* The coverage dispute was treated as a separate matter for litigation. *See id.*

After an extensive arbitration proceeding, the arbitrator found in favor of the Boyds and against Vandenberg, awarding more than $4 million in damages. *See id.* In particular, the arbitrator found that the bulk of pollution damage to the land resulted from the underground waste storage tanks and was caused in part by Vandenberg's improper installation, maintenance and use of the tanks. *See id.* The arbitrator also found that the discharge of pollutants from the tanks had taken place gradually over a number of years. *See id.*

On the basis of the arbitrator's findings, Vandenberg's CGL insurers rejected his request for indemnification, prompting Vandenberg to sue seeking coverage. *See id.* The insurers moved for judgment in their favor on the basis of the arbitration findings. *See id.* In particular, the insurers argued that the arbitrator's finding that the oil waste pollution took place over several years made it impossible for Vandenberg to obtain coverage for the matter pursuant to the "sudden and accidental" pollution clause contained in the policies. *See id.* at 235-36. In addition, the insurers (particularly those without a qualified pollution exclusion in the policy) argued that because the arbitrator had awarded damages to the Boyds for "breach of lease," the damages owed by Vandenberg to the third party claimants were contractual rather than tortious and thus outside the scope of CGL coverage. *See id.* at 236.

This type of motion for summary judgment by the insurers sought to make "offensive" use of "collateral estoppel," or issue preclusion. The doctrine of issue preclusion (more commonly referred to as collateral estoppel) provides that a fact that is fully and fairly litigated may be binding in subsequent proceedings against a party who was part of the earlier factual determination. Issue preclusion may apply where: (1) the fact in question is the same in both cases; (2) where it was actually litigated in the earlier action; (3) where the proceeding was fair and the fact fully and completely litigated, and (4) where the fact in question was a necessary part of the earlier tribunal's decision.

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Ordinarily, issue preclusion is invoked on the basis of a prior judicial opinion rather than on the basis of a prior arbitration hearing or similar form of alternative dispute resolution. In addition, the most common form of issue preclusion is to prevent a party from the earlier action (or those in close association with the party) from bringing again charges that were rejected in the first action. For example, one partner in a stock brokerage firm may sue a lawyer for malpractice. If the lawyer wins the claim, he or she may generally use the decision as a basis for dismissing a second claim by another partner in the same brokerage firm or by the brokerage firm itself.[1]

This is generally referred to as "defensive" collateral estoppel (issue preclusion) because the party invoking issue preclusion is using the result of the first matter to bar a relitigation of the issue on which the defending party prevailed in the prior action.

For many years, defensive issue preclusion was not only the most common form of collateral estoppel but was also viewed more favorably by the law than offensive issue preclusion. As the example above illustrates, defensive issue preclusion can be used against someone who was not part of the earlier action so long the party that was in the first action had a similar incentive to litigate the point and had the actual opportunity to fully and fairly litigate the point. Thus, the defensive use of issue preclusion need not be "mutual" – the winning party can use its win on the issue to prevent strangers to the first litigation from challenging the earlier determination, so long as the first litigation was fair and actually decided an issue that was necessary to resolution of the first claim.

By contrast, offensive collateral estoppel takes place where a stranger to the first proceeding seeks to use the first proceeding's determination of an issue to prevent the losing party in the first case from contesting the issue in a second proceeding brought by this stranger to the first case. For example, the second partner of the brokerage in the example previously

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1. The lawyer certainly may use the first result to preclude a second claim by a partner who sued in the first action, even if the partner's legal arguments for recovery are different – but this is barred under the doctrine of "res judicata" or "claim preclusion," which precludes relitigation of the same dispute between the same parties. Claim preclusion was not at issue in *Vandenberg* because Case 1, the arbitration dispute, was Boyd v. Vandenberg (on the breach of lease/damage to property claim). Case 2, the litigation dispute, was Insurance Companies v. Vandenberg (regarding coverage).

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given might try to win a summary judgment motion against the law firm if the law firm lost the first case against a different partner in the brokerage firm. For years, such offensive collateral estoppel was frowned upon where the party seeking offensive use was not involved in the prior litigation. This view has been relaxed in recent years – "mutuality" is not required for offensive use of collateral estoppel – but courts generally give offensive collateral estoppel greater scrutiny. To gain offensive issue preclusion, the movant must ordinarily demonstrate that this is fair and consistent with the state's public policy.

The status of arbitration and collateral estoppel has been a matter of some controversy. Because arbitration is not a judicial proceeding, arbitration results were not historically considered to give rise to issue preclusion. During the past twenty years, as social policy endorsed arbitration and other forms of alternative dispute resolution (ADR), many courts moved away from this view and found that an arbitration award could result in either offensive or defensive collateral estoppel depending on the facts and circumstances of the case. As the *Vandenberg* court itself observed:

> We realize that some commentators and most other courts addressing the issue, have taken a contrary approach [to the *Vandenberg* majority]. The predominant view is that unless the arbitral parties agreed otherwise, a judicially confirmed private arbitration award will have collateral estoppel effect, even in favor of nonparties to the arbitration, if the arbitrator actually and necessarily decided the issue sought to be foreclosed and the party against whom estoppel is invoked had full incentive and opportunity to litigate the matter.

Id. at 240; *see, e.g.*, *Witowkski v. Welch*, 173 F.3d 192, 198, 205 (3d Cir. 1999) (applying federal and Pennsylvania law); *Mandich v. Watters*, 970 F.2d 462, 465-67 (8th Cir. 1992) (applying Minnesota law); *Cities Service Co. v. Gulf Oil Corp.*, 980 P.2d 116, 123-30 (Okla. 1999) (applying federal and Oklahoma law). For example, in many states, an arbitration decision may be accorded preclusive effect as to a fact if the arbitration made a firm determination of a fact necessarily at issue and was fair, thorough, and hotly contested. The chances for preclusion are greater where the arbitration involves a matter that the parties knew would likely be at issue with other parties in subsequent proceedings.

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In *Vandenberg*, the California Supreme Court embraced the more traditional wariness of arbitration to some extent. The court held that arbitration, a form of ADR chosen by contract, cannot automatically be given the issue preclusion effect that would accompany a court judgment. *See Vandenberg*, 982 P.2d at 239. Because the parties to an arbitration clause agree only that they will arbitrate a particular matter, the court reasoned that it would be unfair to make the results of the arbitration binding as to each issue in the arbitration – at least when strangers to the arbitration attempt to use the results against one of the parties to the arbitration. *See id.* at 239-40.

According to the court, an arbitration determination is not a proper basis for offensive collateral estoppel for a variety of reasons. First, arbitration awards are subject only to limited and deferential judicial review. *See id.* at 239. A commercial arbitration[2] award will not be vacated unless there has been bias, corruption, gross unfairness in the proceeding (such as giving a party insufficient time to prepare a case or barring crucial witness testimony), or the award exceeds the scope of the agreement.[3] Under federal law, an arbitration award may be overturned in rare cases where the arbitrator demonstrates "manifest disregard" of the law.[4] But this is normally interpreted to mean that the arbitrator expressly refused to follow applicable law, not merely that the arbitrator erred in applying the law. As a result, arbitration is not given the type of searching appellate scrutiny applied to trial court decisions. Furthermore, California law appears to make it even less likely that an award could be vacated for manifest disregard of the law. The *Vandenberg* court cited favorably an old California decision stating that "arbitrators are not bound to award on

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2. Commercial arbitration, which includes arbitration of tort claims and need not involve business entities per se, is distinguished from labor arbitration, which involves resolution of management-union disputes. Labor arbitration differs somewhat from commercial arbitration in terms of procedure and standard of review. A labor arbitrator's award is arguably accorded even more generous judicial review and will be affirmed so long as the award "draws its essence from the collective bargaining agreement." United Steelworkers of Am. v. Enterprise Wheel & Car Corp., 363 U.S. 593, 597 (1960). Commercial arbitration is controlled by federal law where the arbitration clause is one reflecting a transaction involving interstate commerce. Absent interstate commerce, arbitration is controlled by state law, which is largely congruent with federal law.

3. *See* 9 U.S.C. §10 (1994).

4. *See, e.g.*, Sheet Metal Workers Int'l Ass'n v. Kinney Air Conditioning Co., 756 F.2d 742, 746 (9th Cir. 1985) (applying federal common law of arbitration).

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principles of dry law, but may decide on principles of equity and good conscience, and make their award *ex aequo et bono* [according to what is just and good]." *Vandenberg*, 982 P.2d at 239 (citations omitted).

Second, according to the *Vandenberg* court:

> [a]n agreement to arbitrate particular claims reflects each party's conclusion that the immediate stakes make it preferable to avoid the delay and expense of court proceedings, and instead to resolve the matter between themselves without resort to the judicial process. Under such circumstances, each party is willing to risk that the arbitration will result in a 'final' and 'binding' *defeat* with respect to *the submitted claims*, even though the party would have won in court, and even though the arbitrator's errors must be accepted without opportunity for review. But this does not mean each arbitral party also consents that issues decided against him by this informal, imprecise method may bind him, in the same manner as a court trial, in *all future* disputes, regardless of the stakes, against all adversaries, known and unknown.

Id. (citation omitted). Because of this reality, the court found it unfair to accord collateral estoppel effect to facts determined by an arbitrator unless the parties had specifically agreed that this would be the case when they entered into the arbitration agreement. *See id.* at 240.

