CONNECTICUT INSURANCE LAW JOURNAL

Volume 25, Number 1
Fall 2018

University of Connecticut School of Law
Hartford, Connecticut

Connecticut Insurance Law Journal (ISSN 1081-9436) is published at least twice a year by the Connecticut Insurance Law Journal Association at the University of Connecticut School of Law. Periodicals postage paid at Hartford, Connecticut. Known office of publication: 55 Elizabeth Street, Hartford, Connecticut 06105-2209. ***Printing location: Western Newspaper Publishing Company, 929 West 16th Street, Indianapolis, Indiana 46202.***

Please visit our website at http://www.insurancejournal.org or see the final page of this issue for subscription and back issue ordering information.

Postmaster: Send address changes to Connecticut Insurance Law Journal, 55 Elizabeth Street, Hartford, Connecticut 06105-2209.

The Journal welcomes the submission of articles and book reviews. Both text and notes should be double or triple-spaced. Submissions in electronic form are encouraged, and should be in Microsoft™ Word™ version 97 *format or higher. Citations should conform to the most recent edition of* A UNIFORM SYSTEM OF CITATION, *published by the Harvard Law Review Association.*

It is the policy of the University of Connecticut to prohibit discrimination in education, employment, and in the provision of services on the basis of race, religion, sex, age, marital status, national origin, ancestry, sexual preference, status as a disabled veteran or veteran of the Vietnam Era, physical or mental disability, or record of such impairments, or mental retardation. University policy also prohibits discrimination in employment on the basis of a criminal record that is not related to the position being sought; and supports all state and federal civil rights statutes whether or not specifically cited within this statement.

Copyright © 2019 by the Connecticut Insurance Law Journal Association.

Cite as CONN. INS. L.J.

CONNECTICUT INSURANCE LAW JOURNAL

VOLUME 25 2018-2019 NUMBER 1

EDITORIAL BOARD 2018-2019

Editor-in-Chief
KYLE ROSEMAN

Co-Managing Editors
FRANCIS AREVALO
JENNIFER BUSH

Assistant Managing Editor
MICHAEL KOCHOL

Administrative Editor
TIFFANY MONTOUTH

Lead Articles & Abstract Editor
JASON THAYER MARTINEZ

Notes & Comments Editors
HENRY ZACCARDI
ANTHONY ZUCARO
KADEEJAH KELLY

Executive Editors
MICHAEL KEATING
KYLE KISTINGER
ZACHARY GAIN

Technology & Research Editor
KRISTY SANANDRES

Symposium & Write-On Editor
SHARIX ALICEA

MEMBERS
JACQUELINE APPELL
ALUNDAI BENJAMIN
JEREMY WEYMAN
GABRIELLE GELOZIN
BRITTANY MCEWAN
WILLIAM KEEFER
JACOB FONSECA
TRISANA SPENCE
CHLOE SCHERPA
KILEIGH NASSAU
WHITNEY LORELLO
ALEXANDER HYDER
HANNAH GARFINKEL
DANIEL CARLSON
JUNHAN ZHANG
JASJEET SAHANI
CHIRSTIAN EDWARDS VAN MUIJEN
JENNIFIER LABBADIA
JULIANA HOULDCROFT

Student Advisor
MATTHEW DIAMOND

FACULTY ADVISOR
BRENDAN S. MAHER

UNIVERSITY OF CONNECTICUT
SCHOOL OF LAW

FACULTY AND OFFICERS OF ADMINISTRATION
FOR THE ACADEMIC YEAR 2018-2019

Officers of Administration

Susan Herbst, Ph.D., *President, University of Connecticut*
Craig H. Kennedy, Ph.D., *Provost and Executive Vice President for Academic Affairs*
Timothy Fisher, J.D., *Dean, School of Law*
Paul Chill, J.D., *Associate Dean for Clinical and Experiential Education*
Darcy Kirk, J.D., *Associate Dean for Academic Affair and Distinguished Professor of Law*
Peter Siegelman, Ph.D., *Associate Dean for Research and Faculty Development*
Karen L. DeMeola, J.D., *Assistant Dean for Finance, Administration and Enrollment*

Faculty Emeriti

Robin Barnes, B.A., J.D., *Professor of Law Emerita*
Loftus E. Becker, Jr., A.B., LL.B., *Professor of Law Emeritus*
Phillip I. Blumberg, A.B., J.D., LL.D. (Hon.), *Dean and Professor of Law and Business, Emeritus*
John C. Brittain, B.A., J.D., *Professor of Law Emeritus*
Deborah A. Calloway, B.A.; J.D., *Professor of Law Emerita*
Clifford Davis, S.B., LL.B., *Professor of Law Emeritus*
Richard S. Kay, A.B., M.A., J.D., *Wallace Stevens Professor of Law Emeritus and Oliver Ellsworth Research Professor of Law*
Lewis S. Kurlantzick, B.A., LL.B., *Zephaniah Swift Professor of Law Emeritus and Oliver Ellsworth Research Professor of Law*
Hugh C. Macgill, B.A., LL.B., *Dean and Professor of Law Emeritus*
Patricia A. McCoy, B.A., J.D., *Professor of Law Emerita*
R. Kent Newmyer, *Professor of Law and History Emeritus*
Nell J. Newton, B.A., J.D., *Dean and Professor of Law Emerita*
Leonard Orland, B.A., LL.B., *Professor of Law Emeritus*
Jeremy R. Paul, A.B., J.D., *Dean and Professor of Law Emeritus*
Howard Sacks, A.B., LL.B., *Dean and Professor of Law Emeritus*
Eileen Silverstein, A.D., J.D., *Professor of Law Emerita*
Lester B. Snyder, B.S., LL.B., LL.M., *Professor of Law Emeritus*
James H. Stark, A.B., J.D., *Roger Sherman Professor of Law Emeritus and Oliver Ellsworth Research Professor*
Kurt Strasser, B.A., J.D., LL.M., J.S.D., *Professor of Law Emeritus*
Colin C. Tait, B.A., LL.B., *Professor of Law Emeritus*
Carol Weisbrod, J.D., *Professor of Law Emerita*
Nicholas Wolfson, A.B., J.D., *Professor of Law Emeritus*

Faculty of Law

Jill Anderson, B.A., University of Washington; J.D., Columbia University; *Professor of Law*
Paul Bader, B.A., Duke University; J.D., Mercer University Walter F. George School of Law; *Assistant Clinical Professor of Law*
Jon Bauer, A.B., Cornell University; J.D., Yale University; *Richard D. Tulisano '69 Human Rights Scholar and Clinical Professor of Law*
Mary Beattie, B.A., Providence College; J.D., University of Bridgeport; *Assistant Clinical Professor of Law and Director, Academic Support*
Bethany Berger, B.A., Wesleyan University; J.D., Yale University; *Wallace Stevens Professor of Law*
Robert Birmingham, A.B., J.D., Ph.D. (Econ.), Ph.D. (Phil.), University of Pittsburgh; LL.M., Harvard University; *Professor of Law*
Kiel Brennan-Marquez, B.A., Pomona College; J.D., Yale University; *Associate Professor of Law and William T. Golden Scholar*

Sara Bronin, B.A., University of Texas; M.Sc., University of Oxford (Magdalen College); J.D., Yale University; *Thomas F. Gallivan, Jr. Chair in Real Property Law and Faculty Director, Center for Energy and Environmental Law*

Paul Chill, B.A., Wesleyan University; J.D., University of Connecticut; *Associate Dean for Clinical and Experiential Education and Clinical Professor of Law*

John A. Cogan, Jr., B.A., University of Massachusetts Amherst; M.A., University of Texas; J.D., University of Texas School of Law; *Associate Professor of Law and Roger S. Baldwin Scholar*

Mathilde Cohen, B.A., M.A., L.L.B., Sorbonne-École Normale Supérieure; LL.M., J.S.D., Columbia University, *Professor of Law*

Diane F. Covello, B.S., University of Kansas; J.D., Duke University School of Law; *Assistant Clinical Professor of Law and Co-Director, Intellectual Property and Entrepreneurship Law Clinic*

Anne C. Dailey, B.A., Yale University; J.D., Harvard University; *Evangeline Starr Professor of Law*

Miguel F. P. de Figueiredo, B.A., Johns Hopkins University; M.A., University of Chicago; Ph.D., University of California, Berkeley; J.D., Yale University; *Associate Professor of Law and Terry J. Tondro Research Scholar*

Jessica de Perio Wittman, B.A., State University of New York at Stony Brook; B.A, M.L.S., State University of New York at Buffalo; J.D., Seattle University School of Law; *Associate Professor of Law and Director, Law Library*

Timothy H. Everett, B.A., M.A., Clark University; J.D., University of Connecticut; *Clinical Professor of Law*

Todd D. Fernow, B.A., Cornell University; J.D., University of Connecticut; *Professor of Law and Director, Criminal Law Clinic*

Richard Michael Fischl, B.A., University of Illinois; J.D., Harvard University; *Professor of Law*

Timothy Fisher, B.A., Yale University; J.D., Columbia University; *Dean and Professor of Law*

Valeria Gomez, B.A., Belmont University; J.D., University of Tennessee College of Law; *William R. Davis Clinical Teaching Fellow*

Hillary Greene, B.A., J.D., Yale University; *Zephaniah Swift Professor of Law*

Mark W. Janis, A.B., Princeton University; B.A., M.A., Oxford University; J.D., Harvard University; *William F. Starr Professor of Law*

Darcy Kirk, A.B., Vassar College; M.S., M.B.A., Simmons College; J.D., Boston College; *Distinguished Professor of Law and Associate Dean for Academic Affairs*

Peter R. Kochenburger, A.B., Yale University; J.D., Harvard University; *Associate Clinical Professor of Law, Executive Director of the Insurance LL.M. Program and Deputy Director of the Insurance Law Center*

James Kwak, A.B., Harvard College; Ph.D., University of California at Berkeley; J.D., Yale Law School; *Professor of Law*

Alexandra Lahav, A.B., Brown University; J.D., Harvard University; *Ellen Ash Peters Professor of Law*

Molly K. Land, B.A., Hamline University; J.D., Yale; *Professor of Law and Associate Director of Human Rights Institute*

Elizabeth Latif, B.A., Boston University; J.D., Boston University School of Law; *Legal Practice Professor*

Leslie C. Levin, B.S.J., Northwestern University; J.D., Columbia University; *Joel Barlow Professor of Law*

Peter L. Lindseth, B.A., J.D., Cornell University; M.A., M. Phil, Ph.D., Columbia University; *Olimpiad S. Ioffe Professor of International and Comparative Law and Director, International Programs*

Joseph A. MacDougald, A.B., Brown University; M.B.A., New York University; J.D., University of Connecticut; M.E.M., Yale University; *Professor-in-Residence; Executive Director, Center for Energy and Environmental Law; and Kurt Strasser Fellow*

Brendan S. Maher, A.B., Stanford; J.D. Harvard University; *Connecticut Mutual Professor of Law and Director of the Insurance Law Center*

Jennifer Brown Mailly, A.B., Brown University; J.D., Ohio State University; *Assistant Clinical Professor of Law and Field Placement Program Director*

Barbara McGrath, B.A., Yale University; J.D., University of Connecticut; *Executive Director, Connecticut Urban Legal Initiative, Inc.*

Willajeanne F. McLean, B.A., Wellesley College; B.S., University of Massachusetts; J.D., Fordham University; LL.M., Free University of Brussels; *Distinguished Professor of Law*

Thomas H. Morawetz, A.B., Harvard College; J.D., M.Phil., Ph.D., Yale University; *Tapping Reeve Professor of Law and Ethics*

Jamelia Morgan, B.A., M.A., Stanford University; J.D., Yale University; *Associate Professor of Law and Robert D. Glass Scholar*

Ángel R. Oquendo, A.B., M.A., Ph.D., Harvard University; J.D., Yale University; *George J. and Helen M. England Professor of Law*

Sachin Pandya, B.A., University of California, Berkeley; M.A., Columbia University; J.D., Yale University; *Professor of Law*

Richard W. Parker, A.B., Princeton University; J.D., Yale University; D.Phil., Oxford University; *Professor of Law*

Lisa Perkins, B.S., J.D., Michigan State University; LL.M., Georgetown University Law Center; *Associate Clinical Professor of Law and Director, Tax Clinic*

Hon. Ellen Ash Peters, B.A., Swarthmore College; LL.B., Yale University; LL.D., Yale University; University of Connecticut; et al.; *Visiting Professor of Law*

Richard D. Pomp, B.S., University of Michigan; J.D., Harvard University; *Alva P. Loiselle Professor of Law*

Jessica S. Rubin, B.S., J.D., Cornell University; *Assistant Clinical Professor of Law*

Susan R. Schmeiser, A.B., Princeton University; J.D., Yale University; Ph.D., Brown University; *Professor of Law*

Peter Siegelman, B.A., Swarthmore College; M.S.L., Ph.D., Yale University; *Associate Dean for Research and Faculty Development and Phillip I. Blumberg Professor of Law*

Julia Simon-Kerr, B.A., Wesleyan University; J.D., Yale Law School; *Professor of Law*

Douglas Spencer, B.A., Columbia University; M.P.P., J.D., Ph.D., University of California Berkeley; *Professor of Law*

Martha Stone, B.A., Wheaton College; J.D., LL.M., Georgetown University; *Director, Center for Children's Advocacy*

Stephen G. Utz, B.A., Louisiana State University; J.D., University of Texas; Ph.D., Cambridge University; *Roger Sherman Professor of Law*

Steven Wilf, B.S., Arizona State University; Ph.D., J.D., Yale University; *Anthony J. Smits Professor of Global Commerce and Professor of Law*

Richard A. Wilson, BSc., Ph.D., London School of Economics and Political Science; *Gladstein Chair and Professor of Anthropology and Law*

Adjunct Faculty of Law

Elizabeth Alquist, B.A., Mount Saint Mary College; J.D., University of Connecticut; *Adjunct Professor of Law*

Morris W. Banks, A.B., Dartmouth College; LL.B., Columbia University; LL.M., New York University; *Adjunct Professor of Law*

Anne D. Barry, B.S., University of Connecticut; M.S., Union College; J.D., University of Connecticut; *Adjunct Professor of Law*

James W. Bergenn, B.A., Catholic University; J.D., Columbia University; *Adjunct Professor of Law*

Leonard C. Boyle, B.A., University of Hartford; J.D., University of Connecticut; *Adjunct Professor of Law*

Michael A. Cantor, B.S., J.D., University of Connecticut; *Adjunct Professor of Law*

Dean M. Cordiano, B.A., SUNY-Binghamton; J.D., Duke University; *Adjunct Professor of Law*

Thomas O. Farrish, B.A., J.D., University of Connecticut; *Adjunct Professor of Law*

Evan D. Flaschen, B.A., Wesleyan University; J.D., University of Connecticut; *Adjunct Professor of Law*

William D. Goddard, B.A., M.B.A., Dartmouth College, J.D., University of Connecticut; Adjunct *Professor of Law*

Ira H. Goldman, B.A., Cornell University; J.D., Yale University; *Adjunct Professor of Law*

Andrew S. Groher, B.A., University of Virginia; J.D., University of Connecticut; *Adjunct Professor of Law*

Albert B. Harper, B.A., University of Texas; J.D., Ph.D., University of Connecticut; *Adjunct Professor of Law*

Wesley Horton, B.A., Harvard University; J.D., University of Connecticut; *Adjunct Professor of Law*

John J. Houlihan, Jr., B.A., Providence College; J.D., St. John's University; *Adjunct Professor of Law*

Daniel Klau, B.A., University of California; J.D., Boston University; *Adjunct Professor of Law*

John Lawrence, B.S., Washington and Lee University; J.D., University of Virginia; *Adjunct Professor of Law*

Henry C. Lee, B.S., John Jay College of Criminal Justice; M.S., Ph.D., New York University; Dr.Sci. (Hon.), University of New Haven; Dr.Hum. (Hon.), St. Joseph College; *Adjunct Professor of Law*

Thomas S. Marrion, A.B., College of the Holy Cross; J.D., University of Connecticut; *Adjunct Professor of Law*

Joseph Mirrione, B.A., Marist College; J.D., Vermont Law School; *Adjunct Professor of Law*

Thomas B. Mooney, B.A., Yale University; J.D., Harvard University; *Adjunct Professor of Law*

Andrew J. O'Keefe, B.S., College of the Holy Cross; J.D., University of Connecticut; *Adjunct Professor of Law*

Cornelius O'Leary, B.A., Williams College; M.A., Trinity College; J.D., University of Connecticut; *Adjunct Professor of Law and Mark A. Weinstein Clinical Teaching Fellow*

Humbert J. Polito, Jr., A.B., College of the Holy Cross; J.D., University of Connecticut; *Adjunct Professor of Law*

Elliott B. Pollack, A.B., Columbia College; LL.B., Columbia Law School; *Adjunct Professor of Law*

Leah M. Reimer, B.S. Baylor University; J.D., University of Connecticut; Ph.D., Stanford University; *Adjunct Professor of Law*

Patrick J. Salve, B.S., J.D., University of Pennsylvania; *Adjunct Professor of Law*

Hon. Michael R. Sheldon, A.B., Princeton University; J.D., Yale University; *Adjunct Professor of Law*

Jay E. Sicklick, B.A., Colgate University; J.D., Boston College; *Adjunct Professor of Law*

Walter C. Welsh, B.S., Tufts Engineering; J.D., University of Connecticut; LL.M., New York University; *Adjunct Professor of Law*

CONNECTICUT INSURANCE LAW JOURNAL

VOLUME 25 2018-2019 NUMBER 1

CONTENTS

ARTICLES

FINANCIAL REGULATION: THE APOTHEOSIS OF THE ADMINISTRATIVE STATE	*The Federalist Society*	1
MINDING THE PROTECTION GAP: RESOLVING UNINTENDED, PERVASIVE, PROFOUND HOMEOWNER UNDERINSURANCE	*Kenneth S. Klein*	35
EXPECTED BAD MORAL LUCK	*Yehonatan Shiman*	117
CONTRACT AND CLAIM IN INSURANCE LAW	*Jay M. Feinman*	159
IS U.S. INSURANCE REGULATION UNCONSTITUTIONAL?	*Daniel Schwarcz*	197

FINANCIAL REGULATION: THE APOTHEOSIS OF THE ADMINISTRATIVE STATE

THE FEDERALIST SOCIETY

WAYNE ABERNATHY:

Good afternoon, everyone. Glad to have you here for our session. My name is Wayne Abernathy, I'm executive Vice President for Financial Institutions Policy at The American Bankers Association but here at the Federalist Society I am the chairman of the Financial Services Practice group, who is sponsoring this session today. Financial Regulation: The Apotheosis of the Administrative State. This is a long term for a very important topic, and we very much appreciate you being here to listen from our very experienced, distinguished, and insightful panel.

By the way, if you happen to be interested in the work of the Financial Services Practice group at the Federalist Society, please contact me or one of the officers of the Federalist Society and we can get you involved. Love to have as many people involved as possible.

And now my important duty besides that is to introduce our moderator for today, Judge Carlos Bea. Judge Carlos Bea serves as a judge on the United States Court of Appeals for the Ninth Circuit. He received his bachelor's degree from Stanford University, and his J.D. from Stanford Law School. Judge Bea was born in San Sebastian, Spain, and immigrated with his family to Cuba in 1939. In 1952, you might not notice it unless he stands up, then of course you will. Judge Bea served on the Cuban national basketball team at the Helsinki Olympics. Wish I could do that.

Judge Bea became a naturalized citizen of the United State in 1958. He taught courses in civil litigation, advocacy at Hastings Law College of Law and Stanford Law School. From 1990 to 2003, Judge Bea served as judge of the San Francisco Superior Court. Judge Bea was nominated by President George W. Bush to the United States Court of Appeals for the Ninth Circuit and confirmed in 2003. Please welcome Judge Bea.

JUDGE BEA:

Thank you very much for that kind introduction. I think that we're required to give disclaimers at this point. I played in the Olympic games in '52, but I was a tourist. We went two and five in the games. I'm happy to say our son, Sebastian, however, is a real athlete. He won a silver medal in Sydney, in the men's pair for the United States.

Also, I don't want there to be any misconceptions. A gentleman walked up to me recently at a cocktail party and said, "I greatly admire the opinions you write," and I told him that I thought he was operating under a case of mistaken identity, because I write only dissents on the Ninth Circuit.

Today's subject, financial regulation: the apotheosis of the administrative state is concerned with a regulatory state, often focuses on reforms of formal institution structures and legal doctrines such as the Chevron Deference. But arguably, these formal constraints are only the tip of the iceberg regarding the issues of individual liberty and the rule of law raised by concerns of the regulatory state.

We have a distinguished set of panelists today. Knowledgeable about the financial industry, financial regulations, and the effect of the administrative state. Your programs will have extensive resumes and biographies, and I will essentially give you name, rank, and serial number.

To my right Professor Hal Scott, Nomura Professor of International Financial Systems and Director of the Committee on Capital Regulations at the Harvard Law School. Professor Scott will talk on contagion, a nicer word than panic, that can cause a run on economic system as being at the heart of the 2008 Great Financial Recession, how the crisis was ended by the Federal Reserve System acting as a lender-of-last-resort to banks and non-banks, and using other tools, and how the Dodd-Frank legislation may impede such future actions by the feds in the future if they're necessary.

Next will be Arthur Wilmarth, a Professor of Law at George Washington Law School who describes himself as a conservative with a small "c." Professor Wilmarth will discuss the need to prevent the creation of government-sponsored enterprises, GSE's, and of measures that allow the creation of firms that are too big to fail. How we should limit federal safety nets and federal subsidies, and how we should take another look at universal banking, the combination of banks, security firms, and insurers into one entity, and perhaps consider the merits of the former Glass-Steagall legislation.

To my left is Peter Wallison, Senior Fellow and Burns Fellow in Financial Policy of the American Enterprise Institute, who is currently writing a book on the growth of the administrative state. Mr. Wallison will discuss a system for the designation of firms as systemically important financial institutions, or SIFI's, by the Dodd-Frank Act[1] that's created the financial security oversight council to include banks and non-banks. The standards, or lack of standards, used to designate firms and the effect of such designation as an example of the growth of standard administration power.

---

[1] Dodd-Frank Wall Street Reform and Consumer Protection Act, Pub. L. No. 111-203, § 929-Z, 124 Stat. 1376, 1871 (2010) (codified at 15 U.S.C. § 78o).

Last, but not least: Professor Richard Epstein. The Tisch Professor at NYU Law School, senior lecturer at Chicago Law School, and Bedford Senior Fellow at Hoover Institution whose most recent book is The Classical Liberal Constitution: The Uncertain Quest for Limited Government. Professor Epstein will center his remarks on the recent case of PHH versus Consumer Financial Protection Bureau, which was in the D.C. Circuit and was granted *en banc* review, and whether administrative agencies can be insulated from legislative, presidential, and judicial review. He will talk about the guaranteed budget of the Bureau from the Federal Reserve and how this bureau fits in with the independent agencies and multiple board members.

With that we give way to Professor Scott.

MR. SCOTT:

So, it's my pleasure to be here today. Contagion, which is a run on the financial system, was the heart of the 2008 financial crisis, and others in the past. The crisis was halted in large part by The Fed's provision of lender-of-last-resort assistance to non-banks as well as banks.

Lehman's failure generated a run on the market money funds, whether or not exposed to Lehman, which then quickly spread to all short-term funding in the financial system including commercial paper issued by non-financials, and funding of major investment banks, and bank-affiliated broker deals.

The Fed responded by creating new facilities under Section 13(3) of the Federal Reserve Act[2] to lend to these institutions. In addition, the FDIC raised deposit insurance levels from $100,000 to $250,000, and to infinity on demand deposit accounts so crucial to the payment system and the economy.

It also guaranteed senior debt of depository institutions, further assuring their access to funding. Treasury used its exchange stabilization fund to guarantee money market funds, and then ultimately Congress enacted the TARP, which was used to provide capital injections into the banks.

Now these measures stopped the crisis, but in the aftermath were criticized as propagating moral hazard and bailing out Wall Street. Now, I do not regard the use of a lender-of-last-resort where there is good collateral and a penalty rate as a bailout. Nor do I regard deposit insurance as a bailout, but both are clearly government support. Yet in my view, highly desirable.

---

[2] Federal Reserve Act, Pub. L. No. 111-203, 124 Stat. 2115 (codified at 12 U.S.C. § 343).

TARP is a bailout and should only be available if the failure of many large, important financial institutions at the same time would heavily impact the economy where their resolution as a group is not a viable option.

Now, there is potential moral hazard from all of these measures, but in the case of lender-of-last-resort and deposit insurance it is small. I do not see how institutions, which are victims of panic runs, which is often the case with contagion, as opposed to bad business decisions, will take more risk as a result of such support.

Do homeowners expose their buildings to the threat of fire from their neighbors because of the existence of a fire department? I don't think so. And we attempt, albeit imperfectly, to minimize the moral hazard from deposit insurance by charging premiums based on the riskiness of the insured, albeit that's a very difficult task to do.

But due to bailout concerns, major restrictions were placed on the measures we took during the crisis. First TARP abolished the Treasury authority to use The Exchange Stabilization Fund to guarantee the money market funds.

Dodd-Frank then placed major restrictions on the use of 13(3), of the Federal Reserve Act, to provide assistance to non-banks. Although, interestingly, the discount window, Section 10B of the Federal Reserve Act, continued to be available to banks without major restrictions.

Now what are these restrictions under 13(3) that apply to non-banks? By the way, non-banks today, in terms of runnables, short-term liabilities, account for about 66% of all runnable liabilities in the system, and they're going to grow as we see more and more disintermediation from the banking system into so-called "shadow banking."

So, the ability to lend to non-banks was important in 2008 and will be even more important in the future.

What are the restrictions that were put on the Fed? The Fed can only lend to non-banks with the approval of the Secretary of Treasury, significantly limiting Fed independence. By the way, such approval is not required under the discount window for banks. Such loans must be part of a "broad program," which may mean under The Fed's own regulation, that implements this section, that the Fed must wait for five institutions to be in trouble, thus making it harder to nip contagion in the bud.

Third, collateral is required for all loans. Previously, loans had to be collateralized to the satisfaction of the Fed, which allowed them to buy unsecured, highly-rated commercial paper from non-financials during the crisis.

Fourth, the Fed can only lend to a solvent borrower, which is a sound principle, but difficult to actually determine in a crisis where asset values are uncertain.

Fifth, loans to non-banks must be disclosed within seven days to the Chairmen of the House Financial Services and Senate Banking Committees, with the attendant risk that they may leak out, thus deterring borrowers from obtaining loans in the first place or accelerating the run when the news does leak.

Sixth, banks can no longer freely pass onto their broker-dealer affiliates loans obtained from the discount window, instead such pass-throughs are now subject to 23(A) of the Federal Reserve Act, which allows them only to be ten percent of the bank's capital. And even further restrictions on 13(3) have since been passed by the House although not by the Senate.

In addition, the FDIC's authority to raise deposit insurance limits in crisis have been taken away, only to be restored upon request by FDIC through a joint resolution of Congress, making it impractical in a timely way, and the authority to make new loans under TARP has expired.

So, let me just say a few words about lender-of-last-resort. Am I happy with how the Fed operates as a lender-of-last-resort? No.

First, we need better coordination between fiscal authorities, the Treasury and the Fed, where there is a reasonable possibility that the borrower may be insolvent, or clearly is insolvent, as was the case with AIG. At the very least, we should regard any investment in equity by the Fed as outside their authority, which of course they did in AIG. That should be a fiscal decision reserved for the Treasury.

Second, we need more of a rule of law for the operations of the Fed as lender-in-last-resort, in the sense that the Fed should articulate its general policies, including facilities and programs, how they determine solvency, what a broad program really is, penalty rates, collateral, et cetera. Not only is ambiguity not constructive in this instance, it is positively harmful. With weapons deployed in advance, the very use of a lender-of-last-resort might not be necessary.

This is a lesson from Draghi's Eurozone declaration, that the ECB would do whatever it takes to stop contagion. Critics legitimately criticize the Fed for operating without articulated constraints and doing so in a non-transparent way. This is not tenable if the Fed is to have support for the powers it needs. A rule of law need not unduly confine discretion but should articulate the principles for exercising such discretion.

Finally, I would require that those institutions borrowing from the Fed, or receiving fiscal report, pay a sensible price, particularly where their

own losses trigger the need for support. And this price could range from penalty rates to enhanced supervision, or even the replacement of management. The failure to impose a cost on institutions benefiting from public support is a major factor for popular opposition to the use of these measures that we so successfully employed in 2008. Thank you.

MR. WILMARTH:

Good afternoon. I would like to thank The Federalist Society for inviting me to participate in this panel discussion.

Madisonian conservatives among whom I would classify myself as a Madisonian conservative, which I believe is equivalent to Professor Epstein's reference to classical liberals. I will argue that Madisonian conservatives should embrace the following four principles of financial regulation.

First, we should stop allowing privately-owned financial institutions to operate, in effect, as government-sponsored enterprises with implicit federal guarantees. We all know about the disasters at Fannie Mae and Freddie Mac, which were privately-owned, government-sponsored enterprises and imposed huge costs on the federal government and taxpayers. I contend that too-big-to-fail financial conglomerates are today's government-sponsored enterprises.

Second, to be faithful to the first principle, we have to end government policies that encourage financial institutions to become too big to fail, and that reward them for doing so.

Third we must strictly limit the scope of the federal safety net for banks. Most would agree that banks perform essential social services by accepting deposits from savers, providing payment services, and making loans to small and medium-sized business firms that are not able to raise funds by selling securities in the capital markets. Those are legitimate and important functions for banks to perform.

Banks are subject to depositor runs, partly because they have a maturity mismatch between their short-term deposit liabilities, and their longer-term assets. The Great Depression proved, and the recent crisis also proved (if you look, for example, at the Northern Rock episode in the United Kingdom), that we need deposit insurance for chartered and supervised banks.

I also agree with Professor Scott that we need lender-of-last-resort assistance for chartered and supervised banks. However, I differ with him on whether non-banks should be given the same assistance. In my view any additional forms of federal support for banks should be carefully scrutinized, because support means subsidy.

Fourth, we should oppose any federal subsidies for non-bank financial institutions and non-bank financial activities, because federal subsidies distort market pricing, provide unfair competitive advantages to non-bank firms that receive them, and undermine the effectiveness of market discipline.

In my view, if non-banks want to be protected by the federal safety net, they should become chartered banks and accept the same types of supervision and regulation applied to banks. Non-banks should not expect to receive the same kind of federal support when they are not subject to the same regulation and oversight that banks must accept.

Universal banking, which allows banks to combine with securities firms and insurance companies, and to engage in a full range of capital markets activities, violates all four of the principles I have described.

The last crisis demonstrated that you cannot limit the federal safety net to banks when they are affiliated with non-bank firms engaged in significant capital markets activities. When a major crisis occurs, the federal government will inevitably decide to save the entire conglomerate to save the bank.

For example, the federal government provided $850 billion of combined support to save two giant bank-centered financial conglomerates, Citigroup and Bank of America. That support included capital infusions, lender-of-last-resort assistance, sales of commercial paper to the Federal Reserve, and debt guarantees provided by the FDIC. That $850 billion of support for Citigroup and Bank of America was only a small part of the total bill we paid to save troubled financial conglomerates during the financial crisis.

The problem with Dodd-Frank is that it does not change the universal banking model. Unlike the Glass-Steagall Act of 1933, which responded to the Great Depression by requiring banks to separate from securities firms, Dodd-Frank basically says, "We have these nuclear reactors (called universal banks) that blew up. Rather than prohibiting such reactors or requiring an entirely different form of reactor, let's just improve all the valves and controls. If we have better valves and better controls, maybe they won't blow up next time."[3]

In my view, Dodd-Frank's approach is unsound, and unviable. The last 20 years have made clear that giant financial conglomerates cannot be effectively managed or regulated. If we don't change the business model of

[3] The nuclear reactor metaphor for universal banks was borrowed from Neel Kashkari, President of the Federal Reserve Bank of Minneapolis.

universal banks, I am quite sure that we will have a comparable financial crisis within the not-distant future.

I believe we have two choices. One is to adopt what I would call an "internal Glass-Steagall" approach, which is similar to the ring-fencing legislation adopted by the United Kingdom. An "internal Glass-Steagall" policy would put strong firewalls around the bank and say to the bank, "You cannot make any loans or other transfers of funds to your affiliates, except for paying lawful dividends to your parent holding company. In addition, the federal government is not going to protect your affiliates."

That's a defensible approach, but I think there are two big problems with making it work. First, will regulators actually monitor and enforce those firewalls over the longer term? Second, when a large financial conglomerate is threatened with failure, will the government actually refuse to bail out the affiliates outside the bank's ring fence?

The second approach would be to go back to 1933 and reestablish an "external Glass-Steagall" policy. That policy would say, "We want banks to be strictly separated from the capital markets. We want capital markets to operate outside the banking system and not to depend on any subsidies related to the banking system."

I agree with Professor Scott that we have a major problem with shadow banking. The problem is that non-bank companies are essentially engaged in taking deposits. Section 21 of the Glass-Steagall Act, which is still in force, provides that non-banks are prohibited from accepting any deposits, period. In fact, it's a criminal offense for anyone other than a chartered bank to accept deposits.

What are deposits? They are short-term, debt instruments, payable at par on demand. We have trillions of dollars of de facto deposits today in the form of short-term commercial paper, repurchase agreements (repos), and money market funds.

I agree with Morgan Ricks, who has written a very persuasive book called The Money Problem. Ricks argues that short-term money claims, including de facto deposits, should be limited to banks. In fact, we didn't any significant volume of de facto deposits and shadow banking before 1965.

Regulators have ignored Section 21 over the past 50 years and have allowed non-banks to create massive amounts of de facto deposits, thereby creating the shadow banking system. De facto deposits and shadow banking are distorting our entire system. In addition, many shadow banks are closely connected to, and are often affiliated with, our big universal banking conglomerates.

We have to get back to the point where we say, "If you want to issue a short-term debt claim, payable at par on demand, you have to be a chartered

and supervised bank." Whether the dividing line for deposit status is 60 days or 90 days, we have to stop non-banks from issuing short-term debt claims that function as de facto deposits.

I look forward to our discussion after our presentations. Thank you.

MR. WALLISON:

Well, it's a great pleasure to be here and I want to thank The Federal Society for sponsoring this. This is a massive organization that's done wonderful work. And I'm just delighted to be a part of it.

I'm going to talk about basically the subject that I'm writing a book about now, which is the growth of the administrative state and why it has come about. And since I specialize in regulation of financial institutions, it will be from that perspective.

I'm going to be talking about the Dodd-Frank Act, and the provisions of the Dodd-Frank Act, which allows a group of financial regulators to designate certain institutions as systemically important financial institutions, and then to regulate them very strictly.

I'm going to go through some of the background, which many of you know if you are part of the regulatory process, the financial regulatory process, but just for those who are not, I want to go through some of the background here, so you will understand it.

The Dodd-Frank Act created a new agency called a Financial Stability Oversight Council, or FSOC to coordinate and oversee financial regulation in the wake of the 2008 financial crisis. The agency is headed by the Secretary of the Treasury, and consists of all the federal financial regulators, The Fed, the FDIC, the SCC and others, and was given the power to designate any non-bank financial firm, non-bank financial firm, for special, stringent regulation by the Federal Reserve.

The firms that are designated are generally described as systemically important financial institutions, or SIFIs because their financial structure, their financial failure or distress could in theory create a systemic breakdown in the United States economy.

The precise language of Section 113 of the Act says that a financial firm may be designated by the FSAC if its material financial distress or its activities could pose a threat to the financial stability of the United States.

The provision was a response to the mistaken belief in Congress and elsewhere that Lehman's bankruptcy in September 2008, caused the financial crisis. The idea was that large firms are interconnected, and the failure of one, like Lehman, will drag down others, creating a systemic condition.

To prevent this, special, stringent regulation by The Fed was considered necessary. In reality, however, no other firm failed as a result of Lehman's failure. So, the interconnectedness theory is wrong. But the law, as often happens, is still in effect. Accordingly, under the material financial distress or activities standard, the FSOC has designated four large non-bank institutions: AIG, Prudential Insurance, GE Capital, and MetLife.

Designation can be a seriously destructive event to a firm because it gives The Fed virtually unlimited authority to control the firm's business. In fact, after having experience[d] Fed regulation, GE virtually terminated the business of its huge subsidiary GE Capital, in order to hopefully eliminate its designation, which was successful. But at the same time, it eliminated a significant source of funding for small firms.

MetLife, on the other hand, did not agree to its designation and sued the FSOC in the D.C. District Court. In March 2016, the court overturned MetLife's designation, and the FSOC applied to the DC Circuit, which has not yet rendered a decision.

Now, the relevance of all this about Dodd-Frank to the apotheosis, what a title, the apotheosis of the administrative state, and that of course means, all you Greeks out there know, that it means the high point of the administrative state. If it were the high point of the administrative state, I would be happy. I'm afraid it's only the beginning.

To repeat the statutory language again, any non-bank financial firm can be designated as a SIFI and subjected to this designation this special regulation, if it poses a threat to the stability of the United States. The act contains no standards that restrict the discretion of the FSOC. There is no definition of material financial distress, no definition of activities, no definition of threat, or what was meant by "the financial stability of the United States." Nor does the act contain any statement of what size a firm must be before it can be designated as a SIFI.

Yet, in the case of bank holding companies, Congress was able to set at least that much of a standard for these firms if a bank holding company has more than $50 billion in assets, it will be subject to the stringent regulation of The Fed as a SIFI. In other words, to designate a firm as a SIFI, FSOC was authorized to predict that at some unknown time in the future, in an unknown future, the financial distress of a particular firm or its activities, will have an adverse effect on the entire US financial system.

This is impossible to know. No matter how skilled or expert the members of an administrative agency might be, they cannot predict the future. The decision is pure discretion. Moreover, the ability to stop certain activities can apply to a whole industry, giving FSOC the authority to control whole, entire markets.

But when the Congress gives these extraordinary discretionary powers to an administrative agency, it is further empowering the administrative state. The courts could stop this process, but they have not. Although the broad discretion given to the FSOC in this case could be considered an unconstitutional delegation of legislative power, the Supreme Court has not invoked this concept since 1935, and many people think it's simply dead.

One of the reasons for the court's reluctance is that we don't have a very good definition of the difference between legislation on the one hand and administrative action on the other. But this should not be impossible for a court to decide and determine in individual cases.

A legislative decision has one distinguishing characteristic: it can be wholly arbitrary, taking from some and giving to others, and does not require any justification as long as the Constitution is not violated.

Just like Congress setting a $50 billion threshold for treating a bank holding company as a SIFI, that's an example of a legislative standard-setting decision that is completely arbitrary. $50 billion makes no more sense than $200 billion in this context. So, bank holding companies cannot and have not challenged that. They've challenged it legislatively, they have not challenged it in the courts, because Congress is allowed to make those kinds of arbitrary decisions which an administrative agency cannot.

Once these key decisions are made, the administrative agency can be tasked to carry them out. This goes back to Chief Justice Marshall's decision in *Wayman v. Southard* in 1825, when he was also faced with this question of, "What's the difference between an administrative and a legislative decision?" And his point was that the important issues, the important decisions are made by the legislature. The administrative agency can have some delegated responsibilities, but not for the important ones.

This, of course, means someone has to determine what the important decisions actually are, and that is the responsibility of the courts under Article Three of the Constitution.

The unwillingness of the courts to make these decisions is responsible for the growth of the administrative state that we have seen now and will see in the future. Because Congress has been happy to send difficult decisions to the administrative agencies.

The framers, it turns out, were wrong in this respect. Congress will not jealously guard its powers. In addition, as Chief Justice Marshall said in Marbury and Madison, and we heard this from the Attorney General it is emphatically the province and duty of the Judicial Department to say what the law is.

Yet, if anything, the Supreme Court has gone the other way. In the Chevron line of cases, for example, they have deferred to the administrative agencies' interpretation of what Congress authorized, and in effect, they are allowing the agencies to say what the law is.

So, in the MetLife case, when MetLife won, the District Court did actually not give the FSOC any deference, but they didn't decide that it had received excessive discretionary powers, either. Instead, it said that FSOC's decision was arbitrary and capricious, because it didn't consider the costs of designating MetLife something actually that was not required by the statute.

In other words, although MetLife created an opportunity for the court to consider the scope of discretion Congress gave to the FSOC. This decision does nothing to restrain that growth.

Until the Supreme Court begins to use the authority to define where legislation ends, and administration begins, the administrative state will continue to grow. Thanks very much.

MR. EPSTEIN:

Peter speaks in his usual dramatic way, and I think essentially has been a consistent and accurate prophet of doom over these many years. My job is to continue, and to see if I can find some horror story that will one-up his, explaining how it is that there are other horrors in the administrative state.

The difference between us is I think the horrors that I'm about to talk about do have solutions, where the ones that he has talked about are extremely difficult. And the thesis that I'm going to propose using *PHH Corporation v. Consumer Financial Protection Bureau*[4] as a vehicle, if at least I can remember some of its facts, which I can, is as follows.

Whenever you put together an administrative agency which as an independent status, lawfully it can only do two things. It can issue regulations and it can prosecute cases, but it cannot internalize inside the organization the functions of a federal district court by putting together a panel or commission. Or, in the case of the Consumer Financial Protection Bureau—I got that right, it took me a long time to memorize that—you cannot put

[4] PHH Corp. v. Consumer Fin. Prot. Bureau, 839 F.3d 1 (D.C. Cir. 2016), *rev'd*, 881 F.3d 75 (D.C. Circuit 2018 en banc) (decided after this panel conversation). *See also*, Richard A. Epstein, *Regulatory Enforcement Under New York's Martin Act: From Financial Fraud to Global Warming*, 14 N.Y.U. J.L. & BUS. 805, 810-813 (2018) (Professor Epstein discussing the larger issues of the administrative state).

these people together to give them the power to adjudicate so that the only kind of judicial review that you can receive is that which comes from an appellate court.

This is an issue that starts in financial regulation with the CFPB and, but it continues everywhere else. Many of you, I think, have followed *Oil States Energy Services, LLC v. Greene's Energy Group, LLC*,[5] case, where exactly the same pattern takes place, where only now it's the PTAB, which is the Patent Trial and Appeal Board, which is essentially designed to substitute for the adjudicative system. And as we heard from Attorney General Sessions earlier on today, separation of powers is indeed a very important protection of liberty, because you'd never want to have a situation, which one person holds all the keys to the safe, and if that person is very, very good, things may go pretty well. But if that person is very bad, then things will turn out to be horrid, and that's the risk that you always have to guard again, systematically, in all these cases.

Now the situation that we have with the Elizabeth Warren legislation having to do with the CFPB, is, in fact, an absolute architectural masterpiece if you want to adhere to the aggressive playbook on how it is that administrative agencies ought to be organized. Essentially, it rests on the assumption that there are people out there who are disembodied experts, but who, in fact, often turn out to be very vigorously partisan. But the dominant conceit today is that what we have to do is to insulate them from political pressure so that they can protect the public from various kinds of private abuses that are going to be inflicted upon them.

There is no question that a very powerful metaphor in the United States is the relationship between Wall Street on the one hand and Main Street on the other hand. Wall Street is essentially thought to be an object of disapprobation, and therefore extensive regulation. And so, when they put the CFPB together, what they did is they managed to do everything within their power to insulate it from various kinds of oversight. They gave its head

---

[5] Oil States Energy Servs., v. Greene's Energy Grp., 138 S. Ct. 1365 (Apr. 24, 2018). For further discussion on *Oil States*, see Richard A. Epstein, *The Supreme Court Tackles Patent Reform*: *Why the Supreme Court Should End Inter Partes Review in* Oil States, 19 FED. SOC. REV. 116 (2017); Richard Epstein, *The Supreme Court Tackles Patent Reform: Further Reflections on the* Oil States *Case after Oral Argument in the Supreme Court*, 19 FED SOC. REV. 124 (2018); and Richard A. Epstein, *The Supreme Court Tackles Patent Reform: Post-Decision Article: Inter Partes Review Under the AIA Undermines the Structural Protections Offered by Article III Courts*, 19 FED. SOC. REV.132 (2018).

a five-year term; they gave it guaranteed budget protection by funding it through The Federal Reserve, and essentially, they gave the single commission a total autonomous power to decide cases.

And in the *PHH* case, you could see the powers that came through, there was a rather complicated financial transaction in which I thought liability was rather questionable. It had to do with the application of rules that had been put together by a predecessor organization and the extent to which they bound the CFPB. And it turns out that Mr. Cordray not only said that did he have the power, but unilaterally he decided to increase the fine from about $4 million to about $104 million, saying, as it were, "I really think that this is a perfectly ideal situation to give a public spanking to a corporation which probably committed no kind of violation at all."

And then the case comes up to the District Circuit on Appeal, Judge Kavanaugh essentially decided that he was going to give the Congress a choice. He said, as it were, "If, in fact, what you want to do is to have single commissioner then you must be prepared to accept is that this person can now be removed at the pleasure of the President," at which point the Wall Street Journal began a remove Cordray campaign on the grounds that he could be dismissed, not only for cause, but certainly at the will of the President. And, at the other hand, Kavanaugh said if you want to have these people insulated, as you may do, unfortunately, the appropriate way in which to do that is to have a commission which has multiple members on it so as to blunt the force of a single individual.