Third, the policies behind collateral estoppel for court decisions have less weight when applied to arbitration results. The rationale for the doctrine of issue preclusion is to prevent a losing litigant from having the proverbial second bite at the apple but also to conserve judicial resources. The *Vandenberg* court reasoned that conservation of judicial resources was not really an issue because by definition the judiciary has expended little or no effort in the course of an arbitration, which takes place outside the judicial system. *See id.* However, courts may be involved, even heavily involved, in prearbitration motions seeking to force or prohibit an arbitration where one of the parties attempts to avoid the arbitration clause.

The *Vandenberg* court concluded: "the policies underlying the doctrine of collateral estoppel must yield to the contractual basis of private arbitration, *i.e.*, the principle that the scope and effect of the arbitration are for the parties themselves to decide." *Id.* at 240.

Vandenberg's issue preclusion assessment can be criticized as insufficiently supportive of arbitration results, but it can also be defended

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on the facts of the case itself. *Vandenberg* involved a "post-dispute" arbitration agreement, one that arose after a controversy was apparent to all concerned – the Boyds, Vandenberg, and their respective insurers. An agreement between the Boyds and Vandenberg to arbitrate just the disputes between them in order to expedite matters is by implication not one designed to resolve all the coverage questions that may be lurking in the background. The context of the Boyd-Vandenberg arbitration strongly appears to be one directed toward only the Boyd-Vandenberg dispute, not to disputes between Vandenberg and his insurers.

On the other hand, it should hardly have been a surprise to Vandenberg that the insurers would invoke the pollution exclusion and hope to convince a court that the oil waste pollution was insufficiently "sudden" to be covered. Thus, policyholder Vandenberg had a strong incentive to fight any implication in the arbitration that the oil waste pollution was gradual or intentional.

However, insurance law may view facts differently than tort or contract law. For example, a party may be liable in tort for reckless conduct, but does not necessarily "expect or intend" injury within the meaning of the "occurrence" definition of an insurance policy. Thus, an arbitrator's determination that a party "should have known" that its conduct would cause injury does not necessarily result in a successful, expected or intended defense against a policyholder. Similarly, an arbitrator may find that pollution occurred over many years. But if the pollutants were released sporadically in a series of unforeseen and abrupt bursts of damage to storage tanks, the events could qualify as "sudden and accidental" discharges eligible for coverage. Further, in a jurisdiction that requires only that a "sudden and accidental" discharge be unintentional rather than abrupt, the policyholder might obtain coverage even if the arbitrator had correctly found the pollution discharges to span many years.

Put another way, perhaps the California Supreme Court could have protected the policyholder without setting forth such a seemingly broad rule disfavoring collateral estoppel based on arbitration results. To qualify for collateral estoppel effect, the matter in question must involve the "same" issue and be "necessary" to the decision. The issue of whether Vandenberg polluted the Boyd land during the course of the lease is not exactly the same issue as whether the pollution was "sudden and accidental" within the meaning of the qualified pollution exclusion. Although the arbitrator needed to determine whether Vandenberg polluted and injured the Boyd property, the arbitrator did not necessarily need to make any findings as to the time and manner of the pollution. Thus, the

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California Supreme Court could have adopted the majority approach to issue preclusion based on an arbitration finding, but instead found the test for collateral estoppel was not satisfied in Vandenberg's particular case.

In California or other states that might endorse *Vandenberg*, its analysis would probably control and prevent collateral estoppel if a party to a mandated arbitration attempted to make offensive use of issue preclusion. For example, most states require arbitration of disputes concerning first-party automobile insurance benefits.[5] Should the results of these determinations be given preclusive effect? Defensively? Offensively? Presumably, the California Supreme Court would find that such mandated proceedings are intended to have a narrow scope (deciding the first-party claim) and will not be accorded collateral estoppel effect if used offensively. But defensive use of such arbitration determinations may subsequently find more favor in California simply because defensive collateral estoppel is generally regarded with less suspicion.

Vandenberg's application is less clear regarding "predispute" arbitration agreements – those in which the parties agree to arbitrate when making a contract without having any particular dispute between them at the time of contracting. These common forms of arbitration clauses generally state that the parties to the contract agree to arbitrate "all disputes arising out of the contract."[6] Some broad clauses may even obligate the parties to arbitrate disputes "relating to" the contract. When parties arbitrate pursuant to this sort of broad agreement, should they be regarded as having consented to accord collateral estoppel impact to the resulting arbitration award?

Vandenberg is silent on the question and predicting California law for broadly worded predispute arbitration agreements is uncertain. On the one hand, a broadly worded clause suggests that a party willing to arbitrate a wide range of disputes is willing to have the arbitration create collateral estoppel for a wide range of determinations. On the other hand, such broad arbitration clauses have a boilerplate quality, are made without either party appreciating the potential collateral estoppel impact, and often

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5. *See* JEFFREY W. STEMPEL, LAW OF INSURANCE CONTRACT DISPUTES §9.09 (2d ed. 1999 & Supp. 2000).

6. *See, e.g.*, Smith v. Smith Cogeneration Int'l, Inc., 198 F.3d 88 (2d Cir. 1999) (applying federal common law of arbitration; reviewing one such clause). My Lexis search of 1999 cases (conducted April 4, 2000) finds more than 100 cases examining clauses of this type, a reflection of the popularity of this arbitration clause language.

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result from contracts of adhesion between parties of quite disparate sophistication, wealth, and bargaining power. Consequently, one should be wary of interpreting *Vandenberg* to give a green light to issue preclusion if the arbitration agreement is broadly worded.

However, in light of *Vandenberg*, a party drafting an arbitration agreement that implicates California law may want to specifically address collateral estoppel questions in the arbitration clause itself. *Vandenberg* suggests that the California Supreme Court would enforce an arbitration clause that specifically states that matters determined in an arbitration shall have preclusive effect.[7] Conversely, *Vandenberg* clearly establishes that an arbitration clause that states that matters determined in the arbitration will not have preclusive effect in subsequent proceedings will be enforced under California law to prohibit collateral estoppel.

Of perhaps particular interest to parties drafting arbitration agreements after *Vandenberg*, and to insurers and policyholders, is the fact that the *Vandenberg* court rejected issue preclusion in part on the facts of the case because it was inconsistent with the "reasonable expectations of the arbitral parties." *See Vandenberg*, 982 P.2d at 241. The reasonable expectations principle is, of course, more commonly regarded as a part of contract and insurance law rather than procedural law. *Vandenberg* suggests some solicitude for this factor by the California Supreme Court.

On the more specifically insurance related issue before it, the *Vandenberg* court held that the mere fact that an arbitration award or third-party claim was denominated a breach of contract did not conclusively determine whether CGL coverage was available for the claim. *See id.* at 244. The court acknowledged that liability insurance exists to cover fortuitous losses and not losses that were under the effective control of the policyholder. *See id.* Consequently, liability insurance is generally regarded as providing coverage for tort claims but not contract claims. The theory is that a breach of contract is not fortuitous but results from intentional nonperformance by the breaching party. *See id.* at 244 n.12 (citing cases). Although this is true as a general matter,

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7. Two Justices dissented from the *Vandenberg* majority on the question of collateral estoppel. These Justices would have given issue preclusion effect to the arbitrator's finding that the oil waste discharge was gradual and took place over many years. Thus, there are at least two votes on the Court favoring issue preclusion if the party arguing a subsequent case can differentiate its case and arbitration agreement from *Vandenberg* on the facts.

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> [c]overage under a CGL insurance policy is not based upon the fortuity of the form of action chosen by the injured party. Thus, as the Court of Appeal stated, determination of coverage must be made individually by considering 'the nature of [the] property, the injury, and the risk that caused the injury, in light of the particular provisions of each applicable insurance policy.'0

Id. at 243-44 (quoting California Court of Appeal opinion).

The *Vandenberg* court noted that "the same act may constitute both a breach of contract and a tort. Predicating coverage upon an injured party's choice of remedy or the form of action sought is not the law of this state." *Id.* at 245 (citations omitted). "[T]he legal theory asserted by the claimant is immaterial to the determination of whether the risk is covered." *Id.* (quoting 9 COUCH, COUCH ON INSURANCE §126:3, 126-28 (3d ed. 1997)). *Vandenberg* also found support for its analysis in two frequently cited insurance industry authorities: DONALD S. MALECKI & ARTHUR L. FLITNER, COMMERCIAL GENERAL LIABILITY 6 (6th ed. 1997) and George Tinker, *Comprehensive General Liability Insurance – Perspective and Overview*, 25 FED. INS. COUNSEL. Q. 217, 265 (1975). *See Vandenberg*, 982 P.2d at 246.

Although the *Vandenberg* court's decision on the "breach of lease" issue was a victory for the policyholder in that particular case, it is not clear that its holding will always benefit policyholders. If, as *Vandenberg* declared, the key to coverage is the essential nature of the claim rather than the third-party's framing of the claim, this principle is something of a two-way street. On the one hand, it may permit a policyholder like *Vandenberg* to recover if it is sued for despoiling land or other tort-like damage under the rubric of breaching a lease. On the other hand, it may permit an insurer to deny coverage where the claim is framed as a tort action but the underlying offense can be shown not to be fortuitous within the meaning of CGL.