In my own view, this is not a perfect protection, to put it mildly, because if you start to look at the many commissions that are put together, with three-to-two majorities, the President's party having the deciding vote, you discover that there's a rigid partisan separation on virtually every major issue, and that the so-called expertise essentially is a cloak for very sharp political divisions and bias.

The common practice in courts of general jurisdiction is for judges to sit on cases by way of rotation, which makes it much less likely that you could have this particular sort of fixed division, and so I think, in effect, that the mistake in the Kavanaugh opinion was not that it went too far in trying to upset this particular feature of the administrative state. Rather, I think it did not go far enough, and that what we have to do is to come up with a consistent and powerful consensus that calls for the complete separation of the enforcement and regulatory function on one side, and the adjudicative function on the other.

But this does not solve all of your institutional problems, to be sure. Because there's then always that further question, exactly what kind of body do you want to put together? And there is the further question of whether

you want specialized courts, like those that exist in taxation or bankruptcy, or whether you want to put these matters in the hands of courts of general jurisdiction.

Now on that question I'm relatively agnostic, at least on this particular occasion, because the long terms that are associated with these Article I courts, I think, gives them a certain insulation from political pressure, and the fact that these particular judges tend to be appointed by judges in the judiciary rather than the President, tends to soften the very sharp political divisions that otherwise take place.

But make no mistake about it: we have agency after agency from the New Deal that present this very difficult situation of three-two commissions, or one-zero commissions, and what is the problem associated with this? Well, not only do you have the problem of bias, but you have the problem of flip-over. Every time there's a change in a presidential administration, the majority now goes from one party to another, and then you see the commission trying to undo the particular decisions that were made somewhere else.

So, you have exactly the same thing in the Securities and Exchange Commission, as with the CFPB, and so forth. And indeed, in many ways the Securities and Exchange Commission is one of the worst offenders on this particular situation, because it has now institutionalized the process under which it turns out it can bring prosecutions before an administrative law judge of its own appointment.[6] Of course, these internal do not have unanimous success for the SEC, but if you're winning 97% of your cases in front of your own tribunal, the only conclusion that you can reach, is that you're playing with, shall we say, a deck of marked cards. Socially, you do not want to allow that kind of a situation ever to exist.

So, as I have three learned companions here, all of whom spoke about the arcana of various issues associated with financial regulation, I'm basically making a rather simple-minded point that goes back to the principles of separation of powers at the beginning of the Republic, in financial areas, but it seems to me carries over pretty much everywhere else. It is not possible, nor even desirable, to undo the administrative state, given the complexity of functions that government has to discharge. But none of these complexities justify the current amalgamation of adjudication, legislation, and prosecution in the same agency. It is critical to hive off the adjudicative function, and the agencies will run just fine, and the rest of the

---

[6] Lucia v. Sec. & Exch. Comm'n, 138 S. Ct. 2044 (2018) *Lucia* was decided in the Supreme Court after this talk was given.

public can take a deeper breath and sleep more quietly and contentedly at night. Thank you.

JUDGE BEA:

I'd like to open up the conversation among the members of the panel, but one thought struck me. When we first had a conference call a couple of weeks ago, and I was waiting for somebody to say something on this subject. Does anybody have anything nice to say about Dodd-Frank?

MR. EPSTEIN:

Yes, it's short! I have another nice thing to say about it. Most of the regulations under it have yet to be issued since it's only been seven years since its adoption.

JUDGE BEA:

Alright. Professor Scott, I was thinking as you were talking about the lender-of-last-resort. The classical theory of lender-of-last-resort as I remember my economics history, was Mister Walter Bagehot, who was the publisher of The Economist magazine, and he said, "Lend freely, but at high rates." We've lent freely at very low rates. Is this emblematic of a new economic theory?

MR. SCOTT:

Well you're making a good point. Let's go back to the 2008 crisis. This was a particular problem for banks under the discount window. The Fed had a 50-basis point penalty rate for borrowing at the window when the crisis occurred, and lo and behold, nobody came to them to borrow. They knew the banks were in trouble, so they lowered the rate to 25 basis points, still a penalty, this is over market rate. Still nobody came. Why?

Because the banks were concerned that if they came to the Fed for money, even though the Fed had no obligation to disclose the identity of particular borrowers, that this would leak out, through reports that the Fed issued where you could kind of infer who the borrower was.

If somebody borrowed in the North Carolina area, it must be Bank of America. So, they still did not borrow. So, what the Fed then did is create something called a Term Auction Facility where anybody could borrow at an auction rate. And then they borrowed because you couldn't tell the good banks from the bad banks who were borrowing.

So, here is the dilemma, that was exposed in 2008. If the penalty rate is high, or if you specifically penalize the borrower, and then that particular

borrower could leak out they won't borrow, the situation gets worse, and, you even have a more difficult problem.

So, in principle, they should pay a penalty, whether it should be a penalty in the form of a penalty rate or something else, for instance discipline or replacement of management, or some other consequence. There should definitely be a consequence. But maybe after the borrowing.

JUDGE BEA:

Was it just too much information out there? Just too much information out there, as to who's borrowing?

MR. SCOTT:

Well, it would leak out, that was the concern.

JUDGE BEA:

Okay.

MR. WILMARTH:

Judge Bea, I'd like to comment on your question, which I think is a very important one.

There are studies showing that the Term Auction Facility and other lending facilities established by the Federal Reserve allowed Bank of America to borrow huge amounts while paying an average interest rate of 0.8%. Goldman Sachs paid an average interest rate of 1.4%. No ordinary firm could have borrowed money at such ultra-low rates during 2008 and 2009. Thus, once the federal government allows too-big-to-fail institutions to exist, the government essentially decides that, like nuclear reactors, they're not going to allow those institutions to fail.

The Fed and the Treasury did everything necessary to subsidize and prop up big financial conglomerates after Lehman Brothers failed. Those institutions received enormous subsidies until the crisis was over.

MR. SCOTT:

Yes, in some cases.

MR. EPSTEIN:

I have another point, which is related to that. I mean, what Hal says is essentially the standard dilemma. We charge you a fair market rate, you're down to fail. If we charge you a lower rate, you're bound to get an excessive subsidy. One of the things that's wrong about the whole federal reserve

lending system is that it only allows the government to act as a lender who is restricted to taking on interest on loans.

In my view, if you start thinking about the flexibility which was abused but nonetheless available to the Federal Housing Financial Agency, what they do is they allow the government to take an equity piece of some sort or another.

What you can say is, we're going to give you a situation where you've got 2% interest, but by the way, when this project goes up in value, welcome, my friend, to an equity kicker because we now own 15% of this business, which we may sell it in the open market at some point or another, but it will allow for the recoupment.

Essentially what happens is you don't want people in the lending business to have to make an all-or-nothing judgment at the front end on success or failure. You would rather have a workout with two components. An absolute fixed payment plus a contingent payment if all goes well.

Now, with the AIG situation, the Federal Reserved didn't have that flexibility, so Davis Polk essentially created a sham transaction in which you a third-party corporation announced that it was taking equity. The problem is that entity was owned completely by the United States government, and then you've got litigation before Judge Wheeler in D.C. and Erlenmeyer I think in New York.

You don't want to essentially force people to work under the wrong statutory framework, which will then lead to the wrong result. What you really have to understand, and this is my next-to-last sentence, is when you call The Fed the lender-of-last-resort, the word "lender" is a very dangerous term because it limits the way in which government could provide relief.

No private party, which is going to come and give some kind of assistance, would say either it's going to be a loan or nothing, and we should not handicap The Fed in that particular way.

JUDGE BEA:

All right.

MR. WALLISON:

I'd like to make a comment about this whole question of too-big-to-fail, because I don't think people are making enough in the way of distinctions on this issue.

When we say "banks," when you read in the press that the banks were too big to fail there's some distinctions that should be made. Bank holding companies are ordinary corporations. I don't think that they are too big to fail, and I think what we saw in the financial crisis when Lehman

failed, was that there isn't any interconnection between these very large financial institutions so that when one fails it will drag down others.

Now, the too-big-to-fail institutions are the banks. The ones that are the deposit-takers, that have deposit insurance, and they are gigantic. We have four of them, that are over, about or over the trillion-dollar mark. Those institutions are too big to fail. They are not covered by the Dodd-Frank Act. They are still under the jurisdiction of the FDIC, which has nothing like the resources that is necessary to deal with the failure of a bank.

Let's leave aside bank holding companies. So, we are still in the position where we have no way of handling the failure of one of these very large institutions.

Now I'm not, at this point, trying to propose any kind of action, but what we ought to understand is that the Dodd-Frank Act, which was intended to deal with the too-big-to-fail problem, is a total failure at that, because it doesn't deal with the real institutions that could cause a financial crisis if one of them failed.

JUDGE BEA:

Professor Wilmarth, you are suggesting that we go back to a division under the Glass-Steagall Act. Because I remember when the Glass-Steagall Act was gotten rid of, the idea was that our banks here in America could not compete with the foreign banks that were doing universal banking, and that the reason we were abolishing Glass-Steagall, was to be able to compete in the universal globalist market. Is that not a problem?

MR. WILMARTH:

There's been a lot of discussion about whether U.S. banks could compete with foreign universal banks if we reestablished the Glass-Steagall Act. During the 1990's, European universal banks said they couldn't compete with our major institutions, including the specialized commercial banks like J.P Morgan & Co. and Citigroup and the specialized investment banks like Goldman Sachs, Morgan Stanley, and Merrill Lynch.

In other words, our institutions were doing extremely well in international markets before Glass-Steagall was repealed. I believe that if we go back to Glass-Steagall, we would have institutions that are more specialized, more focused, better managed, and more effective at what they do. In addition, we would not have the massive conflict of interests created by universal banking.

Giant universal banks have repeatedly gotten themselves into big problems because they're trying to do everything and the range of their

activities create huge challenges for effective management. When you try to do everything, you tend not to do anything very well.

JUDGE BEA:

Professor Scott?

MR. SCOTT:

Banking crises are almost universally caused by bad loans, not by securities activities. So, if you want to make sure that you're not subsidizing the banking system, let them do everything but making loans.

The idea behind broadening their powers was in terms of risk, so that you would diversify their activities to decrease the overall risk of their enterprise. That idea, to me, is totally valid. And so, I don't think we want to go back to the world in which if the bank part goes down, the whole thing necessarily goes down. I think it's good that we have diversification in the banking system.

MR. WALLISON:

Can I add to that, also? And that is that the reason why there was permission for bank holding companies to acquire securities firms and other kinds of financial institutions, was because if you look at the data, you will see that most of the financing that is done in this country is done through the securities markets.

And the trend is all in that direction. The banks have been basically flat in terms of the financing that they provide to the corporate world.

So, if you want to have successful financial institutions, you cannot freeze them into a position where they are basically losing their role in the economy. They have to be allowed, as I see it, to compete in the areas that are growing, and that is the securities markets.

MR. EPSTEIN:

Yes, I agree with all of this, and I'd like to make one other point. You always want to reverse engineer past failures; it may not cure against future mistakes but at least you don't make the same dumb mistake twice, and certainly if you start looking back at, say, banking practices in the 1930's and 40's, it was very common to have situations where the loans would be limited to 50% of asset value, very low, and, it turns out you, don't get a lot of leverage and you don't get yourself a lot of failures. And what we then did, is we decided, no, we want to goose up home ownership as an independent ideal.

Anytime you have an end-state ideal, it's a mistake. If it turns out that home ownership is good, it should be able to survive without having to receive crazy subsidies, which arises when government tells the banks, "W-we would like you to lend at 80 or 90%, or sometimes even 98%."

Well, nobody's going to do that unless you give them a guarantee. So, what you do is you then have the implicit Fanny and Freddie guarantee. These implicit guarantees are always terrible because you don't know exactly how much they cost. They're not on the books. In addition, they also generate some collateral obligation on the ban, such as making risky community redevelopment loans, which are, generally speaking, a complete disaster.

And then the economic bill comes due because of the social failure. Going forward, you have to let banks compete in markets in which there is potential growth securities and so forth, but you cannot go back to another system in which there are any implicit guarantees of their risky loans.

If we were to take that unwise course again, we will see a repetition of what happened in 2008. Even if Fanny and Freddie may be out of that next round, there's some federal housing bureau that'll pick up the slack, because the political situation calls for subsidies for racial and non-racial reasons alike, as if we will beat the odds is we take a huge number of losing bets, and then somehow assume that through the law of large numbers that this new strategy will all work out.

Or, as in the old days in the Jewish garment businesses was the joke, "you don't make up what you lose on every piece by having large volume," and that's something that the lenders in the United States seems not to have learned.

MR. WILMARTH:

Could I provide a brief response? In my view, the key catalysts for the crisis were mortgage-backed securities, collateralized debt obligations and credit default swaps.

Banks securitized really bad mortgage loans, and they sold mortgage-backed securities around the world pretending that they were sound investments, just like the big universal banks that sold foreign bonds in the 1920's. Banks obtained credit default swaps, which were a form of insurance, from firms like AIG to convince people that "someone will step in to cover these mortgage-backed securities if things go wrong."

During the 2000's, as during the 1920's, we combined banking with securities and insurance, and allowed universal banks to sell what were really terrible securities as if they were sound, guaranteed investments. When everything blew up, Uncle Sam had to step in because the institutions that

were securitizing bad mortgages and selling mortgage-backed securities were so gigantic that they couldn't be allowed to fail.

Universal banking also created perverse incentives because the big banks said to themselves, "We're not putting these loans on our own books. We can package them up into securities, sell them around the world, get triple A ratings by bribing the credit rating agencies, and pay some more fees to AIG to obtain credit default swaps to back up the securities."

Thus, I would emphasize the pervasive conflicts of interest and perverse incentives created by universal banking.

There was an interesting article about Deutsche Bank the other day. Deutsche Bank is one of the biggest European universal banks. The article pointed out that the shareholders of Deutsche Bank received something like 15 billion euros of dividends since 2001. In contrast, senior executives at Deutsche Bank received 71 billion of euros in bonuses. The universal banking franchise has been a bonanza for the insiders. They have made out like bandits. Shareholders have not done nearly so well. Meanwhile, governments and taxpayers have been left holding the bag for losses. Thank you.

MR. WALLISON:

Yeah, one comment, of course, on what you said. We've been debating this for years, but the way it was phrased is that the banks sold these mortgage-backed securities around the world.

In fact, they were bought, is the other way to look at it. They were bought around the world, and why were they bought around the world? Because the government's housing policy here in the United States caused a gigantic bubble.

A bubble that was far beyond any we'd ever had in the past, and what was happening in the bubble is that people were taking out mortgages with good, high rates on them, the banks were willing to lend to them, or others were willing to lend to them, because there were no defaults. There were never any defaults, or very few at least when there's a bubble. Because everyone can refinance in the United States without any problem.

So, you never see defaults, but you see high rates, and people in Europe and elsewhere around the world, wanted these obligations. So, the banks actually were running out of the available mortgages as things got hotter and hotter towards 2008 and began to use credit default swaps.

Now, I want to say one thing, you can use a credit default swap to imitate an actual mortgage-backed security, which is what they did. But I want to say one thing about credit default swaps, very complicated subject, of course.

But Lehman Brothers was a big player in the credit default swap market. When they failed, suddenly, without any warning, the credit default swap market kept operating all through the financial crisis.

So, don't get frightened by something like a credit default swap. It turns out that it is not as harmful as people suggest it is. And it is very useful for institutions to manage their risk. And what we've done with credit default swaps since the crisis in the Dodd-Frank Act is to make that much more difficult, and also to set up a set of institutions financial market utilities, they're called which are now backed by The Fed, and which will be the cause of the next crisis.

MR. EPSTEIN:

Next crisis. Yeah.

MR. WALLISON:

You've got it.

MR. EPSTEIN:

Just one sort of comment on this stuff. One of the things about regulation and about financial businesses is the way in which they look at their book of business.

Essentially, if you're a responsible financial company, you start thinking about diversification and all the rest of that stuff, by looking at an entire portfolio of assets to measure its internal stability.

You may have some credit default swaps or other kinds of derivative arrangements that may look highly loaded in one direction or the other, but if you've got physical assets on the other side of the portfolio, that to complement them. the volatility of the portfolio is far lower than the volatility of one of its components, taken in isolation.

When a regulator comes in, it turns out that there are often jurisdictional boundary lines. Hence it is often the case that the default swaps are going to be regulated by one guy and the physical assets are going to be regulated by another. Each, of them are going to see an unstable portfolio because each can't take into account the other portion of the combined operation. This form of regulatory provincialism tends to exacerbate risks for regulated market institutions.

The reason I chimed in with Peter is because essentially what we have now are these regulatory hothouses, which are going to have blinkered vision, because they are only getting limited information, which leads to systematic mistake with respect to the volatility of the portfolios, which in

turn leads to erroneous regulations and market interventions, it's likely to get them wrong. Thank you.

No, I mean smart regulation. Trust it to Peter and me. And Arthur. And Hal. You know, we do a fine job.

JUDGE BEA:

I'd like to open the session to questions from the audience. Now, I would ask you two things: when you ask a question, identify who you are and where you're from. And secondly, make it a question. Thank you.

So, first of all, here in front.

AUDIENCE:

Thank you, my name is Bert Ely, I'm a banking consultant here in Washington, and very active with the Federal Society's financial institutions practice group.

Following up on Professor Wilmarth's comments, I have a very simple question for the panel: what should be the federal government's response, if any, should a funding crisis and consequent contagion erupt in the shadow banking world, and given the requirements of mark-to-market accounting, trigger substantial capital losses in FDIC insured banks, which in turn triggers the costly failure of some of those banks? Again, a very simple question.

JUDGE BEA:

Who wants to take this one?

MR. WALLISON:

I think it was directed at Wilmarth.

MR. WILMARTH:

My simple-minded response is to change the status quo. The status quo is unacceptable because I agree that our next crisis is likely to start within the shadow banking system and spread to banks, as the last one did.

Would it be a magic bullet to treat all short-term debt claims payable at par as deposits and to force all that short-term money into chartered and supervised banks? Maybe it's not a magic bullet, but at least you would know where the short-term money claims are, and you would have an opportunity to regulate them and charge deposit insurance premiums and do other things to control the growth of short-term money claims. Right now, we don't even know where a lot of those claims are.

The regulators don't know, for example, the full scope of the repo market. Credit default swaps are still a mystery in many respects. The regulators' lack of knowledge about short-term claims in the capital markets was a fundamental problem in 2007 and 2008. Regulators didn't know that AIG had $80 billion of credit default swaps backing up collateralized debt obligations and another $500 billion of credit default swaps backing up loans made by European banks. In October 2008, regulators suddenly discovered that allowing AIG to fail would threaten many of the world's leading financial intuitions.

In fact, $50 billion of the bailout money given to AIG was used by AIG to pay off credit default swaps to major financial institutions, including almost every leading financial conglomerate in the United States and Europe.

If AIG had defaulted on its credit default swaps, the CDS market would have collapsed, and a number of big institutions would have been in serious trouble. So, the AIG bailout was a CDS bailout, among other things.

JUDGE BEA:

A dissenting opinion from Professor Scott.

MR. SCOTT:

Well, just on that.

MR. WALLISON:

There's so much to disagree with. Let me just say one thing and that is all of this, all of this faith in regulation is remarkable when you understand that the banks that got into trouble, as Arthur was talking about, were all heavily regulated, and the regulators were inside them every day.

And so, still they didn't know what was going on. What happens with regulation is that people believe, like Arthur does, that regulation stops risk-taking, and as a result of that, they put more money in banks or make more investments in banks, when if they were ... aware of what the risks were, instead of relying on the regulators, they wouldn't.

MR. EPSTEIN:

Look, I have another point. One of the things about these credit default swaps.

JUDGE BEA:

I've got to call on Professor Scott.

MR. EPSTEIN:

Oh, call on him. Why would I interfere?

MR. SCOTT:

Just a factual point. if you look at the exposures on the CDS portfolio of AIG and look at the major counterparties. You take Goldman Sachs as an example.

Goldman Sachs had 18% of its capital at risk from the failure of AIG. 18%. That's large number, but it's not close to insolvency. And that 18% number doesn't count the CDS's that Goldman purchased on AIG itself as a hedge against the inability of AIG to pay off on the CDS's. So, if you take that into account, that the exposure of counterparties was limited, is that surprising?

Risk 101. You don't put all your eggs in one basket to a counterparty. And I think Goldman understood that idea.

MR. EPSTEIN:

I was going to make a similar point, which is to say...

MR. SCOTT:

So, the fact of the matter is, Art, if AIG had not been saved by the Fed, Goldman would've been fine.

MR. WILMARTH:

Yes, Goldman would've been OK, but not some others.

MR. EPSTEIN:

Yes.

MR. SCOTT:

Other counterparties were in similar positions.

MR. EPSTEIN:

Yeah, look, I mean one of the other things to understand about Goldman is these were not just hedges as bare promises, they also took security interests of one kind or another, I'm not mistaken, right?

MR. SCOTT

That's counted in the 18%.

MR. EPSTEIN:

You know all the technical stuff, but the basic point that I'm trying to make is simple: that financial markets with their repos are organized in a way which allows for instantaneous foreclosures independent of the usual rules on mortgage markets. That also kind of protects things; you have to protect Goldman in order to get out of AIG because otherwise Goldman will protect itself.

The other point I wanted to make on mark-to-market, which is a two-fold answer. To the extent that you have readily ascertainable market prices on various assets, marking to market on a daily basis is perfectly sensible. But what happened in 1988, and which could happen again, is we're trying to mark-to-market those kinds of securities that do not have a ready market, and then in effect what you do is deny a regulated bank the thing that most of the banks want most, which is the ability to say, "I'm going to keep my assets off the market during a bad period of time, and wait 'til some time later."

And it's that inability to delay then forces them to sell into hostile markets, which then lowers the price even further, at which point the cycle starts to repeat. Instead of thinking of this bank as a regulated institution, think of it as a single owner of a particular asset, then ask yourself whether or not in bad markets the owner of a house is under the duty to sell. And I think in that last case, you' fundamentally want to reject the mark-to-market. It is valuable when prices are ascertainable; otherwise, it can prove quite perverse.

JUDGE BEA:

In the back. Question.

AUDIENCE:

About these systemically important institutions it seems to me that once they have been designated as that, the federal government's taking a lot of control of the internal governance away from the shareholders, and to me, that should really be classified as it is taking them.

You have the government instituting for public purposes and taking control away from people's private property interests in the company that they own share in. you know, I think changing that would really improve a lot of the things from the judicial philosophy, at least.

MR. EPSTEIN:

Did I hear you talk about takings? My answer for that takings is half the problem. But there's a second half of the problem, which is whether or

not when the government takes, it gives you just compensation for the loss, so that the shareholders regard themselves as better off than before. And in fact, if you were running a sensible bailout program where you inject money into the situation, which gives you liquidity and takes back the senior interests, that's fine.

And that was maybe, but arguably the situation that you have with FHFA and Fannie and Freddie with its 2008 September bailout when it took a preferred stock with a 10% dividend on money that was put in. But when they then switched the terms of compensation in August 2012 so that the amount left over to the shareholders is nothing, ever, and then announce that since you're getting nothing, ever, you should be extremely happy. Which is the government's position.

The reason why a takings issue is always raised is that there are two sides to the problem, and what happens in many of these cases, most notably with the GSE's, is that nothing whatsoever is given to the shareholders when their wealth was confiscated. What was so terrible about this episode politically is that it revealed a bipartisan willingness to steal on both the Republican and the Democratic side. I've written about this problem for years, on behalf of these hedge funds.[7]

And I'm always amazed at the casual arguments that people make saying that we regard FHFA as a faithful agent of the individuals whom it's milking every dollar that they have.

JUDGE BEA:

Alright. Another question.

---

[7] *See, e.g.*, Richard A. Epstein, *D.C. Circuit Refuses To See Limits To Government Power And Inexcusably Upholds The Net Worth Sweep*, FORBES, Mar. 3, 2017, https://www.forbes.com/sites/richardepstein/2017/03/03/d-c-circuit-refuses-to-see-limits-to-government-power-and-inexcusably-upholds-the-net-worth-sweep/#4c0899924167; *see also*, Richard A. Epstein, *Will Fannie and Freddie Shareholders Be Able to Set Aside the Third Amendment? Judge Royce Lamberth's Indefensible Decision Is Only One Battle in a Long War*, FORBES, Sept. 30, 2014), https://www.forbes.com/sites/richardepstein/2014/09/30/will-fannie-and-freddie-shareholders-be-able-to-set-aside-the-third-amendment-the-recent-sweeney-decision-will-not-alter-the-basic-dynamics/#68b572967f67.

AUDIENCE:

I'm Kai Albert from Port Angeles, Washington. I'd like to ask the panelists, if you had a magic wand you could wave over Dodd-Frank, what parts of it would you amend or repeal, and then turning to reality, what, if anything, do you think, is it realistic to expect is likely to happen with regard to Dodd-Frank reform during the current presidential term?

MR. WALLISON:

Well, let me try that.

MR. SCOTT

I'll answer the second. It's easier than the first. There is a bipartisan bill that was introduced this week, which basically tries to reduce the burdens of Dodd-Frank and limit them to, in some cases to banks that are under $250 billion, and in other cases, even smaller banks. Banks at which, provisions of Dodd-Frank.

Bipartisan, I would say there's a very good chance it will pass. But I think that'll be it. There is such a narrow majority of the Republicans in the Senate, and such disagreement among those Republicans that I think any other practical change to Dodd-Frank other than for smaller banks, which I think we'll see, will not pass. If I were czar, I would sort of scrap Dodd-Frank and start over.

AUDIENCE:

Thank you.

JUDGE BEA:

Anybody else want to chime in?

MR. WALLISON:

Yeah, I'd mention two things right off the bat, and that is the Financial Stability Oversight Council should be closed down, it's a danger. And to the extent that they go into things such as activities, which many people have been for, that is a real danger when they are going to be able to stop entire markets from operating, or entire industries from operating, because they don't like the way they are operating.

Now, that probably won't happen in the Trump administration, but it could well happen in the next administration if it turns out to be from the Left.

MR. EPSTEIN:

First of all, I think the CFPB, you know, marked for extinction would not be a bad thing, and reassign its regulatory authority to other agencies, which are perhaps better able to do it. But the one that I particularly hate, which is self-contained and separate, is the Durbin Amendment, which sort of wrecked the debit card markets for many years by announcing that the interchange system, which had been the greatest success in financial innovation over the last 15 years was completely crazy because it allowed, essentially people to charge the debit card-holders a transaction fee, which the regulators wanted to drive as close as possible to zero.

That's separate. I mean, people like Todd Zywicki who may end up running, if the Lord is kind to us, the CFPB has essentially killed off all sorts of innovation in this particular banking section, and the reason why I think it may be reparable is not only are its effects particularly odious, in many cases, but because the Durbin Amendment is separable from the rest of the statute. And at that particular point, the interaction and overlap problems are much less severe than they are with trying to deal, for example, with SIFIs.

JUDGE BEA:

Arthur?

MR. WILMARTH:

I certainly agree that regulatory relief for traditional community banks is long overdue. Among other things, why are we imposing Basel's international capital requirements on traditional community banks? It makes no sense to do that. A strong leverage capital requirement would clearly be sufficient. Traditional community banks are doing what banks are supposed to be doing, and they're the lifeblood of most of our small or medium-sized communities.

If we want to have a culture that encourages start-up businesses, we need more community banks and we need our existing community banks to thrive. We're loading them down with way too many mandates. I hope regulatory relief for community banks can be accomplished, if nothing else.

MR. SCOTT:

Could I just add that I don't think the villain of the piece is all Dodd-Frank, and this is what Arthur has just alluded to, big villains of the piece reside outside the United States in the form of the Basel Committee and the Financial Stability Board.

The two major regulations that have really affected growth, economic growth in this country, are capital and liquidity requirements.

Those did not originate in the Dodd-Frank legislation, it came out of the Basel Committee and the Financial Stability Board.

So, how we deal with these international organizations going forward in terms of providing regulatory relief is absolutely crucial. This is not only an issue about Dodd-Frank.

JUDGE BEA:

Next question.

AUDIENCE:

Thank you, my name is Carl Domino. I am an attorney but since 1972 I've been a money manager in the equity markets, and as a general proposition I'd say that the big declines we've had always been caused by something different.

Inflation in the 70's, portfolio insurance, the dot com bubble, the financial crisis.

So, as a money manager I'm always looking for the next thing. I mean, everything you said is great, I've studied it, I'm not sure if that's not the last.

I don't know if any of you had looked at what Jamie Diamond said was a fraud, it's very small now, it's growing rapidly, and that's Bitcoin. It looks like the tulip bubble in Holland.

So, the question is this: have any of you looked at it, have a sense of the danger it poses to the capital of markets, and is there an administrative body that should be, if not regulating, at least closely monitoring the growth of Bitcoin?

JUDGE BEA:

Anybody want to talk on that one?

MR. WILMARTH:

I've read a little bit about the recent failure of a Bitcoin market in Japan. No one has yet explained why that market failed, but many investors lost their money and the money just disappeared. My feeling is that a market in which suddenly investors' money just disappears, and nobody has any explanation for it, looks like a Ponzi scheme.

I therefore think that Bitcoin could well be a Ponzi scheme, which is operating on the greater fool theory. I have yet to see any clear explanation about where expected payoffs on Bitcoin investments will come from. Everybody is promised payoffs, but where will the payoffs come from? And investors do not know who invented Bitcoin or who is behind it.

I am perplexed that a market like Bitcoin, which no one is vouching for, which no one is regulating or overseeing, and where some collapses have already occurred, can continue to attract a lot of money.

MR. WALLISON:

Let me. Yeah, I'd like to say something about that because, and probably Richard does too, but look, our economy is great because of innovation. And if people lose money on something like Bitcoin because they've speculated on it and they've lost. If it's a Ponzi scheme, then there's a criminal violation there, but let's not get into the business of regulating innovation. Let's let it work out, and if people lose money, that's their problem.

MR. EPSTEIN:

Now, I have the following explanation, I heard the following statement: you cannot possibly imagine how people are allowed to put in monies into a banking system which has systemic failures when there's no real accountability.

As I listen to that statement, it seems to me you have to close down every bank in the United States because they all have had very similar problems. Regulatory failure in this country is much more frequent overall than it is for example in Canada, where they've never had this particular problem.

And so, the danger that you really have about this is if you want to apply that to Bitcoin, you're going to have to apply it to everything else and at that particular point it may well be that we're going to start going back to only having gold bullion to run our exchange markets.

JUDGE BEA:

Last question.

AUDIENCE:

Thanks. Professor Wilmarth, first of all, thank you for coming today. you decry the tragedy of the federal government having to spend $850 million to bail out Citigroup and Bank of America, and I understand that your take on what happened in 2008 is a little different from the other panelists, but still, we can take certainly as a matter of just judicial notice, that there is a strong push coming out of Congress to readdress income inequality by asking financial institutions to make loans to people who otherwise would not be qualified.

And it's my understanding that FHA losses are astronomical in terms of, in comparison to other forms of loans, so in that sense the government spends plenty of money on behalf of the taxpayers for its own problems.

Could you take a position on that form of lending? Do you decry that socially-induced lending also, along with your other concerns?

MR. WILMARTH:

Oh, yes. I've said repeatedly that the idea about getting people into homes they can't afford makes no sense at all. After all, what is dishonorable about renting? We essentially made it possible for millions of people to buy homes they couldn't afford, and then their homes were foreclosed, they lost everything, they lost their credit ratings, meaning they're ruined for years.

Home ownership for everyone was a horribly misguided policy. I agree that the federal government and the largest banks share a lot of responsibility for the housing disaster.

Unfortunately, the biggest banks found that subprime lending was a very profitable business for about five years. It proved to be an unmitigated disaster over the longer term.

MR. EPSTEIN:

I have a one-sentence answer. One-word answer. It's called "rent."

JUDGE BEA:

On that optimistic note, I've got the hook over here. So, can we thank our panelists. Thank you very much.

MINDING THE PROTECTION GAP: RESOLVING UNINTENDED, PERVASIVE, PROFOUND HOMEOWNER UNDERINSURANCE

KENNETH S. KLEIN*

A significant majority of homeowners in the United States unwittingly have less insurance than necessary to rebuild their home in the

---

* Professor of Law, California Western School of Law. Louis & Hermione Brown Professorship in Preventative Law.

Writing on insurance, construction, and economics is challenging, because there is so little publicly available information about insurance, and so little economics or construction information that is published for the uninitiated. As a consequence, even non-controversial propositions – such as that an insurance producer receives a commission on the amount of premium written, or that prices go up in the wake of natural disaster – can be difficult to source and support with citation. This article depended upon the generosity of many people who were willing to take my telephone calls and shared with me their time and expertise. My thanks to Professor Peter Siegelman from University of Connecticut School of Law; Professor Daniel Schwarcz from the University of Minnesota Law School; Professor Howard Kunreuther from The Wharton School, University of Pennsylvania; Professor Tom Baker from the University of Pennsylvania School of Law; Professor Jay Feinman from Rutgers Law; Professor Jeffrey Stempel from the UNLV – William S. Boyd School of Law; Professor Benjamin L. Collier from Temple University's Department of Risk, Insurance, and Healthcare Management; Professor Peter Kochenburger from University of Connecticut School of Law; Amy Bach from United Policyholders; Valerie Saunders from the National Association of Mortgage Brokers; Guy Kopperund from CoreLogic; Todd Rissel from e2Value; Mark Whatley from Actionable Insights; Chris McCloy of Yapacopia; David Shaffer from David Shaffer Insurance Services; Gary T. Fye from Gary T. Fye Company; Attorney Frederick C. Berry, Jr.; Jonathan Klein from Safe Auto, Ins. Co. (I love you like a brother!); retired insurance executive Elliot Flood; Professor Martin Grace from Temple University Fox School of Business; Madelyn Flanagan, Vice President, Agent Development, Education, and Research of the Independent Insurance Agents and Brokers of America, Inc.; and fire restoration contactor and author, Sean Scott. The generosity of these

event of a complete loss. This persistent, multibillion-dollar protection gap first emerged in the 1990s and has never resolved despite a desire by most homeowners to contract for full replacement coverage. While a great deal of academic and industry literature has addressed the issue of underinsurance, the work has been done without reference to two sources that unlock the conundrum. The first is the 1550+ page administrative rulemaking file of the California Department of Insurance collected in the wake of wildfires in 2007. The second is a deep understanding of the software insurers use to determine the adequacy of coverage limits when a homeowner purchases full replacement coverage.

In addition to these two sources, this Article documents the problem of underinsurance and its causes by synthesizing both prior scholarship and primary source documents, including SEC filings, patents, industry websites, and interviews with trade organization representatives. After establishing the existence of widespread underinsurance, this Article demonstrates how the law's treatment of risk allocation in the wake of inadequate insurance coverage encourages inaccurate coverage limits by uncoupling the risk created by inaccurately calculated coverage limits from the responsibility for the consequences of error. This Article concludes with a proposed regulation that would recouple risk and responsibility while still providing the insurance industry and consumers with the freedom to contract for alternative coverage limits.

---

individuals should not be confused with their agreement with the views and assertions I make in this Article. All errors are entirely my own, and any opinions a reader disagrees with are entirely mine as well.

Thanks to New Media Rights, it's Executive Director, Professor Art Neill, and two of its student interns – Erika Lee and Sarah Borrelli – who researched the legal landscape of recording conversations with insurance agents/brokers. Thanks to Supervising Deputy Attorney General Lisa Chao of the California Department of Justice, Office of the Attorney General, who provided the Administrative Rulemaking File from *Association of California Insurance Companies, et al. v. Jones*. Thanks to the excellent research assistance of the staff of the Library at California Western School of Law, and student research assistant David Bock.

Thanks to colleagues Professor Lisa Black, Professor Hannah Brenner, and Professor Catherine Hardee who served as intellectual and textual editors.

TABLE OF CONTENTS

INTRODUCTION……..…..…38
I. COVERAGE LIMITS ARE PERVASIVELY INADEQUATE TO REPLACE A LOST HOME…..……...……42
A. THE PREVALENCE OF NOMINALLY 'FULL' REPLACEMENT COVERAGE…….…….…44
B. THE PREVALENCE OF INADEQUATE REPLACEMENT COVERAGE……...47
II. THE PREVALENCE OF UNINTENDED, INADEQUATE FULL COVERAGE LIMITS…..……...…….....51
III. HOW THE COST TO REBUILD A HOME IS ESTIMATED….60
A. THE COVERAGE ESTIMATING TOOLS…...……60
1. 360Value…….…62
2. RCT ……65
3. Pronto ……66
B. THE PROBLEMS WITH THE COVERAGE ESTIMATING TOOLS ……..…67
1. Systemic Architecture of Replacement Cost Estimating……...67
2. Human Factors Leading to Software Misuse……..76
IV. TWO NATURAL EXPERIMENTS (COLLECTED ANECDOTES) ON ESTIMATING FULL REPLACEMENT COSTS ……...……81
A. TEST 1 – QUOTING INSURANCE ON THE AUTHOR'S HOUSE…81
B. TEST 2 – REPLACEMENT COST ESTIMATING THE AUTHOR'S HOUSE…….....84
V. RISK ALLOCATION ...…..……86
A. THE CONTRACTUAL LANDSCAPE ……86
B. THE REGULATORY LANDSCAPE.…..……94
C. THE LEGISLATIVE LANDSCAPE……96
D. THE JURISPRUDENTIAL LANDSCAPE……97
VI. MORAL HAZARD-LIKE PROBLEMS ENCOURAGING PERVASIVE, UNWITTING UNDERINSURANCE……..102
A. UNDERINSURING CAN BE PROFITABLE FOR INSURERS……..102
B. AN INSURER MAY BE PUNISHED FOR OVER-INSURING.……109
C. REPUTATIONAL CONCERNS AND MARKET MECHANISMS..…111
VII. A PROPOSED REGULATORY RESOLUTION OF PERVASIVE UNDERINSURANCE ……112
CONCLUSION…..……...……115

INTRODUCTION

The vast majority of American homeowners do not have adequate homeowner insurance,[1] and almost none of them know it. Today, the systems insurers use to identify recommended adequate coverage limits make incidences of profound, unintended underinsurance ubiquitous.[2] Understanding those systems is the key that unlocks the pervasive problem of unintended underinsurance, yet is an undertaking previously largely ignored by the academic and industry literature.

Most homeowners never lose their home, and so have no reason to know whether their insurance is adequate. Until the 1990s, many if not most homeowners had "guaranteed replacement coverage," meaning coverage to rebuild a home whatever the cost.[3] This coverage has all but disappeared, however, and now the ubiquitous form of homeowner insurance, even if purportedly for "full" replacement of the home, has a coverage limit. As a

---

[1] There is a lack of agreement regarding whether the correct generic titling of standard insurance covering the loss of a residence is "homeowners," "homeowner's," "homeowners'," or "homeowner" insurance. This Article adopts the later convention – "homeowner."

[2] *See* Sara Nephew Hassani, Magnifying Disaster: The Causes and Consequences of Home Underinsurance 106 (April 2013) (unpublished doctoral dissertation, Princeton University) ("insurers are aware – and have been aware since at least the late 1930s – that insurance values are far below actual post-disaster replacement costs"). The reinsurer Swiss Re cautions that technically the delta between the economically ideal coverage and the insured loss is 'underinsurance,' while the delta between total economic loss and insured loss is a 'protection gap.' Swiss Re, *Underinsurance of property risk: closing the gap*, 5 SIGMA 1, 2 (2015), http://media.swissre.com/documents/sigma5_2015_en.pdf. This Article uses both the terms "underinsurance" and "protection gap" to refer to the difference between the coverage limits in a homeowner policy for replacement of a lost dwelling, on the one hand, and on the other hand, the actual cost to replace. This is also sometimes referred to as the need to have "insurance to value," or ITV.

[3] *See* Kenneth S. Klein, *When Enough Is Not Enough: Correcting Market Inefficiencies in the Purchase and Sale of Residential Property Insurance*, 18 VA. J. SOC. POL'Y L. 345, 385 (2011); JAY M. FEINMAN, DELAY, DENY, DEFEND: WHY INSURANCE COMPANIES DON'T PAY CLAIMS AND WHAT YOU CAN DO ABOUT IT 135-36 (2010).

consequence, pervasive underinsurance is a predictable news story in the wake of a natural disaster. In 2003, after the Cedar Fire in San Diego, California, the California Department of Insurance found itself besieged by stories of homeowners who were shocked to find they did not have enough insurance to rebuild their homes.[4] The same happened after catastrophic California wildfires in 2007 and 2008.[5] The Texas Department of Insurance received large numbers of homeowner complaints regarding denials, delays, and claims handling both after the 2011 wildfires and after Hurricane Harvey in 2017.[6] In the wake of Hurricanes Irma and Maria, the Florida Division of Banking, Insurance and Financial Regulation received "a higher number of insurance claimants than the division expected" from "homeowners who had insurance policies that covered less than 80 percent of their property's appraised replacement cost," and while the division could not give a percentage as to how many homeowners were over 20% underinsured, the number was "high enough to warrant an emergency order issued by [the] division."[7] In the wake of Hurricane Katrina, litigation in Louisiana blossomed by homeowners who felt duped by the mistaken belief that they

---

[4] *See, e.g.*, Administrative Rulemaking File for CAL. CODE REGS., tit.10, § 2695.183 at 1103, Ass'n. of Cal. Ins. Cos. v. Jones, 235 Cal. App. 4th 1009 (2015) (No. B248622), *rev'd*, 212 Cal. Rptr. 3d 395 (2017) ("The policy underlying the proposed action is to assure that homeowners receive from Department licensees more accurate replacement value estimates regarding their insured structures. The Department and the California Legislature received a significant number of complaints by homeowners who lost their residences in the Southern California wildfires of 2003....[F]ire survivors complained about problems including their experience that after the fire they learned that the replacement value estimates made in setting coverage limits for their homes was too low, causing underinsurance issues to arise during efforts to rebuild or replace their residences.").

[5] Administrative Rulemaking File for CAL. CODE REGS., tit.10, § 2695.183, *supra* note 4, at 29-274, 319-1026.

[6] Tex. Dep't of Ins. Response to TDI Open Records request 194243 (on file with author).

[7] *Senate Hears of Post Hurricane Insurance Complaints*, ST. JOHN SOURCE (Feb. 21. 2018), https://stjohnsource.com/2018/02/21/senate-hears-explanation-of-post-hurricane-complaints/. *See also* Osbert E. Potter, *Emergency Order on Underinsurance* (Feb. 14, 2018), https://www.propertyinsurancecoveragelaw.com/files/2018/02/emergency-order-on-underinsurance.pdf.

had sufficient insurance.[8] The same happened in New Jersey after Hurricane Sandy.[9]

Natural disasters do not create, but rather expose and exacerbate the depth and breadth of underinsurance. When wildfires ravaged California in 2007, the California Department of Insurance ("CDOI") comprehensively studied the problem of underinsurance. The resulting 1550+ page administrative rulemaking file describes how insurers deploy software that purports to account for the likelihood of weather events causing mass loss and concomitant price surges. Yet even when a homeowner both relied on that software to calculate adequate coverage limits and bought 25%, 50%, 100% or even more additional coverage on top of the coverage the insurer and/or producer recommended, over half of homeowners were *still*

---

[8] *See, e.g.*, Freeman v. Travelers Ins. Co., No. 06-8794, 2007 WL 519234 (E.D. La. Feb. 12, 2007); Ruiz v. State Farm Fire and Cas. Co., No. 06-5640, 2007 WL 128800 (E.D. La. Jan. 17, 2007); Halmekangas v. ANPAC La. Ins. Co., 95 So. 3d 1192 (La. Ct. App. 2012); D'Amico v. Scottsdale Ins. Co., No. 06-7174, 2007 WL 854308 (E.D. La. Mar. 15,2007); Dobson v. Allstate Ins. Co., Nos. 06-0252, 06-1097, 06-1064, 06-1255, 06-1734, 06-1585, 2006 WL 2078423 (E.D. La. July 21, 2006); Campo v. State Farm Ins. Co., No. 06-7324, 2007 WL 840125 (E.D. La. Mar. 16, 2007); Tillery v. State Farm Fire and Cas. Ins. Co., No. 06-6876, 2007 WL 805785 (E.D. La. Mar. 13, 2007). These are the residential underinsurance cases from just the first twenty responsive cases to a Westlaw search in just Louisiana state and federal cases, searching for "'Hurricane Katrina' & underinsure!" (search performed on March 2, 2018). These cases often were reported – in other words, showed up in the WL database – only because of a federal district court decision on a remand motion after removal. Put another way, these cases are just the tip of the iceberg that was the post-Katrina underinsurance litigation.

[9] *See, e.g.*, Linblad v. Nationwide Mut. Ins. Co., No. 14-908, 2014 WL 6895775 (D. N.J. Dec. 4, 2014); Bannon v. Allstate Ins. Co., No. 14-1229, 2015 WL 778828 (D. N.J. Fed 24, 2015); Robert v. Liberty Mut. Ins., No 14-06308, 2015 WL 4138990 (D. N.J. July 8, 2015). Again, these are just the first three of 92 responsive cases identified within Westlaw to the search – within just New Jersey state and federal cases – "'Hurricane Sandy' & insurance" (search conducted on March 3, 2018). All three of these cases involve homeowners who were underinsured and sued their insurers, and all are in the Westlaw database because of procedural motions leading to early written trial court orders. Like with Hurricane Katrina, this paints a suggestive picture of a much, much larger body of filed litigation.

underinsured. Despite the dramatic findings of the CDOI, the administrative record has not been analyzed in any academic literature to date. Simply put, the academic record helps confirm what until now was only inferred – that across the United States, most homeowners are materially underinsured, and are unaware of that fact. Most homeowners *think* they have more than adequate insurance.