Thus, on questions of indemnity, *Vandenberg* may be a precedent cited equally by both insurers and policyholders in the future. *Vandenberg* may also impact determinations of the duty to defend. Most likely, however, *Vandenberg* will not adversely affect policyholders on these questions because duty to defend jurisprudence focuses primarily (almost exclusively in many states) on the language of a third-party complaint

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against the policyholder. Where the language of the complaint makes out a covered claim, the insurer must defend even if the claims are outlandish and defy common sense.[8] Presumably, *Vandenberg* does nothing to change this aspect of duty to defend law in California. Where the third party pleads a claim as something covered (*e.g.*, a tort) rather than as something uncovered (*e.g.*, a breach of contract), the CGL carrier must defend until it can establish as a matter of fact that the claim falls outside coverage. In *Vandenberg* itself, USF&G defended the matter for some time and undoubtedly at considerable expense until it challenged indemnity coverage after the arbitration was concluded. After a matter has been defended, *Vandenberg* can in theory be used to oppose providing indemnity for a judgment against the policyholder that is labeled one of tort if the facts of the case establish that the matter giving rise to liability was not fortuitous or otherwise covered.

DENIAL OF AIDS COVERAGE IN HEALTH POLICY DOES NOT VIOLATE AGE DISCRIMINATION ACT; McCARRAN-FERGUSON ACT FURTHER PRECLUDES POLICYHOLDER'S CLAIM

Doe v. Mutual of Omaha, 179 F.3d 557 (7th Cir. 1999), *reh'g denied*, No. 98-4112, 1999 U.S. App. LEXIS 18360 (7th Cir. Aug. 3, 1999).

The AIDS crisis that emerged in the 1980's prompted many insurers to consider AIDS risk in underwriting and to refuse coverage for AIDS-related disease in health and disability policies. The Americans with Disabilities Act ("ADA"), 42 U.S.C. §§12182(a) – 12213, was passed in 1990 to address the problem of disability discrimination. Since passage of the ADA, there has been debate over whether the statute requires health insurance coverage of AIDS or AIDS-related illnesses, with courts divided on the issue. The Court of Appeals for the Seventh Circuit (covering the

8. At one time, the CGL language on this point was more explicit, stating that the policy would defend the policyholder against even claims that were "groundless, false, or fraudulent." *See, e.g.*, St. Paul Cos. V. Talladega Nursing Home, Inc., 606 F.2d 631, 633 (5th Cir. 1979) (applying Alabama law; reviewing this type of clause).

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states of Illinois, Indiana, and Wisconsin) recently found that the ADA did not bar such insurance restrictions.

Plaintiffs Doe and Smith (pseudonyms to protect their privacy) purchased individual health insurance policies from Mutual of Omaha. *See Doe*, 179 F.3d at 558. The policies placed significant limits on the amount of benefits available to individuals suffering from AIDS or AIDS-related conditions ("ARC") by capping the amount of coverage available at a $25,000 lifetime maximum for Smith and a $100,000 lifetime maximum for Doe. *See id.* The policies' overall limit was $1 million. *See id.* Plaintiffs contended this was disability discrimination in violation of the ADA. *See id.* The federal trial court in Chicago agreed and found this to be a violation of the ADA. *See id.* at 557. On appeal, the appellate court rejected the contention and found no ADA violation in the insurer's establishment of disease-specific limits on coverage. *See id.* at 565.

Mutual of Omaha sold health insurance policies to the applicants that provided for up to $1 million in coverage for health problems other than AIDS or ARC, which had a lifetime benefit limit of $25,000 and $100,000, respectively. *See id.* at 558. The insurer stipulated that AIDS was a disability covered under the ADA and that it cannot show that its AIDS caps were "consistent with sound actuarial principles, actual or reasonably anticipated experience, bona fide risk classification, or state law." *Id.* Mutual of Omaha defended solely on the basis of its argument that the ADA does not regulate the substantive coverage of insurance policies. *See id.*

The ADA states that "no individual shall be discriminated against on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation" by the owner of the operation. *See* 42 U.S.C. §12182(a). The sale of an insurance policy can be said to be the sale of a good or service. However, the Seventh Circuit panel, in an opinion by Chief Judge Richard Posner (joined by fellow University of Chicago law professor Frank Easterbrook), found that the ADA language at issue had a "core meaning" of prohibiting a business from refusing to deal with the disabled. *See* 179 F.3d at 559. According to the panel majority, the ADA does not prevent the business from differentiating its products in a way that may impact upon the disabled:

> [A] dentist cannot refuse to fill a cavity of a person with AIDS unless he demonstrates a direct threat to safety or health, and an insurance company cannot (at least without pleading a special defense [discussed later in the

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> opinion]) refuse to sell an insurance policy to a person with AIDS. Mutual of Omaha does not refuse to sell insurance policies to such persons – it was happy to sell health insurance policies to the two plaintiffs. But because of the AIDS caps, the policies have less value to persons with AIDS than they would have to persons with other, equally expensive diseases or disabilities. This does not make the offer to sell illusory, for people with AIDS have medical needs unrelated to AIDS, and the policies give such people as much coverage for those needs as the policies give people who don't have AIDS.

Id. at 559 (citations omitted). Continued the court:

> The common sense of the [ADA] statute is that the content of the goods or services offered by a place of public accommodation is not regulated. A camera store may not refuse to sell cameras to a disabled person, but it is not required to stock cameras specially designed for such persons. Had Congress proposed to impose so enormous a burden on the retail sector of the economy and so vast a supervisory responsibility on the federal courts, we think it would have made its intention clearer and would at least have imposed some standards. It is hardly a feasible judicial function to decide . . . how many Braille books the Borders or Barnes and Noble bookstore chains should stock in each of their stores.

Id. at 560.

The *Doe* majority also concluded that prohibiting AIDS caps for insurers willing to write health policies would make little sense when insurers retained the right to refuse to cover any pre-existing conditions related to AIDS or HIV-positive status, where "the insurer can in effect cap his AIDS-related coverage at $0." *Id.* at 559. Consequently, the court did not find it counter to the ADA for the insurer to attach some limits on AIDS-related coverage since the insurer has substantial power to refuse to insure HIV-positive applicants altogether. *See id.* In making this argument, however, the majority overlooked an important distinction: a refusal to cover preexisting conditions does not preclude coverage for that condition per se – even expensive coverage – should the condition develop after the policy is in effect. Thus, the majority's decision permits insurers to not only refuse to write coverage for persons that already have AIDS but also allows health insurers to limit or exclude coverage should the HIV-

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free policyholder develop AIDS complications at some later date. As a practical matter, the distinction may mean a large difference in the number of ultimately covered persons and benefit dollars ultimately provided. Of course, one can find the preexisting condition point of the court's opinion unconvincing but still agree with the *Doe* decision as a whole.

The panel majority further found that an insurer's attempt to limit its AIDS exposure would be useless unless the limitation extended to the types of opportunistic diseases most associated with the onset of AIDS. *See id.* at 561. According to the court:

> A refusal to sell insurance to a blind person is not the same thing as a provision in the policy that if the insured becomes blind, the insurer will not pay the expense of his learning Braille. We find nothing in the language or history of the statute to suggest that the latter refusal would be unlawful.

Id. at 562. Continued the court:

> There is, as we have pointed out, a difference between refusing to sell a health-insurance policy at all to a person with AIDS, or charging him a higher price for such a policy, or attaching a condition obviously designed to deter people with AIDS from buying the policy (such as refusing to cover such a person for a broken leg), on the one hand, and on the other, offering insurance policies that contain caps for various diseases some of which may also be disabilities within the meaning of the Americans with Disabilities Act.

Id. at 563.

The *Doe* majority buttressed its holding by noting that other appellate cases had given similar construction to the ADA, even though several district court cases, including the trial court in *Doe*, had found disparate AIDS caps to violate the ADA. *See id.*; *see, e.g.*, *Ford v. Schering-Plough Corp.*, 145 F.3d 601, 612-14 (3d Cir. 1998); *Parker v. Met. Life Ins. Co.*, 121 F.3d 1006, 1010-14 (6th Cir. 1997) (en banc); *Vaughn v. Sullivan*, 83 F.3d 907, 912-13 (7th Cir. 1996). These cases essentially state that disparate benefit structures do not violate the ADA merely because they fall more adversely upon disabled persons so long as the disparate benefit schedule is not directed at disabilities per se.

In addition to its holding regarding the ADA, the *Doe* majority observed that even if its construction of the ADA "is wrong, the [*Doe*] suit

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must fail anyway, because it is barred by the McCarran-Ferguson Act." *Doe*, 179 F.3d at 563. According to the court:

> That Act, so far as bears on this case, forbids construing a federal statute to 'impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance . . . unless such Act specifically relates to the business of insurance.' . . . Direct conflict with state law is not required to trigger this prohibition; it is enough if the interpretation would 'interfere with a State's administrative regime.' The interpretation of section 302(a) of the Americans with Disabilities Act for which the Plaintiffs contend would do this. State regulation of insurance is comprehensive and includes rate and coverage issues, so if federal courts are now to determine whether caps on disabling conditions (by no means limited to AIDS) are actuarially sound and consistent with principles of state law they will be stepping on the toes of state insurance commissioners.

Id. at 563-64 (citations omitted). Continued the court:

> [R]equiring a federal court to decide whether an insurance policy is consistent with state law – obviously would interfere with the administration of the state law. The states are not indifferent to who enforces their laws.

Id. at 564 (citations omitted).