The explanation for the prevalence of profound, unintended underinsurance lies with the cost estimator software insurers use to recommend coverage limits. The CDOI only briefly alluded to this software, and the academic world studying insurance appears largely unaware of it. These replacement cost estimators are at the heart of the problem. Through a combination of software design choices in the way that insurance is bought and sold, underinsurance is almost inevitable. For example, the software allows for a "shortcut" calculation rather than detailed analysis, and insurers compensate producers in ways that encourage using the shortcut. While the software can recalculate replacement costs and adequate coverage limits annually, producers are incentivized to not do so for fear of losing existing customers. The software requires time and expertise to accurately detail all construction components, but the deployment of the software usually relies on the homeowner to input data by answering a handful of questions in a few minutes. These are just some of many software features combined with incentives that routinely cause inadequate calculations of replacement costs that get worse over time.

For insurers, the prevalence of inadequate and eroding coverage limits resulting from cost estimators is a feature, not a glitch. Cost estimating software creates the opportunity to capture and retain more market share by selling nominally 'full' but actually inadequate insurance coverage. It is an unusual market where a buyer wants and is willing to pay for a more expensive product than the seller has sold. What is particularly peculiar in homeowner insurance, however, is that the insurer is aware this is occurring, and the homeowner is not. As big data companies, insurers have known for the better part of three decades that most homeowner insurance has profoundly inadequate coverage limits, and that the policyholder does not know it. But the legal landscape frequently protects and encourages the insurer. Thus, under the current legal landscape of regulation, legislation, and decisional law, because of the ways cost estimators function and insurance is quoted, homeowners usually bear the cost of a shortfall. In turn, the insurer can more than make up in captured and retained business any actual liability for underinsurance.

This is what many economists would call a 'moral hazard problem.' Nobel Prize-winning economist, Paul Krugman, defines 'moral hazard' as,

"any situation in which one person makes the decision about how much risk to take, while someone else bears the cost of things going badly."[10] As Peter Molk, explains, "insurance brings the potential for perverse increases in risk levels and losses…."[11]

Exposing the problem also points to a solution. Unintentional underinsurance can be resolved by rejoining risk and responsibility, which can be achieved without constraining the business flexibility or viability of insurers.

This Article will unwind the confluence of misplaced incentives, software, expectations, regulation, and legal interpretation that all cohere to create pervasive, unwitting underinsurance in the United States. Part I of this Article documents and roughly quantifies what is intuitively understood but hard to confirm – that underinsurance is pervasive in the United States. Part II isolates the prevalence of homeowners *unintentionally* underinsuring. Part III describes the cost estimating tools used by insurers, and the human factors that intersect with those tools result in inadequate replacement cost estimates. Part IV collects anecdotal data to bolster or undermine the theoretical predictions of Parts I-III. Part V describes the mechanisms of allocation of risk from underinsurance. Part VI describes how unwitting underinsurance is a moral hazard-like problem. Finally, Part VII suggests reform – allowing insurers to calculate coverage limits however an insurer wishes, but making the insurer bear the cost of error.

I. COVERAGE LIMITS ARE PERVASIVELY INADEQUATE TO REPLACE A LOST HOME

In 2007, Marshall & Swift/Boeckh ("MSB"), the company that at that time manufactured the industry standard software insurers used to

---

[10] *See* PAUL KRUGMAN, THE RETURN OF DEPRESSION ECONOMICS AND THE CRISIS OF 2008 63 (W.W. Norton Co. Ltd. 2009). *See also, Definition of 'Moral Hazard'*, ECON. TIMES, https://economictimes.indiatimes.com/definition/moral-hazard; Tejvan Pettinger, *Moral Hazard*, ECON. HELP (Nov. 6, 2017), https://www.economicshelp.org/blog/105/economics/what-is-moral-hazard/. ("Examples of moral hazard include: Comprehensive insurance policies decrease incentive to take care of your possessions…. Governments promising to bail out loss-making banks can encourage banks to take greater risks.").

[11] Peter Molk, *Playing with Fire? Testing Moral Hazard in Homeowners Insurance Valued Policies*, 2018 UTAH L. REV. 347, 349 (2018).

calculate insurance coverage limits, reported that for the years it studied, roughly 60% of American homeowners were underinsured by roughly 20-25%.[12] This was not a description of neighborhoods after a flood or fire but rather a snapshot of the entirety of the housing stock in the United States. While the underlying data supporting that conclusion has never been disclosed, MSB has been cited for it even by insurers.[13]

Indeed, empirical verification and quantification of underinsurance is elusive. Even general information about insurance – such as what insurance coverage a company offers – is hard to come by. The insurance industry is, to put it mildly, parsimonious with data.[14] And when it comes to pervasive, inadequate, nominally 'full' insurance coverage, an insurer has little if any reason to gratuitously aggregate and publicly *self*-proffer potentially derogatory data. Nor does a regulator likely have the resources (or the necessary reasonable suspicion) to investigate potential *systemic* problems in response to a single, disgruntled homeowner complaining of a one-off underinsured loss claim.[15]

Thus, until very recently, there was no reliable source to verify or contradict the MSB conclusions. But that has changed with the combination of a new study on flood insurance and a California Department of Insurance Market Conduct investigation that recently made its way into a public court file. It can be concluded with confidence that most American homeowners nominally have coverage limits described as adequate to fully replace a lost

---

[12] PETER M.WELLS, INSURING TO VALUE: MEETING A CRITICAL NEED 46 (2d ed. 2007).

[13] Chubb, *Homes*, https://www2.chubb.com/us-en/individuals-families/Homes.aspx (last visited March 12, 2018) (citing a "2013 survey by Marshall and Swift/Boeckh" which states that "an estimated 60% of homeowners do not have comprehensive protection.").

[14] *See* Daniel Schwarcz, *Transparently Opaque: Understanding the Lack of Transparency in Insurance Protection*, 61 UCLA L. REV. 394, 413-53 (2014).

[15] The matter is further complicated because several states have adopted an NAIC-recommended protocol that empowers state regulators to aggregate market data from insurers in exchange for a commitment that the data remain confidential. *See generally* Frederick C. Berry, Jr., *Shining a Light on Insurer Misconduct*, https://www.uphelp.org/sites/default/files/publications/shinning_a_light_on_insurer_misconduct_12_1_0.pdf.

home, and most of the time that coverage is inadequate. Further, it appears the frequency of underinsurance may be closer to 80% than to 60%.

A. THE PREVALENCE OF NOMINALLY 'FULL' REPLACEMENT COVERAGE

Professor Jay Feinman writes, "96 percent of homeowners carry insurance."[16] But not all homeowner insurance provides replacement coverage. A homeowner may have the option to purchase either "actual cash value" coverage (ACV) or "replacement cost value" coverage (RCV).[17] And not all consumers purchasing RCV opt for 'full' coverage limits.

All that said, likely most homeowners do buy RCV and a relatively small percentage of policyholders choose 'less than full insurance coverage.' In 2010 the trade magazine, *Insurance Journal*, reported that according to insurer-commissioned survey results, 71% of homeowners thought their homes were insured for the full cost to rebuild (and were willing to pay a higher premium to get that).[18] In a 2017 study of homeowners required to purchase flood insurance, Professors Collier and Ragin found that given the choice between less than full, full, or more than full replacement cost coverage limits, only 20.45% of homeowners opted for less than full coverage limits.[19] There is no published study reaching a materially different result for standard homeowner's insurance.

---

[16] Feinman, *supra* note 3, at 122.

[17] FED. INS. OFF., U.S. DEP'T OF THE TREASURY, REPORT PROVIDING AN ASSESSMENT OF THE CURRENT STATE OF THE MARKET FOR NATURAL CATASTROPHE INSURANCE IN THE UNITED STATES 16 (Sept. 2015), https://www.treasury.gov/initiatives/fio/reports-and-notices/Documents/natural%20Catastrophe%20Report.pdf; *See generally* Johnny Parker, *Replacement Cost Coverage: A Legal Primer*, 34 WAKE FOREST L. REV. 295 (1999).

[18] *Homeowners Coverage Knowledge Gap Wide Among Consumers*, INS. J. (Aug. 24, 2010), https://www.insurancejournal.com/news/national/2010/08/24/112704.htm.

[19] Benjamin L. Collier & Marc A. Ragin, *The Influence of Sellers on Contract Choice: Evidence from Flood Insurance* 6-8, 12, tbl.3 (Fox School of Business Research Paper No. 18-017, 2018), https://ssrn.com/abstract=3162388. Usually flood insurance is optional. Standard homeowner insurance, by contrast, is required by any mortgage. But Collier and Ragin confined

While the Collier and Ragin work focused on flood insurance rather than standard homeowner insurance, there are a variety of reasons to extrapolate the findings of the Collier and Ragin study to standard homeowner insurance. For the most part, standard homeowner insurance is required – if a home has a mortgage then it must have insurance protecting the lender.[20] As a consequence, for roughly 70% of homes the required coverage will be for 80% or more of the mortgage.[21] But when selecting coverage limits, standard homeowner insurance is cheap. For example in 2015, the average premium for homeowner insurance in the United States was $1,168,[22] while the average premium to insure a single automobile was $1,009.[23] Or put another way, the average annual cost of auto insurance for an American homeowner with two cars is 42% more than their annual cost of home insurance.[24] Because standard insurance is comparatively cheap,

---

their study to homeowners who were required to purchase flood insurance. *Id*. at 6.

[20] Kenneth S. Klein, *Following the Money – The Chaotic Kerfuffle When Insurance Proceeds Simultaneously are the Only Rebuild Funds and the Only Mortgage Collateral*, 46 CAL. W. L. REV. 305, 308 (2009).

[21] According to the 2015 Housing Survey, of the 56,337,000 owner-occupied homes reporting how their purchase or construction was financed, all but 16,545,000 had a down payment of 20% or less. American Housing Survey, U.S. CENSUS BUREAU (2015), https://www.census.gov/programs-surveys/ahs/data/interactive/ahstablecreator.html#?s_areas=a00000&s_year=n2015&s_tableName=Table13&s_byGroup1=a1&s_byGroup2=a1&s_filterGroup1=t1&s_filterGroup2=g1&s_show=S. In other words, by the terms of their mortgages, slightly over 70% of all mortgaged homes were required, at the time of purchase or construction, to have insurance of at least 80% of the purchase or construction price. In 2015, over 60% of all owner-occupied homes with a mortgage had property insurance as part of the monthly mortgage payment. *Id.*

[22] NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS, DWELLING FIRE, HOMEOWNERS OWNER OCCUPIED, AND HOMEOWNER TENANT AND CONDOMINIUM/COOPERATIVE UNIT OWNER'S INSURANCE REPORT: DATA FOR 2015 at 34, tbl.4 (2017), http://www.naic.org/prod_serv/HMR-ZU-17.pdf.

[23] NAT'L ASS'N OF INS. COMM'RS, AUTO INS. DATABASE REPORT 2014/2015 at 27, tbl.5 (2017), http://www.naic.org/prod_serv/AUT-PB-14.pdf.

[24] *Accord* INS. INFO. INST., *2016 Consumer Insurance Survey –*

there often may be little additional annual expense to a policyholder in purchasing 80% vs. 'full' RCV.[25]

Further, there is a financial incentive for a homeowner to purchase full replacement insurance. Most property insurance policies contain a "coinsurance provision."[26] These provisions penalize a homeowner for less than 80% insured.[27]

But perhaps more to the point, it bears recognizing what Collier and Ragin have been studying. Their goal has been to isolate what the influence of producers (any person or entity licensed to negotiate, solicit, or sell insurance[28]) of insurance and insurers are on the selection of coverage amounts.[29] They chose the context of flood insurance sold to homeowners who are required to purchase it because the product is identical no matter what insurer offers it – in other words, the only variable is the seller.[30] Collier and Ragin characterize their "main result" as showing "that insurers help select households' flood insurance contracts."[31] Importantly, the insurers'

Homeowner Insurance: Understanding, Attitudes and Shopping Practices at 3, Fig. 2 (Feb. 2017), https://www.iii.org/sites/default/files/docs/pdf/pulse-wp-020217-final.pdf ("...only 31 percent of Americans consider homeowner insurance to be a financial burden.").

[25] *Accord* INS. INFO. INST., *2016 Consumer Insurance Survey – Homeowner Insurance: Understanding, Attitudes and Shopping Practices* at 3, fig.2 (Feb. 2017), https://www.iii.org/sites/default/files/docs/pdf/pulse-wp-020217-final.pdf ("[O]nly 31 percent of Americans consider homeowner insurance to be a financial burden.").

[26] *See* ALLEN FIN. INS. GRP., *Coinsurance Defined & Coinsurance Explained*, https://www.eqgroup.com/coinsurance/ (last visited Sept. 10, 2018).

[27] *Id.*; *see also* Yoong-Sin Lee, *A Graphical Treatment of the Coinsurance Clause*, 52 J. RISK & INS. 644 (1985); IRMI, *Coinsurance Provision*, https://www.irmi.com/term/insurance-definitions/coinsurance-provision (last visited Sept. 8, 2018); William K. Austin, *Property Insurance: Coinsurance*, IRMI (2012), https://www.irmi.com/articles/expert-commentary/property-insurance-coinsurance.

[28] *What is an Insurance Producer?*, CT Ins. Dept., www.ct.gov/cid/lib/cid/anscomle.rtf (last visited Sept. 10, 2018).

[29] Collier & Ragin, *supra* note 19, at 1.

[30] Collier & Ragin, *supra* note 19, at 1.

[31] Collier & Ragin, *supra* note 19, at 4.

impact is not trivial, but rather the insurer "significantly affect[s]" the selected coverage amount.[32]

The import of this finding is central to the question of the frequency of homeowners purchasing 'full' replacement coverage in their standard homeowner insurance. Producers – whether captive or independent – are compensated based on the percentage of premium written.[33] Commissions positively relate to the amount of coverage.[34] More coverage leads to more premium which in turn leads to more commission. In this environment of incentives for full insurance and disincentives for less than full insurance, it is hard to articulate a reason to expect that the percent of 'full' RCV coverage limits for standard homeowner coverage is different than for required flood insurance.

All of this suggests that roughly 80% of all homeowners have what they think is standard homeowner insurance coverage limits adequate to fully replace their home if it is lost. Indeed, Madelyn Flannagan – the Vice President, Agent Development, Education, and Research of the Independent Insurance Agents and Brokers of America, Inc. (the trade organization for independent insurance agents) – reports that "at least" 65%-85% of homeowners have full replacement coverage.[35]

B. THE PREVALENCE OF INADEQUATE REPLACEMENT COVERAGE

Since the overwhelming majority of homeowners want, and are willing to pay for full insurance, one would expect that the overwhelming

---

[32] Collier & Ragin, *supra* note 19, at 18, 23-25.

[33] Rick Mikolasek, *How Much Do Insurance Agents Make?*, THE TRUTH ABOUT INS. (Jan. 30, 2012), http://www.thetruthaboutinsurance.com/how-much-do-insurance-agents-make/; John Cain, *How Much Do Insurance Agents Make*, U.S. INS. AGENTS, https://usinsuranceagents.com/how-much-do-insurance-agents-make; *Become An Agent: Agent Costs & Compensation*, STATE FARM, https://www.statefarm.com/careers/become-an-agent/why-state-farm/cost-compensation (last visited Apr. 2, 2018). *Accord* E-mail from Madelyn Flannagan, Vice President, Agent Dev., Educ., & Research, Independent Insurance Agents and Brokers of America, Inc., to Ken Klein (Mar. 29, 2018) (on file with author).

[34] Collier & Ragin, *supra* note 19 at 4.

[35] E-mail from Madelyn Flannagan, Vice President, Agent Dev., Educ., & Research, Independent Insurance Agents and Brokers of America, Inc., to Ken Klein (Mar. 29, 2018) (on file with author).

majority of homeowners have adequate coverage to rebuild in the instance of a total loss. Usually this does not seem like the case.

United Policyholders ("UP"), a pre-eminent consumer advocacy group, has been tracking and working to solve the underinsurance problem since the 1991 Oakland/Berkeley firestorm.[36] As part of the organization's Roadmap to Recovery work in disaster areas it surveys survivors.[37] Even allowing for some selection effect, the data describes profound underinsurance. Twenty-four months after the 2007 Southern California Fires, 66% of respondents reported they were underinsured by an average of $319,500.[38] Twelve months after the 2010 San Bruno Gas Explosion/Fire, 50% of respondents self-reported they were underinsured by an average of $200,000.[39] Twelve months after the 2010 Fourmile Canyon Fire, 64% of respondents self-reported they were underinsured by an average of $200,000.[40] Twelve months after the 2011 Central Texas Wildfire, 56% of respondents self-reported they were underinsured by an average of $110,000.[41] One year after the 2012 Colorado High Park & Woodland Heights Wildfires, and Waldo Canyon Wildfire, respondents self-reported underinsurance respectively 54%, by an average of $101,000 and 27.2% by an average of $77,000.[42] Six months after the 2013 Black Forest Fire, 38% of respondents self-reported they were underinsured by an average of $100,000.[43] Six months after the 2015 Butte Fire, 65.22% of respondents self-reported they were underinsured.[44] Six months after the 2015 Valley

---

[36] *Our Mission*, UNITED POLICYHOLDERS, https://www.uphelp.org/about/mission (last visited May 11, 2018).

[37] *Data Collection Surveys: Roadmap to Recovery Surveys*, UNITED POLICYHOLDERS, https://www.uphelp.org/roadmap-recovery-surveys (last visited Dec. 9, 2018). ("Our Purpose: To collect data from disaster survivors on insurance claims and recovery progress at various intervals; identify coverage issues, individual and common problems and solutions, assess the pace of recovery and the claims handling performance of the various insurers in the region.").

[38] *Id.*

[39] *Id.*

[40] *Id.*

[41] *Id.*

[42] *Id.*

[43] *Id.*

[44] *Butte Fire – 6 Month Survey*, UNITED POLICYHOLDERS, http://www.uphelp.org/sites/default/files/attachments/buttefire_6mo_results.pdf (last

Fire, 53% of respondents self-reported they were underinsured by an average of $103,000.[45] Six months after the 2017 North Bay fires 66% of respondents self-reported they were underinsured on the dwelling portion of their claim by an average of $317,000.[46]

Other sources (reporting conclusions from undisclosed methodology) come to similar conclusions. A 2015 research paper by Swiss Re describes that in the US and Canada, properties valued at under $5 million are underinsured by an average of 38%.[47] A Princeton University doctoral candidate found "the vast majority of interviewed 2003 fire survivors reported that the amount of compensation available to them under their [coverage] limited policies was much less than the cost required to rebuild."[48] The financial-focused media entity, CNBC, reports, "According to real estate data company CoreLogic, more than half of homeowner insurance policies have a maximum payout that is less than the cost to rebuild the home in the event of a catastrophic loss. Moreover, CoreLogic reports that 1 in 4 homes is protected with a homeowner policy that would cover less than 80 percent of the cost to replace the home."[49]

This set of converging conclusions is suggestive but does not necessarily equate to rigorous study. A more rigorous study, however, has emerged in an administrative rulemaking file of the CDOI, filed in defense of a regulatory change in the state insurance code.

In the wake of wildfires in Southern California in 2007, the CDOI studied the problem of underinsurance.[50] The outgrowth of that work was the addition in 2011 of section 2695.183 to Title 10 of the California Code of Regulations (seeking to make replacement cost estimates more adequate). The insurance industry challenged the new regulation in court, with litigation that ultimately ended with a 2017 Opinion by the California Supreme

---

visited Apr. 2, 2018).

[45] UNITED POLICYHOLDERS, *supra* note 37.

[46] *North Bay Fires – 6 Month Survey Results*, UNITED POLICYHOLDERS, https://www.uphelp.org/sites/default/files/attachments/north_bay_fires_-_6_month_survey_results_v.2_4.26.18.pdf (last visited Apr. 2, 2018).

[47] Swiss Re, *supra* note 2, at 22.

[48] Hassani, *supra* fn. 2 at 149.

[49] Carla Fried, *Recent Disasters are a Wake-Up Call to Check your Homeowners Insurance*, CNBC (Sept. 5, 2017, 9:01 AM), https://www.cnbc.com/2017/09/05/harvey-is-a-wake-up-call-to-check-your-homeowners-insurance.html.

[50] Ass'n. of Cal. Ins. Cos. v. Jones, 386 P.3d 1188, 1191-93 (2017).

Court.[51] And buried in the Administrative Rulemaking File that the CDOI filed with the trial court is the market conduct study the CDOI performed on the prevalence of underinsurance amongst homeowners generally as well as amongst homeowners who had purchased "extended coverage."[52]

The CDOI's focus on extended coverage is important – "Extended coverage is based on a basic coverage amount that is equal to or greater than the estimated replacement cost. In fact, extended coverage cannot be provided unless the basic coverage is at least as great as the estimated replacement cost of the property."[53] In other words, underinsurance amongst homeowners with extended coverage is, by definition, unwitting

---

[51] *Id.* at 1194-95.

[52] Ass'n. of Cal. Ins. Cos., 235 Cal. App. 4th at 1027-30. The work was done by the Department of Insurance's Market Conduct Division ("MCD"), and before being submitted to the court was reviewed by the Bureau Chief of the Field Rating and Underwriting Bureau. *Id*. MCD "commenced examinations of four insurers who together accounted for approximately 50% of the market share in the residential property insurance line at the time" – Farmers, Allstate, State Farm, and Travelers. *Id*. The "examinations targeted the claim-handling practices related to total losses that resulted from the [2007 El Dorado, Los Angeles, Orange, San Bernardino, San Diego, and Ventura] wildfires, and the underwriting practices related to insurance to value and the customer's selection of coverage limits when purchasing and continuing the policy." *Id*. "Similar processes surrounding the dwelling of replacement cost and the selection of Coverage A dwelling limits were observed in each of the four examinations." *Id*. "In general, each insurer had its own replacement cost estimating tool and value generated by this tool and the value generated by this tool was considered (from the insurer's perspective) to be the minimum Coverage A limit for which the policy could be issued." *Id*. "MCD staff examined a total of 188 policies during these examinations. In 126 of these cases, the Coverage A limit selected matched the figure produced by the insurer's tool…of these 126 cases, the Coverage A limit was lower than the cost to rebuild following the loss in 102 cases." *Id*. "When factoring in any extended replacement cost coverage that applied, 72 continued to be underinsured for the total loss." *Id*. "[T]he examinations revealed that regardless of the insurers' stated positions, the policyholder is relying upon the insurer's estimate…to select Coverage A limits in a significant number of cases." *Id*.

[53] Ass'n. of Cal. Ins. Cos. v. Jones, No. B248622, 2014 WL 1576212 at *34 (Cal. App. 2d. Apr. 4, 2014) (Respondent's Brief).

underinsurance – homeowners who wanted full coverage, were willing to pay for full coverage, and indeed who thought they had *more than* full coverage.[54]

The California Supreme Court later described the survey results, as well as some of its methodology:

> In 2008, the Department of Insurance's market conduct division conducted an investigation of the four largest insurers—ones that together accounted for approximately half the market covering these losses. The survey revealed that for a majority of the policies examined, coverage limits matched what was indicated by the insurer's own coverage calculator. But the recommended coverage nonetheless understated what was actually needed to rebuild the insured's home over 80 percent of the time. Even when the homeowner had purchased extended replacement cost coverage, 57 percent of these policies still underinsured their policyholders relative to the cost of rebuilding their homes.[55]

All of this data is in harmony – roughly 80% of Americans do not have 'full' insurance, and most are short by a material amount.

II. THE PREVALENCE OF UNINTENDED, INADEQUATE FULL COVERAGE LIMITS

Sometimes when insurance coverage limits are inadequate to rebuild a home that is a homeowner's intention. As reinsurer Swiss Re notes, "undervaluation of residential property…can be driven by homeowner… policy choice based on affordability rather than adequate coverage."[56] Indeed, some economists theorize an economically rational actor's 'optimal'

---

[54] *See, e.g.*, State Farm's answer in 2008 to why for one of its insureds it did nothing to confirm that the Coverage A limit was high enough to qualify the insured for extended replacement cost extensions that the insured had: "The underwriter did not need to confirm that the Coverage A limit was high enough…because the Coverage A amount selected by the insured met or exceeded the insurance-to-value estimate." Ass'n. of Cal. Ins. Cos., 235 Cal. App. 4th at 698.

[55] *Jones*, 2 Cal. 5th at 383.

[56] Swiss Re, *supra* fn. 2 at 22.

amount of insurance coverage often may not be full insurance.[57] This all raises the question of how a homeowner decides on coverage limits.

Many homeowners do not devote much time or attention to purchasing or renewing homeowner's insurance According to a survey by the Insurance Information Institute ("I.I.I."), less than half of homeowner insurance policyholders comparison shop at all when their policy is up for renewal,[58] and of those who do comparison shop, well over half do so either by phone or online[59] (neither of which are processes conducive to the kind of detailed inquiry needed to properly determine coverage limits adequate to fully fund a rebuild of a home). Indeed, because for over 60% of homeowners with a mortgage,[60] their insurance premium is a component of their mortgage payment, the price of insurance may be essentially invisible.

And even for the engaged customer, there is little reason to expect a productive price comparison. According to the I.I.I., 70% of homeowner insurance – measured by premium – is directly written, meaning through

---

[57] *See, e.g.*, Jan Mossin, *Aspects of Rational Insurance Purchasing*, 76 J. POL. ECON. 553 (1968). *But see* Eric J. Johnson, John Hershey, Jacqueline Meszaros, & Howard Kunruether, *Framing, Probability Distortions, and Insurance Decisions*, 7 J. RISK & UNCERTAINTY 35, 36 (1993) ("There is abundant evidence, although much of it is anecdotal, that consumers do not make these decisions rationally."). *See also* Vernon L. Smith, *Optimal Insurance Coverage*, 76 J. POL. ECON. 68 (1968); George G. Szpiro, *Optimal Insurance Coverage*, 52 J. RISK & INS. 704 (1985); Artur Raviv, *The Design of an Optimal Insurance Policy*, 69 AM. ECON. REV. 84 (1979), reprinted in FOUNDATIONS OF INSURANCE ECONOMICS: READINGS IN ECONOMICS AND FINANCE 251, 261 (Georges Dionne & Scott E. Harrington, eds.) (Kluwer 1991) ("the Pareto optimal insurance contract involves a deductible and co- insurance of losses above the deductible."). *But see* Christian Gollier, *Optimal Insurance Design: What Can We Do With and Without Expected Utility?* printed in GEORGES DIONNE, HANDBOOK OF INSURANCE 97-115 (Kluwer 2000) (arguing that if information is adequate and symmetrical, the optimal insurance for a risk adverse purchaser may be full insurance, depending upon various factors, such as the type of deductible).

[58] INS. INFO. INST., *supra* note 24, at 13.

[59] *Id.*

[60] U.S. CENSUS BUREAU, *supra* note 21.

captive agents, the internet, or other direct means.[61] Directly written insurance does not generate a price comparison of two or more insurers.[62]

This all would suggest a lack of price sensitivity by purchasers of homeowner's insurance. This is interesting, because academic research is inconsistent about whether property insurance customers are price elastic.[63] Yet one must ask whether resolving this inconsistency matters, since as a former insurance executive confirms, "Insurance companies *believe* their customers are extremely price sensitive, and for this reason are more likely to seek to reduce premium than increase coverage."[64]

But generalized price elasticity does not necessarily equate to *intended* less than nominally 'full' RCV. While real or perceived price elasticity could result in less than full coverage limits to reduce premiums,[65] it also could manifest in higher deductibles to reduce premiums,[66] aggressive

---

[61] *Background on: Buy Insurance: Evolving Distribution Channels* INS. INFO. INST., (last visited Dec. 9, 2018), https://www.iii.org/article/background-on-buying-insurance. A report published by the Independent Insurance Agents & Brokers Association of America, Inc. places this figure at 55.7%. Indep. Ins. Agents & Brokers Ass'n of Am., Inc., *2017 Market Share Report* at "Homeowners" Table, https://www.independentagent.com/Resources/Research/SiteAssets/MarketShareReport/default/2017-Market-Share-Final.pdf.

[62] Some confirmation that the difference between captive and independent agent matters is a study of the purchase of flood insurance that found the coverage behavior of agents differed depending upon whether the agent was a captive agent or an independent agent. Collier, *supra* note 19, at 4, 31.

[63] Grace, *supra* note 25, at 362 Table 4; *accord* INS. SERV. OFFICE, *Managing Catastrophe Risk* 4 (1996) ("An insurer willing to pay the price of sufficient catastrophe insurance could have trouble competing for business."). *But see* Justin Sydnor, *(Over)insuring Modest Risks*, 2. AM. ECON. J. 179 (2010) (finding Americans are inefficiently risk averse and so pay more than they should for low deductibles).

[64] Email from Elliott Flood to Ken Klein (Mar. 9, 2018). (Explaining the related issue of policyholder behavior, Molk confirmed the primacy of belief in explaining behavior). Molk, s*upra* note 11, at 6-7.

[65] Swiss Re, *supra* note 2, at 21.

[66] Grace, *supra* note 25, at 378 ("[Explaining] that consumers tend to follow experts' advice to increase their deductibles and use the premium savings to purchase additional coverage that offers a better value in terms of protection against risk"). *But see* Johnson, *supra* note 57, at 42 ("Consumers

comparison shopping between insurers, or some combination of these factors.[67]

Stephan Young, Senior Vice President & General Counsel of the trade association, Insurance Brokers and Agents of the West, suggests that the answer is *intentional* understated replacement cost *both* by producers and their customers:

> Both insurers and homeowners have an economic incentive to underestimate replacement costs. Simply put, the lower the replacement cost valuation, the lower the premium. And the lower the premium, the more likely an insurer is to sell its policies in a highly competitive marketplace, and the more money a homeowner can save.[68]

But that explanation falls flat when – as the CDOI found with frequency – insurance coverage is inadequate even with the purchase of extended coverage.

In reality, most policyholders almost certainly are without reflection following the advice generated by a producer or insurer of what coverage limit is adequate to fully replace a home. Why? Because doing just that is the unanimous advice of anyone knowledgeable about buying insurance. State Departments of Insurance across the country advise homeowners to ask their insurer or agent for the amount of coverage necessary to replace a home.[69]

---

appear to dislike deductibles."); Sydnor, *supra* note 63 (customers overpay for lower deductibles).

[67] *But see* Benjamin Collier, Howard Kunreuther, Erwann Michel-Kerjan, & Daniel Schwartz, *Risk Preferences in Small and Large Stakes: Evidence from Insurance Contract Decisions*, NBER Working Paper No. w23579 (July 17, 2017), https://ssrn.com/abstract=3003717 (examining risk preferences in flood insurance, policyholders have substantial risk aversion, strongly preferring low deductibles and high coverages).

[68] Administrative Rulemaking File for Cal. Code Regs., tit.10, § 2695.183, *supra* note 4, at 1198.

[69] *See, e.g.* TEX. DEP'T OF INS., *Homeowners Insurance* (September 2017), www.tdi.texas.gov/pubs/consumer/cb025.html ("Ask your insurance company if you aren't sure how much it would cost to rebuild your home…. Consider whether your property coverage limits are high enough to replace your house…. You can increase property…coverages if you don't think they

The I.I.I. describes itself as "the leading independent source of objective information, insight, analysis and referral on insurance."[70] The I.I.I.

---

are high enough."); STATE OF WIS., OFFICE OF THE COMM'R OF INS., *Frequently Asked Questions, Homeowner's Insurance* 2 (Jan. 2017), https://oci.wi.gov/Documents/Consumers/PI-232.pdf ("[a]mount should equal the cost of rebuilding your home in the event that it is destroyed…. Your agent will be able to assist you in determining the amount of insurance that is appropriate for your home…"); IND. DEP'T OF INS., *Property Insurance*, https://www.in.gov/iDOI/2573.html ("To adequately insure your dwelling, you must know its replacement value. If you aren't sure of your home's value, play it safe and get help from your agent."); PENN. DEP'T OF INS., *Insurance Facts for Pennsylvania Consumers, Your Guide to Homeowners Insurance* 6-7, http://www.insurance.pa.gov/Coverage/Documents/homeowners.pdf ("It is important to insure your home to replacement cost value because under certain circumstances you may be subject to a recovery amount less than what it would cost you to restore your home to its pre-loss condition.… You should also check with your agent or insurance company at least once a year to make sure your policy provides adequate coverage."); N.C DEP'T OF INS., *A Consumer Guide to Homeowner's Insurance* 15 (2010), http://www.ncDOI.com/_Publications/Consumer%20Guide%20to%20Homeowners%20Insurance_CHO1.pdf ("You should also discuss your insurance needs with an insurance agent. It is this person's job to help you choose the right type and amount of insurance."); COMMONWEALTH OF VA., STATE CORP. COMM'N, *Homeowners Insurance: Consumer's Guide* 15 (2011), https://www.scc.virginia.gov/boi/pubs/hoguide.pdf ("The first step towards determining what policy limits you need is to determine what it would cost to replace your house. The best way to do this is to have an appraiser estimate how much it would cost to rebuild your home if it were totally destroyed and document his estimate in writing. However, appraisals are expensive, so you may want to rely on advice from your insurance agent. Most agents have charts and home replacement cost estimation procedures to help you determine how much insurance you need. If you are not sure of the replacement cost of your house, ask your agent for help.").

[70] INS. INFO. INST., *About Us*, https://www.iii.org/about-us (last visited Feb. 20, 2018). It bears mention, however, that the membership of the Board of Directors of the I.I.I. is 100% comprised of representatives from insurers and reinsurers. INS. INFO. INST., *2018 Board of Directors*, https://www.iii.org/sites/default/files/docs/pdf/2018_board_of_directors.pdf

website posted an article entitled, *How much homeowner insurance do I need?*, and describes, among other things that "… your insurer will provide a recommended coverage limit for the structure of your home…."[71] In another informational document the I.I.I. generates for homeowners, it advises, "[t]he amount of insurance you buy should be based on rebuilding costs…. Your insurance agent or company representative generally can calculate rebuilding costs for you…."[72]

The National Association of Mortgage Bankers ("NAMB") describes itself as "…the voice of the mortgage industry representing the interests of mortgage professionals and homebuyers since 1973."[73] The NAMB's Executive Director describes that in order to close a purchase of a mortgaged home, typically the anticipated insurer provides to the anticipated lender a binder that reflects the "proposed dwelling coverage which would include replacement cost of the home."[74] Indeed, the Executive Director of the NAMB reports that she "would presume that the insurer would inform the consumer regarding the maximum coverage that they would be able to purchase based on replacement cost."[75]

In testimony before the National Association of Insurance Commissioners, Ron Papa, past President of the National Association of Public Insurance Adjusters, explained, "Many consumers believe *having insurance* equates to *having insurance for everything* and that is the way some in the industry seem to like it."[76]

(last visited Feb. 20, 2018).

[71] INS. INFO. INST., *How Much Homeowners Insurance Do I Need?*, https://www.iii.org/article/how-much-homeowners-insurance-do-you-need (last visited Feb. 27, 2018).

[72] INS. INFO. INST., *Insurance for Your House and Personal Possessions: Deciding How Much You Need*, https://www.iii.org/sites/default/files/docs/pdf/possessions.pdf (last visited Apr. 2, 2018).

[73] NAT'L ASS'N OF MORTG. BROKERS, *About NAMB*, https://www.namb.org/about_namb.php. (last visited Apr. 2, 2018).

[74] E-mail from Valerie Saunders (Feb. 21, 2018) (on file with author).

[75] *Id.*

[76] Ronald J. Papa, *Testimony of the National Association of Public Insurance. Adjusters Before the National Association of Insurance Commissioners Property. and Casualty Insurance. (C) Committee Public Hearing on Catastrophe Claims* at 10, NAIC (Dec. 2, 2012), http://www.naic.org/documents/committees_c_related_hearing_testimony_docs.pdf?160.

There are companies that build and sell tools directly to insurance companies for determining the cost to replace a particular property during underwriting. These companies generate the tools as well as extensive training videos and directions for agents as to how to use these tools. While a consumer *could* buy the tool, that is not these companies' target customer. Their business model simply assumes it is the insurer who calculates replacement cost when coverage determinations are made in the course of selling or renewing insurance.[77]

Finally, of course, there are the consumers themselves. They tell the same story repetitively – they relied on their agent to set coverage.[78] As one

---

[77] Verisk, *360Value*, https://www.verisk.com/insurance/products/360value-overview/ (last visited Apr. 4, 2018) ("360Value helps property insurers meet evolving customer expectations, while maintaining rating integrity."); CoreLogic, *RCT Express: Risk Assessment and Valuation Platform*, https://www.corelogic.com/products/rct-express.aspx (last visited Apr. 4, 2018) ("RCT Express delivers the reliable reconstruction cost estimating that carriers have come to rely on for their new business and renewal workflows.").

[78] *See, e.g.*, ASS'N. OF CAL. INS. COS., 235 Cal. App. 4th at 56 ("I ask about the $186,000 total if it was necessary for I was going to remodel my kitchen. He told me with replacement costs built into my policy I would be fine."), 65 ("I had a conversation with my agent 3 months before the fires about the possibility of being under insured...."), 80 ("After the Cedar fire [sic] in San Diego I contacted my broker to increase my coverage."), 100 ("Given the fact that my Agent stated that we were fully covered, I felt we were indeed 'in good hands' and believed that, in the case of a total loss, we would indeed have enough to fully replace our lost home."), 175-76 ("I contacted State Farm in the fall of 2004 and told Ms. Bowman that I was concerned about being underinsured in the aftermath of the Cedar Fire.... Ms. Bowman told me unequivocally that we had enough insurance coverage and were fully protected.... At one point she used the phrase 'buckets of money' to describe the protection that the State Farm policy provided."), 200 ("In 2003, after the Old Fire, I called Allstate to ask if my policy limits were adequate in the event of a total loss.... I was told they were.... I called Allstate again.... My policy limits were raised .... I was thoroughly reassured...that I had 'more than enough coverage'...."), 562 ("My husband said the amount seemed low, he offered to increase the insurance, and he questioned the amount several times. The agent represented that the amount was enough to replace the house.").

homeowner wrote to the CDOI in 2008, "I assumed that the insurance agent was an expert in determining the cost to rebuild my home based on the fact that she is an insurance broker; insurance is her business in my community."[79]

Here is how the CDOI described essentially the same point in briefing to the California Supreme Court:

> [D]espite insurers' attempts to place the responsibility to select appropriate coverage limits on homeowners, homeowners in fact relied on insurers' estimates of replacement cost to determine the amount of coverage to buy, and, as a result of insurers' failure to include all reasonable and necessary expenses in their estimates, a large number of homeowners were underinsured…. "[T]he insurers' processes and tools for estimating replacement cost are inadequate for formulating a realistic dwelling rebuilding cost" and their use "result[s] in insureds who believe they are adequately covered for the full reconstruction cost of their dwelling…."[80]

United Policyholders filed an amicus brief with the California Supreme Court, along with the neighborhood associations of two San Diego neighborhoods devastated by two separate wildfires, summarizing what all industry insiders have always known:

> The vast majority of underinsured homeowner *followed an agent or insurer's recommendations and purchased an amount of home insurance that was based on a replacement estimate provided by the agent or insurer*. Insurance sales representatives routinely perform a replacement estimate calculation and provide it to the insured at the point of sale. They induce consumers to rely on their professional expertise and consumers do so. Insurance sales representatives advertise themselves as experts in protecting people's assets. That expertise and the quality of the protection…is the essence of their sales pitch.[81]

---

[79] Ass'n. of Cal. Ins. Cos., 235 Cal. App. 4th at 723.

[80] Ass'n. Cal. Ins. Cos. v. Jones, No-S226529, 2014 WL 508598 at *11 (Cal. App. Feb. 5, 2014) (Appellant's Opening Brief).

[81] Ass'n. of Cal. Ins. Cos. v. Jones, No. S226529 2014 WL 3428812 at *16-17 (Cal. App. July 10, 2014) (Amicus Brief of United Policyholders,

There simply is no real dispute from the interested parties on all sides – other than in a post natural disaster public relations or legal damage control context[82] – that a homeowner buys homeowner insurance on the basis of a coverage recommendation given at the point of sale by the insurer or insurer's producer.[83] Indeed, in the files of the CDOI, insurers routinely acknowledge that at least historically, insurers or their producers were the ones that estimated coverage limits.[84]

Of course, producers have at least two reasons to quote *full* coverage limits. First, producers are paid on commission, and presumably know the infrequency of customers price-shopping insurance. Second, intentionally mis-describing and understating the adequacy of coverage exposes the producer to liability.[85] So, one would reasonably expect that in the majority of instances, producers want to quote full coverage at whatever number the producer actually thinks is 'full' RCV.[86]

Scripps Ranch Civic Association, Rancho Bernardo Community Council in Support of Defendant and Appellant) (emphasis in original).

[82] Klein, *supra* note 3, at 364-65.

[83] *See, e.g.*, Hassani, *supra* note 2, at 151-72.

[84] *See, e.g.*, Ass'n. of Cal. Ins. Cos., 235 Cal. App. 4th at 74, 146, 154, 186, 196, 227, 323 ("The agent appears to have calculated coverage...."), 371, 411, 414 ("agency calculated...dwelling coverage limit ...."), 464 ("The Coverage A limit was figured at policy inception. Over the years...I figured...."), 520 ("With the information provided by the insured I used the CAN replacement cost estimator to calculate the estimated coverage ...."), 562, 584, 689 ("My agency did not calculate the Coverage A amount. We did, however, calculate an estimate ...."), 993-94.

[85] For an overview of the complex set of regulations concerning duties of producers, see UNITED POLICYHOLDERS, *Links to Materials Produced in the Agents E&O Standard of Care Project which was Commissioned by the Big "I" Professional Liability Program and Swiss Re Corporate Solutions* (October 2016), http://www.uphelp.org/sites/default/files/publications/listing_of_big_i_swiss_re_agents_standard_of_care_information.pdf. It bears noting that through the device of the insurable interest requirement, an insurer can limit the amount paid to the actual replacement value even if the coverage exceeds that amount. *See* Molk, *supra* note 11, at 360.

[86] In 2008, the trade magazine, *National Underwriter Property & Casualty*, asked its readers, "what producers and insurers should ethically do to have properties properly insured;" it summarized the answers it got as, "very few responding believed there was no ethical responsibility for

And yet this leads to a conundrum – if a policyholder is willing to buy 'full' coverage and a producer has a financial incentive to sell 'full' coverage then why is the estimated 'full' coverage so routinely low?

III. HOW THE COST TO REBUILD A HOME IS ESTIMATED

Why are RCV coverage limits pervasively and profoundly inadequate? The answer comes from knowing where the predicted 'cost of full replacement' number comes from. And the answer to that question is replacement cost estimating tools.[87] To understand why coverage limits are ubiquitously low, one must understand the tools.[88]

A. THE COVERAGE ESTIMATING TOOLS

There are two companies – Verisk Analytics, Inc.[89] and CoreLogic, Inc.[90] – that dominate the market of creating and selling to insurers software

---

producers to offer advice as to insurance-to-value. On the other hand, no one claimed there was any legal duty to do so, either." Peter R. Kensicki, *Whose Fault is it When Properties are Underinsured?*, NAT'L UNDERWRITER PROP. & CAS. (Apr. 27, 2008), https://www.propertycasualty360.com/2008/04/27/whose-fault-is-it-when-properties-are-underinsured/.

[87] *See, e.g.*, Ass'n. of Cal. Ins. Cos., 235 Cal. App. 4th at 464 ("The Coverage A limit was figured at policy inception. Over the years in talking with contractors, and seeing the typical replacement cost figures that the Farmers system (which uses Marshall-Swift) would give me, I figured ...."), 520 ("With the information provided by the insured I used the CAN replacement cost estimator to calculate the estimated coverage ...."), 689 ("My agency did not calculate the Coverage A amount. We did, however, calculate an estimate using the Marshall & Swift/Boeckh tool State Farm provided at the time."). *See also Id.* at 1029 ("each insurer had its own replacement cost estimating tool.").

[88] Hassani, *supra* note 2, at 33 ("valuation algorithms and methodologies have routinely failed to generate accurate home reconstruction costs ...").

[89] Verisk began as the Insurance Services Office – the property and casualty insurer trade organization – but now describes itself as, among other things, "a leading data analytics provider serving customers in insurance ...." Verisk, Annual Report (Form 10-K) at 4 (Dec. 2, 2018).

[90] CoreLogic self-describes itself as a "leading property information, analytics and data-enabled services provider in North America...."

to calculate appropriate homeowner insurance coverage limits. Between them, they capture close to the entirety of the market.[91] A third company – e2Value – is a relatively recent market entrant trying to compete by doing something largely different.[92] For residential underwriting, Verisk's underwriting product is 360Value. CoreLogic's underwriting product is RCT. e2Value's underwriting product is Pronto (a later generation trade name of a sister-product, Mainstreet). The most straightforward way to describe the three coverage estimating tools is to detail what 360Value does and then to differentiate RCT and Pronto.