In dissent, Judge Terence Evans noted the breadth of the ADA's prohibition of discrimination and disagreed that enforcing a broad ADA prohibition would either involve courts in micromanaging the economy or run afoul of the McCarran-Ferguson Act. *See id.* at 565 (Evans, J., dissenting). Judge Evans viewed the ADA as like other civil rights laws that are enforced to vindicate the rights of the protected class rather than to meddle in markets or state regulatory systems. "[W]e are not being asked to regulate [insurance policy] content; we are being asked to decide whether an insurer can discriminate against people with AIDS, refusing to pay for them the same expenses it would pay if they did not have AIDS. The ADA assigns to courts the task of passing judgment on such conduct." *Id.*

Judge Evans also took issue with Judge Posner's analogies of a business's outright refusal to deal with disabled customers:

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> While I agree that the ADA would not require a store owner to alter its inventory, I think the analogy misses the mark. The better analogy would be that of a store which lets disabled customers in the door, but then refuses to sell them anything but inferior cameras.
>
> * * *
>
> [The ADA's] 'safe harbor' [allowing insurers to make distinctions for reasons of actuarial soundness] would allow Mutual of Omaha to treat insureds with AIDS differently than those without AIDS if the discrimination were consistent with Illinois law or could be justified by actuarial principles or claims experience. But Mutual of Omaha conceded that its AIDS and ARC caps do not fall under the ADA's safe harbor protection.
>
> The parties stipulated that the very same affliction (e.g., pneumonia) may be both AIDS-related and not AIDS-related and that, in such cases, coverage depends solely on whether the patient has AIDS. In my view that is more than enough to trigger an ADA violation.

Id.

Judge Evans further attacked the majority result as creating a situation where reasonable policyholders would have great difficulty determining the confines of coverage due to the vagueness of the term "AIDS-related condition." *See id.*

The policies don't even hint at what illnesses or afflictions might fall within the ARC exclusion. Nor has the medical community embraced an accepted definition for what "conditions" are "AIDS-related." The practical effect of all this, as Mutual of Omaha concedes, is that coverage for certain expenses would be approved or denied based solely on whether the insured had AIDS. *See id.*

On the McCarran-Ferguson Act issue, Judge Evans further disagreed with the majority because Mutual of Omaha's stipulations had removed the issue of possible actuarial justification from the case. *See id.* at 566. Consequently, reasoned Judge Evans, enforcement of the ADA to strike down the caps at issue in the two policies before the court would not impermissibly alter or interfere with state regulation. *See id.* But Judge Evans on this point seems to overlook the need for an appellate ruling to provide a consistent set for rules to govern a large number and wide array

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of current and future cases. Although Mutual of Omaha's willingness to stipulate on the actuarial issues may have removed those issues from that case, the potential conflict between underwriting practice and the ADA is one that the federal courts would need to address in any event.

Both the majority and dissenting opinions set forth thoughtful and strong arguments. Not surprisingly, the unsuccessful plaintiff policyholders petitioned for rehearing before the entire Seventh Circuit. It is perhaps similarly unsurprising that the full circuit court of twelve judges split seven to five on the issue of whether to grant a rehearing of the *Doe* case before the full court. Predictably, dissenting Judge Evans wanted rehearing. *See id.* at 557. He was joined by Judges Joel Flaum, Kenneth Ripple, Illana Diamond Rovner, and Diane Wood. *See id.* Supporting Judges Posner and Easterbrook in opposition to rehearing were Judges William Bauer, Richard Cudahy, John Coffey, Daniel Manion, and Michael Kanne. *See id.*

Although the bulk of other cases on the issue, particularly appellate opinions, accord with the *Doe* majority rather than with the dissent, there is sharp division on the issue among federal judges. For example, the Seventh Circuit was closely divided on the issue. Although generally, the more "conservative" members of the court supported the *Doe* majority while the more "liberal" members of the court voted to grant rehearing, the split is not uniformly ideological, either in the Seventh Circuit or other courts. Presumably, the United States Supreme Court will be compelled to hear and decide a case such as *Doe* in order to finally resolve the tension between the ADA and disability-restricted health coverage. To date, however, the Supreme Court has avoided the issue, denying certiorari in cases that have presented the opportunity to rule on the issue.

VIRGINIA SUPREME COURT OVERTURNS $100 MILLION PUNITIVE DAMAGES VERDICT IN DISCRIMINATION CASE ON GROUND HOUSING RIGHTS ORGANIZATION LACKED STANDING TO BRING SUIT

Nationwide Mut. Ins. Co. v. Housing Opportunities Made Equal, Inc., 523 S.E.2d 217 (Va. 2000), *withdrawn and reh'g granted*, 2000 Va. LEXIS 56 (Va. March 3, 2000).

The Virginia Supreme Court tossed out a punitive damages verdict that had startled the insurance industry – but did so based on the technicalities

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of standing doctrine rather than on the merits of the suit, which alleged discrimination in the availability of homeowners insurance.

Housing Opportunities Made Equal, Inc. ("HOME"), a fair housing organization, sued Nationwide Mutual Insurance Company and Nationwide Mutual Fire Insurance Company for alleged discriminatory practices in the marketing and sales of homeowners insurance to blacks in the Richmond area. *See* 523 S.E.2d at 219. HOME's case asserted that Nationwide had adopted an intentional strategy of avoiding black neighborhoods and black customers. *See id.* At trial, HOME presented evidence of a marketing and advertising policy that could be construed as avoidance of sales to black customers and also produced evidence of bias in Nationwide's underwriting, pricing, location of agents, hiring policies, and training policies. *See id.* at 220. HOME also used "testers" – agents for HOME who shopped for insurance and encountered barriers from Nationwide's agents. *See id.* at 221. HOME argued that this quilt of conduct demonstrated race bias by Nationwide. *See id.* at 219. A jury apparently agreed, awarding $500,000 in compensatory damages and $100 million in punitive damages to HOME. *See id.*

HOME made claims under both Virginia common law and the state Fair Housing Law. *See id.* After the verdict, Nationwide appealed, arguing that HOME did not have standing to bring a lawsuit since HOME itself was not a policyholder or actual applicant for insurance. *See id.* at 222. The Virginia Supreme Court agreed and reversed the decision in its entirety, eradicating the verdict against Nationwide. *See id.* at 226.

Standing doctrine requires that a claimant have a tangible stake in the controversy so that there will be sufficient concrete adversity to facilitate adjudication. The standing doctrine is designed to avoid putting courts in the position of rendering advisory opinions and to limit the possibility of manufactured litigation.

Standing doctrine is most developed in the federal courts because Article III of the Constitution requires that the judicial power of the United States be limited to "cases" or "controversies." *See* U.S. CONST. Art. III, § 2, cl. 1. Federal courts are generally considered to be stricter about standing requirements than most state courts. Some states, most notably Massachusetts, expressly permit courts to issue advisory opinions prior to a controversy actually materializing.

In both federal and state court, much of the standing litigation involves claims against the government, where separation of powers concerns generally prompt courts toward a stricter view of standing so that the judiciary will not be required to pass on executive or legislative branch

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conduct unless the case genuinely demands it and is not merely a vehicle for airing political grievances.

Virginia's common law standing doctrine is, however, "more restrictive than its federal counterpart." *See* 523 S.E.2d at 224 (citing *Nicholas v. Lawrence*, 171 S.E. 673 (Va. 1933) (to have standing, litigant "must show that he has an immediate, pecuniary and substantial interest in the litigation, and not a remote or indirect interest.")). More recently, the Virginia high court stated that a litigant must have a "direct interest" in the matter at issue and that

> it is not sufficient that the sole interest of the petitioner is to advance some perceived public right or to redress some anticipated public injury . . . . The word 'aggrieved' in a statute contemplates a substantial grievance and means a denial of some personal or property right . . . or imposition of a burden or obligation upon the petitioner different from that suffered by the public generally.

Virginia Beach Beautification Comm'n v. Board of Zoning Appeals, 344 S.E.2d 899, 902-03 (Va. 1986).

In addition, the *HOME* court noted that "Virginia is not a class-action state" and does not consider an entity to have standing to sue in a representative capacity by asserting the rights of another, unless so authorized by statute. *See HOME*, 523 S.E.2d at 225.

In light of these precedents, it is probably not surprising that the court found HOME not to have common law standing to pursue its claims as an entity on behalf of black residents of the Richmond area who alleged wrongful impediments to obtaining insurance. However, the Fair Housing Law provides that an "aggrieved person" may bring an action against discriminatory housing practices where the person claims she has been injured or will be injured by the discriminatory practices.

HOME argued for standing because the alleged discrimination had resulted in "frustration of its mission, the diversion of its resources, and the discrimination practiced against its 'tester/agents.'" *Id.* at 224. The majority found these bases for standing to be insufficiently substantial, personal, and concrete. *See id.* For example, the majority found HOME's assertion of damage to its cause of nondiscrimination in housing to be too indirect and attenuated and that HOME had not suffered any injury not suffered by the public in general. *See id.* at 225. The court also found no standing claim could be founded on discrimination toward testers. *See id.*

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at 226. The court reasoned that the testers suffered no real loss since they were not genuinely shopping for homeowner's insurance. *See id.*

The majority used state common law to determine who was an "aggrieved person" under the statute. *See id.* at 224. Three dissenting justices argued that the statute evidenced legislative intent to provide standing on a less restrictive basis than does state common law. According to the dissent, the "statutory standard is less restrictive than the common law and, therefore, the common law cannot be used to provide a definition for the term 'injured' because the Virginia Fair Housing Law expressly expands the scope of persons who can incur a legally cognizable injury." *Id.* at 234.

The dissenters also viewed the majority opinion as gutting the state's fair housing statute, stating:

> Significantly, and most disturbing, the majority is unable to explain how a housing organization could ever have standing to pursue a claim under the Virginia Fair Housing Law.
>
> The effect of the majority's construction of the word 'injured' is to render meaningless the General Assembly's 1991 amendment of the Virginia Fair Housing Law to include housing organizations within the definition of 'person' . . . . the majority has effectively repealed those portions of the Virginia Fair Housing Law which relate to fair housing organizations such as HOME.