CoreLogic, Inc., Annual Report (Form 10-K) at 3 (Feb. 24, 2017). According to CoreLogic, central to CoreLogic's ability to compete with Verisk as a provider of tools for estimating rebuilding costs is that CoreLogic acquired Marshall & Swift/Boeckh in March of 2015. *Id.* at 79. MSB, which CoreLogic headlines as "the gold standard of building cost data," is described by CoreLogic as having "80 years of experience ... ensuring users have the tools for a complete and defendable determination of value." CoreLogic, *Marshall & Swift: The Gold Standard of Building Cost Data*, http://www.corelogic.com/solutions/marshall-swift.aspx (last visited Apr. 2, 2018).

[91] E-mail from Guy Kopperud to Ken Klein (Mar. 22, 2018, 9:20 PST) (on file with author). Verisk says its decision analytics customers are "the majority of the P&C insurers in the U.S." Verisk Analytics, Inc., Annual Report (Form 10-K) at 4 (Feb. 20, 2018). *Accord* Collier & Ragin, *supra* note 61, at 7 ("Out of the eight [insurers identifying] their replacement cost software, six currently use Marshall & Swift ..."). According to its co-founder, e2Value's market share as measured by percentage of insurer entities in the U.S. (~1500) is about a third, but as measured by written premium would not be nearly that. e2Value's market share has a higher penetration in high-value insured properties. E-mail from Todd Rissel to Ken Klein (May 2, 2018).

[92] e2Value is a private company formed in 2000 by George Moore and Todd Rissel. *Company*, E2VALUE, http://e2value.com/coompany (last visited Mar. 1, 2018). On May 13, 2008, the United States Patent and Trademark Office issued Patent No. 7,373,303 to Moore and Rissel for a method and system for "estimating building reconstruction costs." U.S. Patent No. 7,373,303, at [21] (issued May 13, 2008).

1. 360Value

Verisk describes 360Value as a tool for insurers – when underwriting new insurance or renewing existing coverage -- for determining the cost to rebuild a home: "From underwriting to policy renewal" 360Value provides a "replacement cost estimation system to generate reliable estimates for every property…."[93] And per Verisk, a *lot* of insurers use it: "Insurers already use 360Value to conduct almost 50% of all property replacement cost estimates in the United States…. 360Value is becoming the most widely used reconstruction cost estimator in the United States."[94] For these 50% of all U.S. property replacement cost estimates, Verisk makes a promise: using 360Value, there will be "no surprises for underwriters or policyholders in the event of a total loss."[95]

360Value seeks to deliver on Verisk's promise by leveraging Verisk's existing data and tools for claims adjusting. The data and tools primarily are those of Xactware Solutions, Inc. Xactware is a wholly owned subsidiary of Verisk.[96] Verisk represents that Xactware is "a leading supplier of estimation software for professionals involved in building repair and reconstruction."[97] 360Value starts with Xactware's database, and massages the numbers to account for some variables such as rising building costs over time[98] and demand surge in the wake of natural disaster[99], and thus derives an estimated cost to replace for purposes of underwriting at the time of selling insurance or revisiting coverage limits at the time of renewal. Or in

---

[93] VERISK, 360VALUE 3 (2016), https://www.verisk.com/siteassets/media/underwriting-v/resources/360value-overview.pdf.

[94] *Id*. at 2. This is a serious encroachment on the market share of MSB, which as recently as 2006 was described as having a monopoly position. Elliot Spagat, *Insurance Calculator Questioned: Homeowners Discover Coverage Was Insufficient*, WASH. POST, at G3 (July 24, 2004), http://www.washingtonpost.com/wp-dyn/articles/A9509-2004Jul23.html?noredirect=on.

[95] VERISK, *supra* note 93, at 8.

[96] VERISK, *supra* note 91, at 112.

[97] VERISK, *supra* note 91, at 5.

[98] VERISK, *supra* note 93, at 3.

[99] VERISK, *360Value Overview*, https://www.verisk.com/insurance/products/360value-overview/ (last visited Feb. 28, 2018).

the words of Verisk, 360Value is designed to "match the front end to the back end."[100]

But while 360Value utilizes a variety of data sources (the delineated data sources are "public records, global information system (GIS) data, existing underwriting and claims estimates, [and] regional modeling"),[101] fundamentally 360Value is reliant upon Xactware's data and technology, which Verisk describes as, "The key to the accuracy and reliability of 360 Value estimates…."[102] That 'data and technology' set comes from claims adjusting – it is "Xactimate, Xactware's industry-leading claims estimation solution."[103] That is an extensive set, because 360Value claims Xactimate is used by "80 percent of insurance repair contractors" and "22 of the top 25 U.S. property insurers."[104] As Verisk brags, 360Value uses "true component-based replacement cost estimates based on actual claims information…. This true component-based approach…is what sets 360Value apart from other cost-estimating tools."[105]

So, what is Xactimate? Xactimate is aptly described by an Xactimate Affiliate Trainer, Mark Whatley:

> Xactimate gives users access to pricing databases for 468 distinct markets throughout the United States and Canada. Xactware publishes and maintains these price lists for both structural repair and cleaning, updating them at least once per quarter.
>
> Each structural repair and cleaning database contains more than 19,500 unit-cost line items. For each line item, Xactimate provides:
>
> - Labor costs
> - Labor productivity rates (for new construction and restoration)
> - Labor burden and overhead
> - Material costs
> - Equipment costs
> - Contents replacement cost value
>
> The Xactimate price lists seek to contemplate the costs to perform various activities within the confines of the restoration ecosystem.

---

[100] VERISK, *supra* note 93, at 8.
[101] VERISK, *supra* note 93, at 5.
[102] VERISK, *supra* note 93, at 3.
[103] VERISK, *supra* note 93, at 3.
[104] VERISK, *supra* note 93, at 8.
[105] VERISK, *supra* note 93, at 3.

> e.g., storage, contents packouts & restoration, mold remediation, water extraction, environmental testing, asbestos abatement, etc.
> In most regions, a new price list is generated monthly. This updated price list incorporates ~10 new line items and significant modifications to an additional ~30 line items. Traditionally, user feedback is the catalyst for the adoption of new line items and material updates.[106]

To understand Xactimate, and in turn Xactware, and in turn 360Value, it is of immense importance to understand precisely *where* the foundational price data comes from, because it is not simply a download of the prices charged by a big box construction supply store such as Home Depot or Lowe's. Xactimate is the self-described "industry leading" tool for claims adjusting.[107] And the raw data for the "industry leading" tool largely is the aggregated data from billions of line items from previously adjusted claims.[108]

That, in a nutshell, is how 360Value works. Billions of lines of data are aggregated from millions of adjusted claims. That data is combined with localized retail price data as well as a database of construction contracts emerging from those claims negotiations. The claims data then is updated quarterly,[109] monthly,[110] or even more frequently as needed,[111] and for purposes of 360Value is combined with weather and other predictive software to incorporate unusual risk factors.[112] And this then all results in a tool that a producer can use to estimate rebuild costs in order to determine

---

[106] Mark Whatley, *Xactimate: The History & The Future*, ACTIONABLE INSIGHTS 2 (Apr. 2018), https://www.getinsights.org/xactimate-history-future/.

[107] VERISK, *supra* note 93, at 3.

[108] Whatley, *supra* note 104, at 13; XACTWARE, *Pricing Data Services*, https://www.xactware.com/en-us/resources/pricing-data-services/overview/ (last visited Feb. 28, 2018). For a great more detail on the Xactware approach to data analytics generating a price list, *see* XACTWARE, *Pricing Research Methodology* (Feb. 6, 2018), https://www.xactware.com/globalassets/us/pdf/brochures/pricing-research-methodology.pdf.

[109] VERISK, *supra* note 93, at 3.

[110] Whatley, *supra* note 106, at 2.

[111] *See California Wildfires – Xactware Support*, XACTWARE, https://www.xactware.com/enus/support/california-wildfires/.

[112] VERISK, *supra* note 93, at 3-6.

coverage limits and premium. Essentially, used properly, 360Value prices the hypothetical reconstruction of a house down to its nails and screws.[113]

But that takes a lot of time. Time a producer may not have.[114] According to Verisk's literature, "360Value can calculate residential building estimates with as little as the address, year built, and total finished square footage."[115] Additionally, "360Value gives you the option of selecting a quality grade for either the entire property or specific rooms…."[116] An insurer can also simply enter an address and 360Value will pre-fill up to 65 characteristics of a home.[117]

2. RCT

CoreLogic's product is RCT ("RCT Express" as an 'app').[118] As CoreLogic describes its product:

> We've spent the last eight decades perfecting our total component methodology. This unique estimating methodology researches building costs from the ground up, with unparalleled research into local labor, materials and equipment costs in more than 750 independent regions. We research more than 100,000 construction line items; 90 labor trades; and construction crew sizes, productivity, soft costs and code variations to give you consistent and current cost information. We validate our estimates with local and national research, home surveys, contractor estimates, construction samples and insurance loss analysis. In addition, we get inputs from design firms, architects, universities and construction organizations.[119]
>
> We localize costs at the micro-economic level and score property characteristics for reliability based on age, completeness and

---

[113] VERISK, *supra* note 93, at 3-6.

[114] Administrative Rulemaking File for CAL. CODE REGS., tit.10, § 2695.183, *supra* note 4, at 1217 ("Many producers generate hundreds of quotes per week.").

[115] VERISK, *supra* note 93, at 3.

[116] VERISK, *supra* note 93, at 3

[117] VERISK, *supra* note 93, at 5.

[118] *See generally* CoreLogic, *supra* note 77.

[119] *Structural Risk and Valuation*, CORELOGIC, https://www.carelogic .com/solutions/structural-risk-andvaluation-solutions.aspx (last visited April 2, 2018).

> accuracy with our proprietary algorithms. Then, we use those property characteristics to provide more accurate risk values to give you a deeper understanding of residential structural risk, building condition and contents.[120]
>
> Benefits include: One-step estimating and risk assessment.[121]

RCT sounds a lot like 360Value, and in the largest sense – a price list, data base, component-based estimating system – it is. There is one significant difference, however. RCT is not primarily using claims adjusted contracts and prices in its data; rather, RCT primarily is using retail price data.[122]

3. Pronto

As alluded to above, in some ways Pronto is a horse of a different color. Pronto draws upon "public and private data sources" including the company's "own deep data" "to ensure…property estimates are as accurate as possible."[123]

e2Value starts from a different premise than Verisk or CoreLogic. e2Value believes that the predominant drivers of replacement cost are where a house will be built and what the quality/prestige expectations of builders for that neighborhood are.[124] Stated differently, the cost of building the same house in Flint, Michigan, in Detroit, Michigan, and in Grosse Pointe, Michigan will vastly differ even though all three builders have access to the same labor and materials markets. Pronto is based on algorithms that analyze data on the premise that this dimension is far more predictive of accurate costs than detailed component-based price lists.[125]

---

[120] *Id.*

[121] *RCT Express*, CORELOGIC, http://www.corelogic.com/downloadable-docs/rct-express.pdf (last visited Apr. 2, 2018).

[122] E-mail from Guy Kopperud to Ken Klein, Professor of L., Cal.W. Sch. of L. (Apr. 5, 2018).

[123] *About Us*, E2VALUE, http://e2Value.com/us/ (last visited Mar. 1, 2018).

[124] Email from Todd Rissel to Ken Klein, Professor of L., Cal.W. Sch. of L. (Mar. 3, 2018).

[125] *Id.*

Like 360Value and RCT, "Pronto allows…customers to access a comprehensive valuation report instantly, after inputting only the property's address."[126]

B. THE PROBLEMS WITH THE COVERAGE ESTIMATING TOOLS

360Value, RCT, and Pronto are very sophisticated tools for estimating replacement costs of homes when underwriting insurance, and yet unwitting underinsurance persists. Why does it happen? The short answer is that fundamentally it is impossible to precisely predict a future rebuild cost. The longer answer looks at the architecture of replacement cost estimating tools, and the human factors of the people using those tools. The software designs make understating of risk possible and the human factors make understating risk likely.

But before detailing of these systemic and human factors, there is a caveat: As to any of these systemic or human factors, one could posit that they are unlikely or purely theoretical, or that the impact of them is small or not at all. But if all of these factors were of little influence then certainly extended replacement coverage creating a 25%, 50%, 100%, or even 150% fudge factor or buffer would be sufficient to prevent underinsurance, and yet time and again it is not.[127] The CDOI's market conduct examinations of insurers found that the tools used by insurers were "inadequate for formulating a realistic dwelling rebuilding cost."[128] In other words, the estimates often did not come close.

1. Systemic Architecture of Replacement Cost Estimating

a. *shortcuts*

As described above, all three estimating tools – 360Value, RCT, and Pronto – allow estimating to be done with very little information, sometimes just a street address, or an address plus the age of home and its square footage. But in estimating, shortcuts are a problem.

---

[126] e2Value, *supra* note 123.

[127] Administrative Rulemaking File for CAL. CODE REGS., tit.10, § 2695.183, *supra* note 4, at 1027-30.

[128] Administrative Rulemaking File for CAL. CODE REGS., tit.10, § 2695.183, *supra* note 4, at 1030.

As two Assistant Vice-Presidents of Xactware describe, if the goal is accuracy:

> Estimates are calculated by entering all known property-specific building attributes…. The property-specific building attributes drive all system assumptions and the subsequent components used to calculate the estimate. The quantity and quality of this information will influence reliability of the estimate…. The more building attributes used, the more reliable the replacement-cost estimate.[129]

For component-based programs (RCT and 360Value), "Replacement-cost estimators depend on the underlying labor and material component costs that serve as building blocks for the estimate. To ensure accuracy, these components must be comprehensive, accounting for all permutations and combinations of features possible in a given structure."[130]

The following language from the '303 patent (the patent underlying Pronto) is instructive:

> Attempts have been made to simplify the methodology for estimating construction costs. U.S. Pat. No. 5,546,564 to Horie proposes a construction cost estimating system in which a database of completed construction projects is maintained with cost data for each project and other data for sorting the projects for relevance to a particular proposed new project…. This technique, however, is subject to substantial inaccuracy due to the effects of its simplifying assumptions. …there are a great many cost influences that will vary from project to project, thus making it impractical to assess the relevance of any given project to another.[131]

---

[129] Scott Amussen & Mike Fulton, *A Balancing Act: Homeowners writers strive for underwriting efficiency without sacrificing reliable replacement-cost estimates*, BEST'S REV. 1, 2 (Nov. 2010) https://www.xactaware.com/ globalassets/us/pdf/360value/bests-review-nov2010-property-attributes.pdf.

[130] *Id.*

[131] U.S. Patent Application No. 10/013,428, Publication No. 2008/0103991 A1 (published May 1, 2008) (George C. Moore & Todd Rissel, applicants).

But Pronto is not immune from the problem either. As Todd Rissel (one of the two founders of e2Value) describes, while Pronto strives for and claims to achieve accurate estimating within 2.5% of actual cost to replace, failure to put in the detail of a property as actually built – for example, whether the roof cover is clay tile vs. asphalt shingle – can cause discrepancies (per Rissel) of up to 15%.[132]

What is odd and difficult to explain is that shortcuts seem to lead disproportionately to understating valuation. In the wake of the 2003 Cedar Fire, the allegation was made that the shortcut function in the MSB software led to dramatic underinsurance.[133] The same seems to be the experience today with 360Value.[134] And while of course it is difficult to draw too much from these data points because there is no reason to hear complaints when the estimate either is accurate or high, the natural experiments described below suggest that in fact, shortcuts tend disproportionately to lead to low estimates.

Finally, it bears noting that while the shortcut function presumably could be removed from the software, it is not.[135]

b. *timing*

As the Insurance Information Institute recognizes, "If the limits of your policy haven't changed since you bought your home, then you're probably underinsured."[136] There are at least two potential causes – in the absence of extraordinary events – of coverage adequacy deterioration even in a single policy year – inflating building costs and building code changes.

Even in the absence of ordinary inflation "materials prices and labor

---

[132] Email from Todd Rissel to Ken Klein dated March 2, 2018.

[133] *See, e.g.*, Jeanette Steele, *Coverage gap in rebuilding linked to cost calculators*, SAN DIEGO UNION TRIBUNE (Aug. 22, 2004), http://www.carehelp.org/files/News/20040822_Coverage_gap_in_rebuilding_linked_to_cost_calculators.pdf.

[134] *See, e.g.*, Complaint & Demand for Jury Trial, *Bivin v. United Services Automobile Association*, No. SCV-261717 (Super. Ct. of the State of Cal. For the Cty. of Sonoma Dec. 21, 2017).

[135] A company designing the software might hesitate to remove the shortcut feature for fear that it would be economically unsustainable for an insurer or producer to do full, detailed cost estimates.

[136] INS. INFO. INST., *supra* note, 72 at 4.

rates change constantly."[137] Historically, the change is in only one direction – up. As Verisk explains about 360Value, "To incorporate the most current changes in reconstruction material and labor costs, the Xactware team updates reconstruction cost data quarterly."[138] Verisk then publishes every fiscal quarter a "360Value Quarterly Cost Update" on construction costs.[139] The Verisk library of quarterly reports begins with Q3 2011 (which reports on Q2 2011)[140] and thus far runs through Q1 2018 (which does not give a quarterly figure for Q4 2017;[141] the last reported quarterly figure thus far is for Q3 2017).[142] For all but one of these 26 of these reported quarters, each and every quarter, construction costs have increased. The one exception – Q1 2014 – costs are reported as "virtually unchanged."[143] Costs never fall. And annually, costs are reported as rising 1.09% in 2011,[144] 2.02% in

---

[137] Amussen & Fulton, *supra* note 129, at 1-2.

[138] VERISK, *supra* note 92, at 3.

[139] VERISK, *360Value Quarterly Cost Updates*, https://www.verisk.com/insurance/campaigns/360value-quarterly-cost-updates/, (last visited Mar. 7, 2018).

[140] VERISK, *360Value Overview of Property Reconstruction Cost Changes Q3 2011*, https://www.verisk.com/siteassets/media/underwriting-v/resources/360value-quarterly/360value-cost-update-us-2011-q3.pdf (last visited Mar. 7, 2018).

[141] VERISK, *360Value Quarterly Cost Update Q1 2018*, https://www.verisk.com/siteassets/media/underwriting-v/resources/360value-quarterly/q1_2018_usa.pdf (last visited Mar. 7, 2018).

[142] VERISK, *360Value Quarterly Cost Update Q4 2017*, https://www.verisk.com/siteassets/media/underwriting-v/resources/360value-quarterly/360value_quarterly_cost_update_q4_2017.pdf (last visited Mar. 7, 2018).

[143] VERISK, *360Value Overview of Property Reconstruction Cost Changes Q2 2017*, https://www.verisk.com/siteassets/media/underwriting-v/resources/360value-quarterly/360value_cost-update_q2_2014_usa.pdf (last visited Mar. 7, 2018).

[144] VERISK, *360Value Overview of Property Reconstruction Cost Changes Q1 2012*, https://www.verisk.com/siteassets/media/underwriting-v/resources/360value-quarterly/360value-cost-update-us-2012-q1.pdf (last visited Mar. 7, 2018).

2012,[145] 3% in 2013,[146] 4.3% in 2014,[147] 2.2% in 2015,[148] 2.4% in 2016,[149] and 5% in 2017.[150] Put another way, for every year since 2012, the rate of construction cost increase has exceeded the annual rate of general inflation.[151] As a consequence, the coverage limit to rebuild a home is fixed for the entire coverage year, but the actual rebuild cost goes up every day of the coverage year.

A similar problem arises with changing building codes. As I.I.I. explains, "In the event of damage, you may be required to rebuild your home to the new codes…."[152] Changes to the building codes making construction

---

[145] VERISK, *360Value Overview of Property Reconstruction Cost Changes Q1 2013*, https://www.verisk.com/siteassets/media/underwriting-v/resources/360value-quarterly/360value_cost_update_q1_2013_usa.pdf (last visited Mar. 7, 2018).

[146] VERISK, *360Value Overview of Property Reconstruction Cost Changes Q1 2014*, https://www.verisk.com/siteassets/media/underwriting-v/resources/360value-quarterly/360value_cost-update_q1_2014_usa.pdf (last visited Mar. 7, 2018).

[147] VERISK, *360Value Overview of Property Reconstruction Cost Changes Q1 2015*, https://www.verisk.com/siteassets/media/underwriting-v/resources/360value-quarterly/360value_cost-update_q1_2015_usa.pdf (last visited Mar. 7, 2018).

[148] VERISK, *360Value Overview of Property Reconstruction Cost Changes Q1 2016*, https://www.verisk.com/siteassets/media/underwriting-v/resources/360value-quarterly/360value-q1-2016_usa.pdf (last visited Mar. 7, 2018).

[149] VERISK, *360Value Quarterly Cost Update Q1 2017*, https://www.verisk.com/ siteassets/media/underwriting-v/resources/360value-quarterly/360value-q1-2017_usa.pdf (last visited Mar. 7, 2018).

[150] VERISK, *360Value Quarterly Cost Update Q1 2018*, https://www.verisk.com/siteassets/media/underwriting-v/resources/360value-quarterly/q1_2018_usa.pdf (last visited Mar. 7, 2018).

[151] *Historical Inflation Rates: 1914-2018*, US INFLATION CALCULATOR, http://www.usinflationcalculator.com/inflation/historical-inflation-rates/ (last visited Mar. 7, 2018); *accord* Whatley, *supra* note 106, at 2.

[152] INS. INFO. INST., *supra* note 71. *See also* John Caulfield, *Are Building Codes Revised Too Often?*, BUILDER MAGAZINE (Oct. 1, 2013), http://www.builderonline.com/building/code/are-building-codes-revised-too-often_o ("In many states, building codes are reviewed and revised every

costs rise are so ubiquitous, in fact, that the I.I.I. recommends a rider to insurance for these costs.[153]

For both of these reasons – building codes and building costs – even within a single policy year and certainly over the span of several years, the accuracy and adequacy of estimated replacement cost erodes.

Insurers could adjust annually for these factors. They often do not.

c. *predicting catastrophe*

Catastrophes raise costs. The mechanics of this are simple – the construction trades build to expected capacity, and a mass loss in the wake of a natural disaster causes a demand surge.[154]

Demand surge is a complex economic consequence to model, but accurately doing so is of immense importance to insurers.[155] To simply illustrate the issue more concretely, consider concrete. The industry populates inventory, labor, and schedule capacity to anticipated normal

---

three years."). *See also Do's And Don'ts When Insuring Your Home*, UNITED POLICYHOLDERS https://www.uphelp.org/pubs/dos-and-donts-when-insuring-your-home ("Make sure your offers adequate coverage for building code upgrades. The safest bet is full building code upgrade coverage, which is available from companies such as Fireman's Fund, Safeco, Chubb, and Allied. Most other insurers offer either an extra 10% for building coverage or a flat $25,000."). *See also Why You Need Building Code Upgrade Coverage*, GALLI INSURANCE AGENCY, http://www.galliinsurance.com/why-you-need-building-code-upgrade-coverage/.