Id. at 233-34. The dissent was additionally troubled that the majority had so sweepingly vaporized the lower court decision and granted no deference to the trial court's determination that HOME had standing to bring the claim, even though issues of injury would appear to be at least somewhat fact-sensitive. *See id.*

The court subsequently withdrew its decision, finding no standing and granted rehearing, which may indicate that the Court has experienced a change of perspective and that it will ultimately reach the merits of the claim. Irrespective of which side is correct regarding the intricacies of standing doctrine under Virginia law, the initial *HOME* decision is of significant practical importance, particularly if the court continues to deny standing. Most immediately, it saves a prominent insurer from a large judgment and probably produced a collective sigh of relief across the industry. However, the insurance company won this round on the basis of

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what laypersons would call a "technicality" or "loophole." There remains the stark fact that a jury believed Nationwide had discriminated and deserved to be punished with a nine-figure punitive damages judgment. Because of the standing basis for the Supreme Court's decision, it did not disturb the fact findings or other legal conclusions of the court below. In states with less restrictive standing law than Virginia, civil rights groups may be encouraged to continue litigation against perceived discriminatory practices. In its next opinion in *HOME*, the Virginia high court may well address the subsequent issues of discrimination.

PREPONDERANCE OF THE EVIDENCE STANDARD – RATHER THAN CLEAR AND CONVINCING EVIDENCE STANDARD – GOVERNS ISSUE OF BAD FAITH UNDER STATE STATUTE DESIGNED TO ENCOURAGE INSURERS TO ACT REASONABLY OVER SMALL CLAIMS

Nationwide Mut. Ins. Co. v. St. John, 259 Va. 71 (2000).

Nationwide Insurance did not win everything it sought from the Virginia Supreme Court thus far this year. In a decision rendered the same day as *HOME*, discussed above, the court affirmed a finding of bad faith against Nationwide in a small claims matter.

Twelve-year-old Joel St. John was injured in an auto accident. *See* 259 Va. at 73. An examination by a chiropractor revealed significant injuries that were treated by the chiropractor over several weeks, resulting in a medical claim of $1,960 under the family's auto policy with Nationwide. *See id.* at 74. The insurer referred the claim to another chiropractor for review. *See id.* Based on the review, Nationwide agreed to pay only $378.50 of Joel's medical expenses. *See id.* The St. John family sued for benefits and invoked a state law providing that in claims of $2,500 or less, the policyholder may obtain double damages and counsel fees if the "denial, refusal or failure to pay was not made in good faith." *Id.* at 75, n. 1 (*citing* VA. INS. CODE §8.01-66.1(A)).

Nationwide appealed the trial court's decision, awarding Joel the full amount of his chiropractic bill, doubling the amount, and allowing recovery of fees. Although both sides agreed that the standard for determining bad faith was whether the refusal to pay was reasonable, the parties disagreed as to the quantum of proof required to prove reasonableness. Nationwide argued that a finding of bad faith should be

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made by clear and convincing evidence before statutory penalties apply. The court disagreed, holding that proof of bad faith (i.e., lack of a reasonable basis for denying the claim or questioning the amount) was sufficient when made by a preponderance of the evidence.

Although the Virginia standard for common law bad faith claims is "clear and convincing evidence," the court found this case to be governed by a lower evidentiary threshold of "preponderance of the evidence" because of its statutory source. *See St. John*, 259 Va. at 76. The purpose of the statute and the intent of the legislature was to make it possible for policyholders to vindicate small claims by making it less onerous to pursue litigation and to remove the insurer's incentive to merely delay payment and force the policyholder to trial. *See id.* at 75. The higher evidentiary burden was viewed as inconsistent with this purpose and held not to govern this class of small, statutory bad faith claims. *See id.* at 76.

On the facts of the case, the trial court and supreme court ruled against Nationwide because the basis of its denial was uncertainty over whether all of Joel's medical expenses were caused by the auto accident. *See id.* at 77. Prior to trial, however, "Nationwide had no medical evidence that the injuries were not caused by the May 14, 1994 accident . . . . Nevertheless, Nationwide refused to pay the remaining balance of Joel's medical bills and thus forced the matter to proceed to a trial." *Id.* at 78.

In dissent, Justice Compton argued that the common law clear and convincing evidentiary standard for bad faith should govern because the common law and the statute are designed for the same purpose of encouraging good faith contract performance. *See id.* at 80. He stated that "it makes no sense in this insurance contract action alleging bad faith to adopt a preponderance of the evidence standard of proof. Bad faith means the same in any insurance contract context, no matter under what circumstances the lack of good faith is sought to be proved." *Id.*

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INDIANA SUPREME COURT APPROVES INSURER USE OF IN-HOUSE COUNSEL TO DEFEND POLICYHOLDERS FROM THIRD-PARTY CLAIMS BUT FORBIDS CAPTIVE LAW FIRMS FROM PORTRAYING THEMSELVES AS OUTSIDE COUNSEL

Cincinnati Ins. Co. v. Wills, 717 N.E.2d 151 (Ind. 1999).

In recent years, there has been considerable focus on the legal ethics of representation of policyholders pursuant to liability policies. Recently, the Indiana Supreme Court weighed in on aspects of the issue. The court's assessment was largely consistent with decisions in other states. In general, insurers have successfully resisted legal attacks on their use of in-house counsel to represent policyholders against third-party tort claims under standard liability policies.

This case started like most liability claims. David and Marcia Wills asserted tort claims against Elaine Mellenger and Betty Suter. *See* 717 N.E.2d at 153. Suter was insured by Celina Insurance Group, who appointed in-house counsel Keith Faber to defend Suter in the Wills action. *See id.* After being apprised of Faber's house counsel status, Suter consented to the representation. *See id.* The Wills moved to disqualify Faber, asserting that his representation of Suter would be unauthorized practice of law. *See id.* While the case was pending, Cincinnati Insurance sought to intervene because of the possible impact of the case on Cincinnati's practice of representing policyholders in the area through Berlon & Timmel, which Cincinnati characterized as a "captive law firm." *See id.* Berlon & Timmel "is staffed exclusively by employees of Cincinnati who represent only Cincinnati's insureds and Cincinnati itself." *Id.*

The Wills' disqualification motion succeeded before the trial court, which ruled that insurer Celina engaged in unauthorized practice of law by giving its policyholders legal representation through in-house counsel. *See id.* at 153-54. The trial court further viewed the in-house lawyer as assisting unauthorized practice by the non-law firm insurance company, a violation of Indiana Rule of Professional Conduct 5.5(b).[9] *See id.* at 154.

9. The Indiana Rules of Professional Conduct are based largely on the ABA Model Rules of Professional Conduct.

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The trial court also found Cincinnati's use of the name Berlon & Timmel to be unauthorized practice of law and a deceptive practice that would lead policyholders to erroneously think that they were being represented by outside counsel. *See id.*

The Indiana Supreme Court reversed the trial court on the issue of unauthorized practice, with regard to both Celina's in-house counsel and Cincinnati's captive firm, but affirmed the trial court ruling that an insurer's captive law firm could not do business under a name that suggested that it was an outside law firm apart from the insurer's organization. *See id.* at 153.

The Indiana Supreme Court began its analysis with an overview of the types of arguments that have been employed to suggest unauthorized practice by staff counsel and captive firms. *See id.* at 156. The court also summarized legal developments on the issue to date, specifically noting that eight states and the ABA have, in ethics opinions, concluded that practice through in-house counsel does not in and of itself constitute unauthorized practice.[10] In two states, challenges to policyholder representation have been successful: in Kentucky based on potential conflict of interest between insurer and policyholder;[11] and in North Carolina based on a state statutory bar to practice of law by a corporation.[12]

The court found that Celina's notice to its policyholder had been sufficient to alert the insured to the situation and was not misleading. *See Wills*, 717 N.E.2d at 156. In disclosing the in-house status of Attorney Faber, Celina had apparently informed the policyholder that the assigned attorney's primary loyalty was to the policyholder and that confidences between policyholder and attorney could not be shared with the insurer. *See id.*

As to unauthorized practice, the court found that in-house counsel was generally accepted and that counsel's legal services for the company were clearly authorized under the Rules of Professional Conduct. *See id.* at 159.

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10. *See id.* at 155, n.3 (citing to ABA Opinion) and n. 4 (citing to ethics opinions in Alabama, Arizona, Colorado, Illinois, Michigan, New Jersey, New York, Texas and Virginia). The Indiana Supreme Court also noted case law largely favorable to use of in-house counsel. *See id.* at 155, n. 5.

11. *See* American Ins. Ass'n v. Kentucky Bar Ass'n, 917 S.W.2d 568 (Ky. 1996).

12. *See* Gardner v. North Carolina State Bar, 341 S.E.2d 517 (N.C. 1986).

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Although the situation is more complicated when the company lawyer is representing a customer of the company, the court found this to be permissible because the rendering of legal service was done by an attorney who was subject to the control of the policyholder client rather than the nonlawyer company. *See id.* at 160. For example, the court noted that under agency law principles, "where the law requires a license, agency law doctrine permits an unlicensed legal entity to employ licensed agents to perform those acts requiring a license." *Id.*

The court further found that there was no inherently problematic conflict between insurer, policyholder, and counsel. *See id.* The court acknowledged, however, that conflict might well arise in specific cases but found this no reason to issue a blanket prohibition on the use of staff counsel for representation. "If a conflict arises, it will have to be handled, and there are a variety of means to do that.. . . Any abuses can be handled on a case-by-case basis rather than by adoption of the broad prohibition the [third-party claimants] Wills seek." *Id.* at 161.

The court did not specifically adopt the "two-client" model of the insurer-counsel-policyholder relationship, but suggested as much by referring to the insurer as a "co-client" of counsel. *See id.* Most states follow the so-called "one-client" model, which provides that the policyholder is the sole client of counsel and that the insurer is a nonclient third-party paying the legal fees. Of course, the insurer is also an entity with a contractual right to control the litigation under the terms of most liability policies that have a "duty to defend" obligation. Consequently, the one-client/two-client debate cannot be viewed in bipolar and stark terms.[13]

On the matter of the captive law firm, the court concluded:

> We agree with the trial court that the use of the name Berlon & Timmel implies independence and that the ordinary person would assume 'Berlon & Timmel' to be some form of outside counsel. As a result, it is 'misleading' as to identity, responsibility, or status of

13. For further background on this controversy, *see id.* at 161, n. 16 (citing Stephen L. Pepper, *Applying the Fundamentals of Lawyers' Ethics to Insurance Defense Practice*, 4 CONN. INS. L.J. 27 (1997); Charles Silver, *Does Insurance Defense Counsel Represent the Company or the Insured?*, 72 TEX. L. REV. 1583 (1994); Nancy J. Moore, *The Ethical Duties of Insurance Defense Lawyers: Are Special Solutions Required?*, 4 CONN. INS. L.J. 259 (1997)).

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> the attorneys practicing under the name. [However,] the trial court's finding that Cincinnati should close its Indianapolis office was too broad. It is sufficient that the Indiana attorneys practicing under the name Berlon & Timmel take immediate action to discontinue use of Berlon & Timmel or any other name suggesting a legal entity other than Cincinnati to describe their practice as employees of Cincinnati.

Wills, 717 N.E. 2d at 164-65.

Against the four-judge majority, there was a lone dissent, which focused heavily on concerns about conflict of interest, lawyer independence, and lawyer professionalism under in-house arrangements of the sort at issue.[14] Although acknowledging that outside counsel are of course subject to economic incentives to do the client's bidding even when it runs afoul of ethical rules, the dissent found the danger considerably more pronounced when the lawyer was an employee subject to employer control over job security, income, and career advancement. *See id.* at 183. The dissent also found the situation to constitute unauthorized practice since the insurer was providing legal services to an entity other than the insurance company itself.[15]

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14. Quoting Dean Kronman, the dissent observed:

> Every in-house law office is by definition tied to the interests of the business of which it forms a part – a tie that constrains the independence of the lawyers working in it and compromises their imaginative capacity to hold the interests of the business that employs them at arm's length, as lawyers who wish to give the best advice about the most important matters must.

Id. at 183 (quoting ANTHONY T. KRONMAN, THE LOST LAWYER: FAILING IDEALS OF THE LEGAL PROFESSION 379 (1993)). Justice Dickson continued: "Not only do non-lawyers own interests in insurance companies, but also, once house counsel are allowed to represent insureds, non-lawyers, particularly corporate directors and officers, inevitably may control and decide matters related to the legal practice of the salaried attorneys. *Id.* at 183 (Dickson, J., dissenting).

15. *See id.* at 178 (citing GEOFFREY C. HAZARD, JR. & SUSAN P. KONIAK, THE LAW AND ETHICS OF LAWYERING 903 (1990) ("The corporation is engaged in unauthorized practice if its lawyers provide legal assistance to others, such as the corporation's customers. However, the corporation can provide legal assistance to itself without thereby engaging in practice of law")).

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NEW YORK COURT OF APPEALS PERMITS POLICYHOLDERS OF "VANISHING PREMIUM" LIFE INSURANCE TO PLEAD CAUSE OF ACTION FOR DECEPTIVE PRACTICES PURSUANT TO STATUTE BUT REJECTS COMMON LAW FRAUD CLAIM

Gaidon v. Guardian Life Ins. Co. of Am., Nos. 173, 174, 1999 N.Y. LEXIS 3932 (N.Y. Ct. App., Dec. 20, 1999).

A current litigation issue involves a life insurance product that was popular during the 1980's – "vanishing premium" life insurance. These products were a form of "universal" life insurance, a life insurance policy in which premiums were designed to exceed the amount strictly required to pay for the death benefit purchased by the policyholder. The additional premium dollars were to be invested by the insurer, with return on investment reinvested to pay future premiums. The idea was that after a few years of paying premiums, the return on investment would equal the present value of required future premiums so that no further premium payments would be required to maintain the policy. Universal life is described as a "cash value" insurance policy that combines "pure" life insurance (where the premium charged matches the mortality risk in light of the death benefit) and an investment component that seeks to accumulate the funds to pay future premiums.[16]

In traditional cash value policies, any return on premium in excess of that required to immediately pay for coverage is returned to the

16. Universal life is thus distinguished from traditional "whole" life, in which the policyholder pays a level premium throughout the time of the policy. During the early years of the policy when the mortality risk is lower (because the policyholder is younger and less likely to die), the premium is higher than required to pay for a given policy year's death benefit. During the later years of the policy (when the policyholder is older and more likely to die, ultimately certain to die), the premium is lower than would otherwise be required for a given policy year's detriment. In effect, higher than required premiums during the early years of the policy subsidize lower than required premiums during the later years of the policy. *See* 1999 N.Y. LEXIS 3932 at *9-*12. Whole life is traditionally contrasted with term insurance, in which the premium charged is linked to the death benefit offered and mortality risk entailed during the immediate policy period. *See generally* Jay M. Zitter, Annotation, *Divorce and Separation: Method of Valuation of Life Insurance Policies In Connection With Trial Court's Division of Property*, 54 A.L.R.4th 1203 (2000).

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policyholder in the form of dividends or interest. Early cash value policies featured conservative investments by insurers. High interest rates during the 1980's made these unattractive products due to low return. In response, insurers began offering universal life policies in which the policyholder's accumulated money is tied to the current rate of interest. According to the *Gaidon* court:

> Carriers marketed interest rate-sensitive insurance under a host of premium payment options, including the 'vanishing premium' plan. Under this plan, the policyholder pays higher than normal premiums in the early years of the policy, resulting in a quicker accumulation of premium dollars for investment purposes. These policies are marketed on the premise that enough cash value will accumulate so that at a fixed date future administrative and insurance costs will be covered and the policyholder relieved of any further out-of-pocket premium obligations.
>
> In the late 1980s, however, sharply declining interest rates 'upset the economics' of these widely marketed policies. Accumulated cash values became insufficient to pay expected future insurance and administrative costs. By the early 1990's, many consumers who purchased such policies were required to continue out-of-pocket payment to keep their policies in force. And the lawsuits followed.

1999 N.Y. LEXIS 3932 at *11-*12 (citations omitted).[17]

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17. In an interesting irony of the case, the Court of Appeals frequently cited Daniel R. Fischel & Robert S. Stillman, *The Law and Economics of Vanishing Premium Life Insurance*, 22 DEL. J. CORP. L. 1 (1997) as authority concerning the nature of insurance and the background of the controversy. Fischel, a University of Chicago law professor and law/economics expert witness, had successfully sued Gaidon attorney Melyvn Weiss's prominent law firm, alleging that firm attempted to defame him in retaliation for past opposition in litigation. The suit was ultimately settled. The Fischel & Stillman article is sympathetic to the insurance industry regarding the vanishing premium litigation explosion (*e.g.*, "Declining interest rates, not deceptive sales practices, are responsible for the failure of vanishing premium life insurance policies to perform as well as initially hoped." *Id.* at 32). It was undoubtedly brought to the court's attention by insurers. But the court majority citing the article approved continued prosecution of a significant part of the *Gaidon* claim.

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Specifically, class representative plaintiff Gaidon[18] and others bought insurance from Guardian Life in the 1980's, allegedly on the strength of what proved to be false representations that they would absolutely be relieved of premiums after a few years. *See id.* at *4. The plaintiffs also alleged that Guardian artificially inflated its current dividend rates "despite waning profits [on the invested premium] because it wanted to continue depicting competitive vanishing rates." *Id.* However, on a separate page, accompanying insurer illustrations of various payment and investment return options, Guardian disclaimed:

> Figures depending on dividends are neither estimated nor guaranteed, but are based on the current year's dividend scale.
>
> The current year's dividend scale reflects current company claims, expense and investment experience and taxes under current laws. Actual future dividends may be higher or lower than those illustrated depending on the company's actual future experience.

Id. at *4-*5. In addition, the policies when delivered contained a statement saying that divisible surplus would be determined on an annual basis and that dividends would "reflect Guardian's mortality, expense, and investment experience." *Id.* at *5.

By the 1990s, it was clear that declining interest rates made it impossible for the life premiums to vanish too quickly. In 1995, Guardian informed plaintiffs that premiums would not vanish at all and would need to be continually paid for the foreseeable future to keep policies in force. In 1996, plaintiffs sued insurers Guardian. In a separate suit, another class of policyholders sued Mutual of New York (MONY) over similar vanishing premium policies. Plaintiffs asserted several causes of action, including breach of contract, negligence, and unjust enrichment. The two causes of action reviewed by the New York Court of Appeals in *Gaidon* were (1) violation of New York's General Business Law §349 and (2) common law fraud. Defendants moved to dismiss these causes of action for failure to state a claim. *See id.* at *15. The court granted the defense

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18. The action was commenced as a class action, but at the time of the *Gaidon* decision by the New York Court of Appeals, there had not been a determination as to whether the proffered class would be certified and whether the matter would be permitted to proceed on a class action basis.

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motion as to fraud, but permitted the actions to continue under the statute. *See id.* at *27-*28.

Under New York General Business Law §349, a defendant is liable if it has engaged "in an act or practice that is deceptive or misleading in a material way" that causes resulting injury to the plaintiff. *See id.* at *14 (citing N.Y. C.L.S. GEN. BUS. §349 (1999)). According to the court:

> Plaintiffs have alleged, in essence, that defendants lured them into purchasing policies by using illustrations that created unrealistic expectations as to the prospects of premium disappearance upon a strategically chosen 'vanishing date.' This vanishing date, plaintiffs allege, was misleading, as based on the premise that interest rates would continue at a high, unprecedented rate for, in some cases, twenty or more years – a premise that defendants allegedly knew to be unlikely.

Id. at *14-*15.

On this issue, plaintiffs were assisted by the New York Attorney General, who filed an amicus brief against dismissal of the Section 349 claims. *See id.* at *15. Under the rules of procedure, a motion to dismiss – which was filed in the claim against Guardian – accepts as true the allegations of the complaint, at least for purposes of deciding the motion. Thus, if the defendants' motions were granted, the court would have been in effect holding that even where significant deception took place, the state statute attacking deceptive practices was inapplicable. The Attorney General took the position ""that a matter-of-law finding that the practices [allegedly committed by the insurers] were not deceptive or misleading would undermine the State's power to redress consumer practices that do not rise to the level of common law fraud." *Id.*

The MONY action involved a summary judgment motion. Summary judgment is similar to a motion to dismiss in that the court does not resolve legitimately contested questions of fact and renders a decision as a matter of law. However, in the case of summary judgment, considerable discovery may be conducted and there is often a large factual record. Further, the court may determine that some facts are clearly established by the record and not subject to reasonable dispute. The court was obviously disturbed by aspects of the MONY record that tended to suggest plaintiffs' allegations had factual support:

> The record contains a sales training videotape that is revealing. It instructs agents how to 'cause the vanish to occur whenever your client wants to see it.' Also,

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> vanishing premium policies were marketed with slogans such as 'Pay one and done,' '4 Pay/No Pay,' 'Pay One Vanish,' 'Accelerated Vanish,' and 'How to get lifetime insurance protection with payments that are . . . GOING, GOING, GONE.'

Id. at *18. The court also noted that other courts had "sustained deceptive trade practices causes of action under statutes similar to New York's."[19]

However, the court was persuaded by the defense argument that plaintiffs had failed to plead a claim for which relief could be granted on grounds of common law fraud, although a number of court decisions have sustained such actions.[20] The court found that

> plaintiffs have not met the threshold elements to support a fraud claim – 'misrepresentation or material omission.' The elements of fraud are narrowly defined, requiring proof by clear and convincing evidence. Not every misrepresentation or omission rises to the level of fraud. An omission or misrepresentation may be so trifling as to be legally inconsequential or so egregious as to be fraudulent, or even criminal. Or it may fall somewhere in between, as it does here.

Id. at *26 (citations and footnote omitted).

Judge Bellacosa, in lone dissent, agreed that plaintiffs had not pleaded a common law fraud claim, but further argued that the sales practices in question were at most puffery and aggressive selling that should not be actionable under New York General Business Law Section 349. *See id.* at *44-*45.

The *Gaidon* decision illustrates the sometimes key differences between attempting to prove traditional fraud (which requires a material misrepresentation) and litigating fraudlike claims under deceptive practices statutes, which may permit recovery were the conduct attacked was not an outright lie but may have been deceptive in whole or part.

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19. *Id.* at *22, n. 11 (citing Nepomoceno v. Knights of Columbus, No. Civ. A 96 C 4789, 1999 U.S. Dist. LEXIS 1366 (N.D. Ill. Feb. 8, 1999); Force v. ITT Hartford Life & Annuity Ins. Co., 4 F. Supp. 2d 843 (D. Minn. 1998); Parkhill v. Minnesota Mut. Life Ins. Co., 995 F. Supp. 983 (D. Minn. 1998)).

20. *See id.* at *25-*26 (citing Greenberg v. Life Ins. Co. of Va., 177 F.3d 507 (6th Cir. 1999); Myers v. Guardian Life Ins. Co. of Am., 5 F. Supp. 2d 423 (N.D. Miss. 1998)).

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NEVADA EMPLOYERS ARE NOT IMMUNIZED FROM SUIT FOR INDEMNITY BY POWER COMPANY BUT SCOPE OF POWER COMPANY'S INDEMNITY RIGHTS LIMITED BY COURT'S STATUTORY INTERPRETATION

Nevada Power Co. v. Haggerty, 989 P.2d 870 (Nev. 1999).

A Nevada statute provides that a power company subject to a personal injury judgment make seek indemnity from other tortfeasors contributing to the injury. Does the power company's right of indemnity extend even to indemnity claims against the injured plaintiff's employer, an entity normally exempt from employee claims under terms of state workers' compensation law? The Nevada Supreme Court recently answered the question in the affirmative, but refused to permit the power company to sue the employer for indemnity in the particular case in question on the ground that the particular statutory right of indemnity applied only where the incident involved "overhead" power lines rather than the ground-level power lines that were the source of the injury-causing electricity. *See* 989 P.2d at 879-80.

Raymond Haggerty was a maintenance engineer employee of the Horseshoe Club, a casino in downtown Las Vegas. *See id.* at 872. While working, Haggerty entered a room in the basement of the Horseshoe that contained electrical equipment. *See id.* The vault that normally secured high-voltage power lines in the room was unlocked, permitting Haggerty to enter the vault to inspect a vent. *See id.* While in the vault, Haggerty's shoulder came in contact with high voltage equipment owned by Nevada Power. *See id.* Haggerty suffered substantial injuries. *See id.* Although precluded from suing the Horseshoe, Haggerty sued Nevada Power for alleged negligence. *See id.* at 873. Nevada Power then filed a third-party complaint to seek indemnity from the Horseshoe on the ground that the employer's negligent maintenance of the area was a substantial factor contributing to the Haggerty injury. *See id.* In particular, Nevada Power alleged that it should have been informed of employee access and the padlock on the vault should not have been removed, allegedly by the employer. *See id.*

Nevada Revised Statutes Sections 455.200 through 455.250 provide that a person working in the vicinity of high voltage overhead power lines must notify the power company before commencing the work. *See id.* Where failure to follow the statute results in injuries and claims against the

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power company, the power company may sue for indemnity against the party that failed to notify the utility. *See id.* at 874. Nevada Power sought to use this statute to force Horseshoe to share in any judgment Haggerty might obtain. *See id.* In addition, Haggerty had applied for and received workers' compensation benefits from Horseshoe pursuant to the Nevada Industrial Insurance Act (NIIA), the state's workers' compensation law. *See id.*

Horseshoe argued that the power company's indemnity claim should be barred as a matter of law under NIIA, which (like workers compensation laws generally) provides employer immunity against tort litigation as the quid pro quo for the employer's strict liability for workplace injuries under the workers compensation law (under workers' compensation principles, the fault of both employer and employee is immaterial but the amounts payable to the employee are determined by a schedule of benefits rather than by ad hoc jury awards). *See id.* The Nevada Supreme Court disagreed with Horseshoe's assertion of immunity, essentially deciding that the indemnity provisions of the overhead power line statute overrode the immunity provisions of the workers' compensation law. *See id.* at 877. Horseshoe had argued that this was contrary to the legislature's intent in passing these laws. *See id.* at 874. The court found that "[t]here is no legislative history in Nevada to support either position" and instead decided the case reasoning from the structure and purpose of the statutes in light of precedent from other jurisdictions. *See id.* at 876. Reviewing analogous precedent from other states, the Nevada Supreme Court noted that a right of indemnity had been held to overcome the workers compensation immunity in Texas,[21] Arizona,[22] Oklahoma,[23] and Georgia.[24] *See Haggerty*, 989 P.2d at 875-76. The only contrary precedent noted by the *Haggerty* court was from Colorado.[25] *See id.* at 876.

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21. *See* Olson v. Central Power and Light Co., 803 S.W.2d 808, 812 (Tex. Ct. App. 1991); Houston Lighting, Etc. v. Eller Outdoor Adver., 635 S.W.2d 133, 135 (Tex. Ct. Civ. App. 1982).

22. *See* Tucson Elec. v. Dooley-Jones and Assoc., 746 P.2d 510, 514 (Ariz. Ct. App. 1987); Tucson Elec. v. Swengel-Robbins Const., 737 P.2d 1385, 1388 (Ariz. Ct. App. 1987).

23. *See* Travelers Ins. v. L.V. French Truck Serv., 770 P.2d 551, 554 (Okla. 1988).

24. *See* Flint Elec. Membership v. Ed Smith Const., 511 S.E.2d 160 (Ga. 1999).

25. *See* Rodriguez v. Nurseries, Inc., 815 P.2d 1006, 1008 (Colo. Ct. App. 1991).

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As to structure and purpose, the court reasoned that the employer retained immunity from litigation by workers and that this would not be unduly undermined by an indemnity action by the power company. *See id.* at 877. In return, subjecting employers to the power line indemnity statute would encourage employers to comply with the law and to notify the power company before working around overhead power lines. *See id.* The court also followed the general rule of statutory construction that posits that a specific statutory provision (power company indemnity) should be given precedence over a general statute (employer immunity from suit pursuant to the workers compensation system). *See id.*

The court further noted that the power line indemnity statute was enacted more recently than the workers compensation law. *See id.* Under traditional rules of statutory construction, the more recent statute takes precedence under the theory that (1) this evidences the most recent will of the legislature, and (2) that the legislature was constructively aware of the preexisting workers' compensation law, but said nothing in the more recent law to preserve employer immunity in the face of the newly-created power company right of indemnity. *See id.* According to the *Haggerty* court, permitting the indemnity action was "a more harmonious resolution of the conflict between the two statutes than gutting the power line statute in favor of the workers' compensation laws." *Id.*

Nevada Power's victory on the statutory conflict was quickly erased by the second half of the *Haggerty* opinion, which held that the statute did not apply in the instant litigation because Haggerty was not injured by an "overhead" power line. *See id.* at 880. The statute imposes duties of notice and a right of indemnity only for "overhead" power lines. *See id.* at 878. The court held that the power lines in the Horseshoe facility that injured Haggerty were at best on-ground power lines and were arguably even underground power lines since the accident occurred in the basement of the casino building. *See id.*

The relevant Nevada statute defines an overhead line as "a bare or insulated electrical conductor installed above ground." NEV. REV. STAT. 455.200(2) (2000). Horseshoe, *amicus curiae* the Nevada Self-Insurers Association, had argued that "above ground" means "in the air," while Nevada Power argued that "above ground" meant unburied. *See id.* at 877. The court found either definition to be reasonable, which meant that the term was ambiguous and must therefore be construed "in line with what reason and public policy would indicate the legislature intended." *Id.* at 878 (citation omitted). Again reviewing at the language, purpose, and structure of the power line law, the *Haggerty* court concluded that the

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statute connoted power lines suspended outdoors and above ground. *See id.* at 879. According to the court, the legislature must have held this conception or the notification requirement would be hopelessly broad, requiring notice whenever anyone was working around any power company lines or transformers:

> If the overhead power line statutes were construed to apply in this situation, then each time a Horseshoe employee conducted work in the electrical room of the building, the Horseshoe might be required to contact Nevada Power, whether or not the employee was actually working in the vault where the high voltage power lines are located, because the proximity of the room and the vault could come within the parameters of the statute. Under the statute, Nevada Power could also charge a fee for supervising the work to ensure no one came into contact with the high voltage equipment. Given the number of times this would occur on a weekly basis, it is unlikely that the legislature intended such a result, since the employees could more easily be protected by Nevada Power restricting access to its equipment. Indeed, applying NRS 455.240 to Nevada Power's indoor equipment would be more likely to undermine worker safety, since there would be no incentive for Nevada Power to maintain safety measures to protect people and property from accidental contact where Nevada Power knew such contact was likely to occur. The statutory intent is better served by not imposing the provisions of the overhead power line laws to high voltage electrical equipment located within a building.

Id. at 879.

Two Justices dissented regarding both the issue of statutory conflict and the definition of overhead power lines. *See id.* at 880. (Agosti, J., with Leavitt, J., dissenting). The dissent argued that although the term "above ground" most logically means "not buried" and that the power lines in the Horseshoe were certainly above the ground upon which Haggerty worked. Further, the dissent argued for a definition of overhead power line that would make the statute more widely applicable in order to promote worker safety. *See id.* at 880-81. The dissent's approach to statutory interpretation relied upon yet another canon of statutory construction –

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"statutes with a protective purpose should be liberally construed in order to effectuate the intended protection." *Id.* at 881.

The dissent also objected to the majority opinion on a number of jurisprudential grounds. According to the dissent, the issue of the meaning of "overhead" was not raised in the court below but appeared for the first time on appeal, suggesting that a remand was in order to permit the lower court to give initial consideration to this legal issue. *See id.* In addition, the dissent found no support in the record for the majority statement that Nevada Power could routinely charge fees for supervising work near power lines and suggested that the majority had improperly based its decision in part on matters not in the record. *See id.* Most important, the dissent characterized the majority holding that the power line statute overcomes the workers' compensation law as an unwarranted advisory opinion because the majority had determined that under the facts of the case Haggerty was not injured by an overhead power line. *See id.* at 880. The power line statute was thus inapplicable and there was no need to decide whether it trumped the workers compensation immunity of the employer. *See id.* at 880.

IN-HOME BABYSITTING FALLS WITHIN "BUSINESS PURSUITS" EXCLUSION IN HOMEOWNER'S POLICY; COVERAGE DENIED FOR SUIT ARISING OUT OF INJURY TO CHILD IN HOME

Dwello v. American Reliance Ins. Co., 990 P.2d 190 (Nev. 1999).

Alisa Dwello was a working mother with an seven-year-old daughter. *See* 990 P.2d at 191. She arranged for her neighbor, Patty Kenyon, to care for the girl while Dwello worked. *See id.* Kenyon generally watched the child in her home ten hours per day, five days a week for $50.00. *See id.* The charges were, to say the least, modest, but accounted for forty percent of Kenyon's monthly income. *See id.* Unfortunately, the arrangement took a tragic turn when Kenyon's dog attacked the child, severely injuring her face, head, and eye. *See id.*

Dwello sued Kenyon for negligence in failing to adequately protect the girl and failing to warn of the dog's dangerous propensities (it had apparently bitten others before). *See id.* The Kenyons tendered the complaint to their homeowner's insurer, American Reliance. *See id.* The insurer refused to defend and commenced a declaratory judgment action

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against the Kenyons, claiming the matter fell outside of coverage because the injury arose out of business activity by the Kenyons, which was specifically excluded from the standard homeowners' policy. *See id.* When the Kenyons filed for bankruptcy, Dwello was permitted to intervene against American Reliance in the declaratory judgment action. *See id.*

After a one-day bench trial, the trial court found for the insurer, a decision which the Nevada Supreme Court unanimously affirmed. *See id.* The exclusion in the policy provided that the liability coverage did not extend to bodily injury or property damage "[a]rising out of your business pursuits. This also includes your occasional or part-time business pursuits." *Id.*

The Nevada Supreme Court found this language undeniably clear in limiting coverage. *See id.* at 192. The Kenyons had argued that they would have watched the child for free if necessary because of the neighbor relationship, and that the exclusion did not apply because Kenyon was not generally operating a child care business (she was not licensed and did not advertise), but watched only the one child as an accommodation to Dwello. *See id.* Notwithstanding the cut-rate charges, the court rejected the Kenyon position on the ground that the childcare in question was provided for a fee and was substantial and ongoing. *See id.*

According to the court, the business pursuits exclusion in the policy "is clear and unambiguous." *Id.* Notwithstanding this pronouncement, the Nevada Supreme Court suggested that it would not read the business pursuits exclusion to exempt from coverage all claims arising out of babysitting. *See id.* Noting that other state courts were divided on whether in-home babysitting fell within the business exclusion, *Dwello* expressly adopted the approach of the New Jersey courts in *Carroll v. Boyce*, 640 A.2d 298 (N.J. App. Div. 1994) and used a two factor test which asks: (1) whether the business pursuit "involves. a continuity or customary engagement in the activity" and (2) "whether the activity involves a profit motive." *Id.* Under the facts of the *Dwello* case, these conditions of continuity and profit made the exclusion applicable.

On one hand, *Dwello* may be part of what seems to be an increasing tendency of courts to apply the business pursuits exclusion to in-home babysitting. On the other hand, the court's adoption of a fact-based inquiry into continuity and profit makes these cases resistant to summary judgment, which is not helpful to insurers. Although the trial below was only one day, it was nonetheless a trial. Further, cases like *Dwello* and *Carroll*, to some extent, beg the question of what courts will do when

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confronted with cases that arise from a teenager's episodic babysitting of neighborhood children. Will a court consider this continuity if there is repeat babysitting but it is not substantial or regularized? Will a court consider it a "profit motive" if the teenager charges, but the parents view the activity primarily as a service for neighbors or a means of inculcating responsibility in the child? This seems unclear and suggests that courts will continue to differ at the margin over the application of the business pursuits exclusion to babysitting. Furthermore, as long as the exclusion is styled as one of "business" pursuits, some courts will fairly ask whether the reasonable construction of "business" really extends to children's activities. For example, does a lemonade stand in the driveway fall within the exclusion? *Dwello* was an easy case because it involved regularized adult activity rather than a child's lemonade stand or babysitting.

In response, insurers could perhaps achieve greater efficacy of the exclusion by adding that the exclusion applies to for-profit activities "no matter how infrequent and regardless of motive." Insurers might also add language such as: "Whenever compensation is received for activity in the home, this exclusion applies to the activity." Although this may seem like overkill for an exclusion that has been deemed clear and unambiguous, additional language may be helpful for insurers. Cases like *Dwello* suggest that courts do not literally mean that the exclusion is ambiguous in all cases or they would not engage in the "continuity and profit motive" analysis but would instead simply exclude coverage whenever there is remunerative activity.

In any event, the practical effect of the state of the law on this point is to suggest that anyone offering even occasional in-home child care would be wise to talk to his or her agent about obtaining express coverage through an endorsement to the policy. In the alternative, families with teenage babysitters should probably insist that the teenager go to the home of the other child rather than permitting the other child to be dropped off at the home of the teenager. In this way, the situs of any unfortunate injury will be the cared-for child's own home, which is not receiving any revenue from the babysitting.

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