[153] *Id.*

[154] Amussen & Fulton, *supra* note 129, at 1–2 ("Many factors influence [rebuild] costs, including...demand surge following a catastrophe...."). *See also Will multiple catastrophes impact costs?*, E2VALUE (Nov. 22, 2017), http://e2value.com/blog/insurance/will-multiple-catastrophes-impact-costs/; *Labor shortages still a concern for builders*, E2VALUE (Dec. 5, 2017), http://e2value.com/blog/general-information/labor-shortages-still-a-concern-for-builders/; Michael Gannon, *Hurricane Sandy Demand Surge Influences Replacement Cost Estimates in the Northeast*, VERISK (Feb. 13, 2013), https://www.verisk.com/blog/hurricane-sandy-demand-surge-influences-replacement-cost-estimates-in-the-northeast/.

[155] *See* David Döhrmann, Marc Gürtler & Martin Hibbeln, *Insured Loss Inflation: How Natural Catastrophes Affect Reconstruction Costs*, 84 J. RISK & INS. 851 (2017).

construction demand supply – there are not trucks and workers and concrete just lying around waiting for the next hurricane or fire or flood. So, when those weather events do happen, demand spikes, and in turn prices spike too.[156]

The insurance industry is well aware of the importance of tracking and understanding the potential impact of natural disasters.[157] More to the point, however, is that Verisk, CoreLogic, and e2Value all recognize the importance of accounting for natural catastrophe and attendant demand surge in order to properly estimate needed coverage to rebuild a lost home.[158]

---

[156] E-mail from Sean Scott to Kenneth S. Klein, Professor of Law, Louis & Hermione Brown Professor in Preventative Law, (April 09, 2018, 19:15 PST) (on file with author). ("To meet the demand, some contractors may bring in or construct their own 'batch plants', which are miniature concrete plants that can be set up on a small plot of ground to produce concrete for a tract of homes or larger construction projects. These are not cheap to set up or operate but are often used to help meet demand. Another example of demand surge wreaking havoc was when drywall was imported by the United States from China during the construction boom between 2004 and 2007. This was spurred by a shortage of American-made drywall due to the rebuilding demand of nine hurricanes that hit Florida from 2004 to 2005, and widespread damage caused along the Gulf Coast by Hurricane Katrina in 2005.... [I]t is safe to say that all construction related materials and labor are affected by disasters, especially in and around the immediate affected areas.") And this assumes, of course, that there are architects and general contractors who are available, and that they do not have to depend upon unlicensed, pirate subs, and trades to do work.

[157] *See, e.g.*, *Background on: Wildfires*, INS. INFO. INST., (Apr. 4, 2018), https://www.iii.org/issue-update/background-on-wildfires; Arindam Samanta, *Key Findings From the 2017 Verisk Wildfire Risk Analysis*, VERISK (July 12, 2017), https://www.verisk.com/insurance/visualize/key-findings-from-the-2017-verisk-wildfire-risk-analysis/?utm_source=Social&utm_medium=Twitter&utm_campaign=VeriskSM&utm_content=842017.

[158] *See, e.g.*, VERISK, *supra* note 93, at 6 ("Because many of the data elements needed for replacement cost estimates are the same elements needed for catastrophe modeling, 360Value is ideally suited to capture the detailed, property-specific data needed for effective catastrophe analysis. The point in the underwriting process when replacement cost is reviewed may also be an ideal opportunity to check on catastrophe risk."); Trish Hopkinson, *Hurricanes Drive Demand Surge in Reconstruction Costs* (Nov.

Improperly accounted for demand surge causes massive underinsurance in the event of total loss.

d. *feedback loops*

360Value and RCT are "component-based" estimating tools. The essence of component-based estimating is in its name – line item components. As Verisk asserts, 360Value "accounts for all labor and material costs down to the screws and nails."[159] Feedback loops create averages, and averages will often be low.

Consider, for example, the approach of 360Value, which estimates by reference to contracts adjusted in the claims process.[160] In claims

---

7, 2017), https://www.verisk.com/insurance/visualize/hurricanes-drive-demand-surge-in-reconstruction-costs/; *Store-Specific Demand Surge from Severe Weather*, VERISK, https://www.verisk.com/insurance/products/respond-weather-analytics-to-predict-demand/store-specific-demand-surge-algorithms/ (last visited April 2, 2018); Anthony Hanson, *What Demand Surge Might Look Like in This Year's Hurricane Season*, VERISK, (Aug. 7, 2017), https://www.verisk.com/insurance/visualize/what-demand-surge-might-look-like-in-this-year-s-hurricane-season/; *Will multiple catastrophes impact costs?* E2VALUE, (Nov. 22, 2017), http://e2value.com/blog/insurance/will-multiple-catastrophes-impact-costs/; *CoreLogic Introduces New Desktop Platform for Insurance Providers to Pinpoint Natural Hazard Risk and Tax Data*, CORELOGIC, (Nov. 1, 2011), https://www.corelogic.com/news/corelogic-introduces-new-desktop-platform-for-insurance-providers-to-pinpoint-natural-hazard-risk-and-tax-data.aspx; *Assess Natural Hazard Risk n RCT Express*, CORELOGIC, https://www.corelogic.com/products/natural-hazards-rct-express.aspx (last visited April 2, 2018); *Hazard HQ*, CORELOGIC, https://www.corelogic.com/landing-pages/hazard-hq.aspx?WT.mc_id=crlg_180813_yVEsA (last visited Aug. 14, 2018). While all the software claim to account for demand surge, there is no disclosure of *how* this is done.

[159] VERISK, *360Value*, https://www.verisk.com/insurance/products/360value-residential/ (last visited April 2, 2018).

[160] *See* Whatley, *supra* note 106, at 5 ("More than 400,000 estimates are returned to Xactware every day...."), 13 ("Xactware's Pricing Data Service …reports cost information based upon actual prices and transactions (completed bids) that have occurred recently in the given market."); Xactware, *supra* note 108, at 7 ("Xactware's role is to report a market price based upon recent transactions that have occurred.").

adjusting Xactware functions as a cost containment tool.[161] If functioning *properly*, Xactware will materially 'contain' line item prices. That, per force, depresses the price list used in underwriting estimating.

As an illustration, assume a homeowner has lost their home and is trying to rebuild. They have a contractor who has made a detailed bid. One line-item of the bid is 1000 widgets. A widget is priced in the database price for $1.00. But the actual price of a widget is $1.05. The insurance adjuster will challenge the line item of any contractor bid that prices the 1000 widgets above $1000.

Because the contractor is unlikely to complete the work at a loss, they have some choices: They can walk away; they can turn to the homeowner for the difference; they perhaps can find some other line item – let's say 50 zoobles – that they have a source to get for under list price and thus make up the loss on the widgets; or they can negotiate to try to get more for widgets.[162] In all likelihood, the contractor will do some combination of more than one of these strategies.

But under any scenario, the contractor has an incentive to have the line item for the 1000 widgets be at or as close as possible to $1000.[163]

---

[161] Whatley, *supra* note 106, at 3 ("[O]ver the last decade, there has been a substantial increase in the frequency with which independent and Staff Adjusters write their own estimates.... [T]his change in policy has likely had a significant impact as it relates to stagnant pricing within the Xactimate price lists.... Why? Those that are operating under the direction of...insurance executives are trained to...(B) Apply a carrier centric custom price list that is comprised of suppressed pricing and a limited number of items.... In…Scenario "B", the custom carrier centric price list actually actively works to suppress reimbursement rates for policyholders."), 4 ("Staff adjusters submitted 63.1 percent of estimates processed by XactAnalysis in 2016.").

[162] In the event that the contractor engages in negotiation, there is the additional problem of asymmetrical expertise and bargaining power between the contractor and the insurer. *Id.* at 8-10.

[163] The contractor views the adjuster as a volume buyer and so faces immense pressure to "give" in the negotiation. SEAN M. SCOTT, SECRETS OF THE INSURANCE GAME: WHAT YOU NEED TO KNOW ABOUT PROPERTY DAMAGE CLAIMS 47-48 (Heritage 2017) ("…there are too many contractors out there who are willing to drop their pants to get on an approved vendor program with an insurance company. Many become mesmerized with the idea that doing so will be the key to fame and fortune and a larger volume of

Indeed, it may ultimately be exactly $1000 – the data base price.[164]

Let's assume that the adjuster ultimately agrees to a price of widgets at $1.01 a widget. That becomes the next real-time entry for a widget in the database. And the algorithm of the database will not simply adopt the most recent entry as controlling – it will incorporate the new entry with other entries, so the price now listed in the data base may move only somewhat up – let's say it moves to $1.005 per widget. Remember – in our example the *actual* current price of a widget is $1.05.[165]

The point here is simple. Feedback loops will average together *all* prices -- including actual prices, stale prices, and below-market prices -- thus creating the risk both of understating prices and price stagnation.[166] And using Xactware in particular as the core of 360Value amplifies the problem because there also are many inevitable soft line item costs to actual reconstruction – such as supervisor and project management time – that adjusters "often claim they don't pay for,"[167] and each time that assertion succeeds it may yet further depress any 360Value estimate that relies in part on that adjusted contract.

2. Human Factors Leading to Software Misuse

Software with all of the above-described features and challenges will function no better than the people who use it. And in cost-estimating, that's a problem.

---

work. This mindset is similar to the lure of gambling where you get a taste of winning a couple of hands, but in the end, the odds of beating the house are always stacked against you.").

[164] *See* Whatley, *supra* note 106, at 3 ("It is incredibly easy for ... major insurance institutions to exercise their will against the boilerplate price list (either intentionally or unintentionally)…. Contractors are rarely taking the time to determine their own individual cost, and subsequently create a custom price list that reflects their unique cost of doing business.").

[165] *See* Kabir Shaal, *Job Estimating Programs*, LINKEDIN, (April 23, 2015), https://www.linkedin.com/pulse/job-estimating-programs-kabir-shaal/ ("The software providers are very, very clear on one thing: Their calculated pricelists are *indicators*, not absolute. They do not claim to offer the 'right' price.").

[166] Whatley, *supra* note 106, at 3-5.

[167] Whatley, *supra* note 106, at 14.

a. *point of sale incentives*

According to Verisk's people, "Insurers strive for reliable estimates but are mindful of the time required to calculate them."[168] A Texas insurance agent candidly disagrees:

> One way an agent can keep the price down is aim low [sic] in valuing houses. The goal, they say, is to keep premiums down to keep customers from going to competitors, and sometimes even a few dollars can make a difference. Sadly, many agents are just plain lazy! Too lazy to gather all the necessary information to accurately determine the cost to rebuild a home.[169]

Perhaps laziness is a real problem. But more likely it is simple economics. Only about five percent of homes change hands in any given year.[170] Put another way, homeowner insurance is a relatively mature market – there may be little gain to investing time and effort into placing new business. Yet, correctly calculating coverage limits accurately takes time[171] – time that producers have little incentive to invest:

> Insurers face competitive pressures to underwrite policies, requiring companies to increase the speed and ease of doing business with agents and streamline underwriting…. This poses a challenge for insurers: How much data should be collected to ensure properties are adequately insured and policyholders are protected, while remaining sensitive to the time investment of the insurance representative and policyholder?[172]

---

[168] Amussen & Fulton, *supra* note 129, at 1; *accord* Papa, *supra* note 76, at 10.

[169] Rahim Virani, *Under-Insured? – Part 3*, TEXAN INSURANCE (Jan. 23, 2012), http://www.texaninsurance.com/client-service/blog/entryid/2860/under-insured-part-3 (last visited Apr. 2, 2018); *see also* Jerry Ramsey & Brian Heffernan, *Underinsurance: A Consumer Fraud,* Not *an Agent Error or Omission*, UNITED POLICYHOLDERS, 8-10, http://uphelp.org/sites/default/files/underinsurancelaws.pdf.

[170] Klein, *supra* note 3, at 356.

[171] *See generally* Amussen & Fulton, *supra* note 129.

[172] *Id.* at 1-2; *accord* Tom Smith, *The Value of Insurance-to-Value Often*

b. *expertise*

Estimating accurately is technical[173] – Xactimate, for example, has four levels of user certification describing a spectrum of proficiency.[174] As an analogy, think of the difference between a competent store clerk deploying basic arithmetic to sum up a bill versus a mechanical engineer who has mastered higher level mathematics to make sure the bridge doesn't fall. Both are doing math, but there's a big difference in proficiency with complexity. Whatley describes the following example: Xactimate is excellent at assigning fair reimbursement for granite countertops, *provided* that the detail is given as to "the proper grade of granite and all of the other related costs are accounted for," such as the work involved with light switches embedded in the back splash or the inset of the sink or the mitering of the corners.[175] Lack of proficiency, lack of rigor, and lack of detail all cause the claims adjustment to be low.[176]

There is no reason to expect that either RCT or Pronto, used correctly, is materially easier. Indeed, both CoreLogic and e2Value provide extensive resources to train insurance personnel to use their tools accurately.[177]

Overlooked, INS. J. (Feb. 20, 2006), https://www.insurancejournal.com/magazines/mag-features/2006/02/20/67985.htm ([T]here often are not many incentives for agents and brokers to calculate accurate property and business interruption (BI) values. As higher insurance values can mean higher premiums, agents and brokers are obviously looking to keep premiums as low as possible for their clients, which can affect their assessment of ITV.").

[173] *See* Amicus Brief of United Policyholders, et al., *supra* note 81, at *15.

[174] Whatley, *supra* note 106, at 8.

[175] Whatley, *supra* note 106, at 16-17.

[176] Whatley, *supra* note 106, at 9; Hassani, *supra* note 2, at 63-66. Insurers as well as producers support the notion that training is necessary to get estimation right. *See, e.g.*, Administrative Rulemaking File for CAL. CODE REGS., tit.10, § 2695.183, *supra* note 4, at 1129-30, 1147, 1156,1186, 1198-99.

[177] *See* CORELOGIC, *RCT Express: Platform Overview*, https://www.corelogic.com/products/rct-express.aspx (touting online videos and materials, private training, and on-site training); E2VALUE, *Help Center*, https://evs.e2value.com/evs/est/InteractiveHelpAdmin/Glossary.aspx?; E2VALUE, *Online University*, http://www.e2valueuniversity.com.

Producers, even with training, may lack the expertise to properly use cost estimators. But proper training is of little value if the producer does not personally visit the property and do a several hour inspection.

In the absence of a visual inspection by a producer with time and expertise, the adequacy of the estimate erodes. When getting estimated replacement cost quotes questions should be asked on a variety of matters such as are finishes above average or expensive; or is the exterior style Spanish Modern or California Ranch; or the angle of slope of one's roof; or whether the slope of one's land is mild or moderate. Often these questions are asked directly to the homeowner. These are judgment calls for which there is not always an objectively correct answer, and/or for which the homeowner is insufficiently knowledgeable to answer accurately. Differences in the answers to these questions, however, can profoundly change the estimated replacement cost. That is particularly troublesome because there is subtle psychological pressure on a homeowner to answer questions in a way that results in lower-priced insurance.

c. *renewal incentives*

All of the factors described above can cause the estimated replacement cost to be understated even in a single policy year. But the reality is that most insurance is in place as a renewed policy, not a new policy, and so the challenges of underinsurance exacerbate.

For producers paid in commissions on premiums written, the lion's share of the money to be made is on renewals, not on selling new policies. Renewals should be easy, because customers have inertia, and so are less price elastic.[178] But a producer nonetheless may hesitate to cause that customer to wonder if the customer might be able to get the product cheaper -- and thus to price shop it – by getting a renewal notice significantly raising the premium.[179]

---

[178] *See* Sydnor, *supra* note 63, at 184; *accord* Benjamin R. Handel & Jonathan T. Kolstad, *Health Insurance for "Humans": Information Frictions, Plan Choice, and Consumer Welfare*, 105 AM. ECON. REV. 2449 (2015) (confirming the influence on hassle and inertia on insurance decisions).

[179] Caitlin Johnson, *Most Homeowners Are Underinsured*, CBS NEWS (Aug. 31, 2006, 11:44 AM), https://www.cbsnews.com/news/most-homeowners-are-underinsured/ ("In the competitive marketplace, the last thing an agent wants is for the customer to run down the street to a competitor because they got a quote for $50 a year less.").

Now for these purposes it does not matter if the customer *is* price elastic; all that matters is that the producer is *concerned* that the customer might be price elastic. This is sufficient to incentivize the producer to not refresh or revisit the estimate of replacement cost, because if the cost has gone up (and remember, as Verisk's data documents, the cost *always* is going up), then the premium for the renewed policy will go up, and the producer will be at risk of losing the customer (and the commission). So, whatever price stagnation exists at the outset, it will worsen over time. Every year that a policy renews without revisiting the estimated replacement cost of the dwelling, the worse underinsurance gets.

A final observation bears noting about underwriting – all of this assumes internal insurance personnel are acting in good faith, yet in auto insurance there is at least one prominently reported example of an insurer quite intentionally setting up systems to increase its profits to the derogation of its policyholders.[180] And in the aftermath of Hurricane Katrina, State Farm was found guilty of falsifying engineering reports in an attempt to evade coverage.[181] This Article does not seek to account for this sort of 'cheating,' but is not blind to its possibility.[182]

---

[180] *See, e.g.*, Steven Gursten, *Allstate Confesses to Using Computer Program to Reduce Settlements for Auto Accident Victims in Michigan*, Michigan Auto Law (Mar. 24, 2011), https://www.michiganautolaw.com/blog/2011/03/24/allstate-confesses-to-using-computer-program-to-reduce-settlements-for-auto-accident-victims-in-michigan/.

[181] State Farm Fire & Cas. Co. v. United States ex rel. Rigsby, 137 S. Ct. 436, 441 (2016) ("Respondents Cori and Kerri Rigsby are former claims adjusters for one of petitioner's contractors, E.A. Renfroe & Co. Together with other adjusters, they were responsible for visiting the damaged homes of petitioner's customers to determine the extent to which a homeowner was entitled to an insurance payout. According to respondents, petitioner instructed them and other adjusters to misclassify wind damage as flood damage in order to shift petitioner's insurance liability to the Government.") and Associated Press, *Jury Finds State Farm Committed Fraud*, JACKSON FREE PRESS (Apr. 9, 2013, 10:46 A.M), http://www.jacksonfreepress.com/news/2013/apr/09/jury-finds-state-farm-committed-fraud/.

[182] *See* Whatley, *supra* note 106, at 3 ("It is incredibly easy for … major insurance institutions to exercise their will against the boilerplate price list (either intentionally or unintentionally)."), 8 ("Xactimate is a tool – a tool

IV. TWO NATURAL EXPERIMENTS (COLLECTED ANECDOTES) ON ESTIMATING FULL REPLACEMENT COSTS

What the foregoing all predicts is that a homeowner buying standard insurance will be quoted 'full' RCV coverage calculated through either 360Value or RCT, and that the quoted coverage limit will be profoundly inadequate. To test this prediction, the Author ran two experiments on his own house – several major insurers were contacted seeking a quote for homeowner insurance on the house and the three estimating tools were run to see what replacement costs each tool generated.

For context, here is a brief relevant history of the house: The house was built in 1979. The Author purchased the house in 1998. In October 2003, the house burned to the ground in the 2003 Cedar Fire. The house was rebuilt and re-occupied in November 2004 (the total rebuild cost was approximately $450,000). In the last five years the house had a roof leak – this was a covered claim. The house also had some drywall cracks – an inquiry was made to the insurer about whether repair work would be covered by insurance, an adjuster performed an inspection, and the insurer reported that this was not a covered event.

A. TEST 1 – QUOTING INSURANCE ON THE AUTHOR'S HOUSE

One way to know how coverage limits are calculated, and what producers represent (or not) about the adequacy of coverage estimates, is to actually gather insurance premium quotes and estimates of adequate coverage. What follows is the results of doing just that on the Author's house, contacting the author's present insurer, an insurer the Author was transferred to in the course of a call, and otherwise the largest homeowner insurers in the United States as identified by the Insurance Information Institute (citing the data collected by the National Association of Insurance

---

that can be used for good or evil."), & 11 ("A paradigm shift occurred in 1992 when Allstate and other major carriers hired McKinsey & Company to develop strategies for managing claim cost. McKinsey referred to the claims settlement process as a 'zero-sum game' - essentially the carrier and the policyholder are competing for the same resources. The idea that an Adjuster's primary objective was to fairly distribute claims benefits was an archaic notion, and the McKinsey report advised that claims be settled on a take-it-or-litigate-it basis. As a result, Allstate moved from 'Good Hands' to 'Boxing Gloves.'").

Commissioners).[183] Here are the results (the identity of each insurer is masked in order to avoid any suggestion that this experiment is intended to be derogatory of a particular insurer):

Insurer A: The estimate was done by filling out a form on-line. The website described it was estimating using 360Value. The estimate required input of details concerning the property taking approximately 15 minutes. Estimated Replacement Cost: $595,000.[184] The written quote states, "Estimated replacement cost is the estimated dollar amount of what it will cost to rebuild your home today…. Please review the 360Value Report if you think you may have entered information in error…. You can then use the 360Value Tool again to recalculate your estimated replacement cost."[185] By a follow-up email, in response to the question, "I want enough insurance to be confident that if my home was lost, I have enough coverage to rebuild it. Is this enough? If not then how much should that be?," a new quote was sent estimating replacement cost at $607,050, and extensions of that coverage raising the total dwelling coverage to $789,165.[186]

Insurer B (and Insurer C): The insurer has the applicant fill out a form online, and then place a follow-up call to the insurer. The form took about five minutes to complete. In the telephone call, the insurer said it was not writing at present (a moratorium) on the address because of wildfire risk. Per the insurer, the insurer "partners" with Insurer C and the insurer transferred the call to a representative of Insurer C. Insurer C quoted Full Replacement Coverage (described as binding), with an Estimated Replacement Cost of $582,000. The quote included a 50% extension of this replacement cost, if necessary. Also, in the conversation, the following exchange occurred: "Q: You are confident that this is sufficient coverage to rebuild our home should it burn down? A: Yes."[187] By email Insurer C gave an estimated replacement coverage limit (including a 50% extension) totaling $873,000, in response to the email inquiry: "I want enough insurance

---

[183] INS. INFO. INST., FACT & STATISTICS: HOMEOWNER AND RENTERS INSURANCE, HOMEOWNER INSURANCE LOSSES 2011-2015, https://www.iii.org/table-archive/21296.

[184] E-mail from Insurer A to author (Mar. 22, 2018) (on file with author).

[185] *Id.*

[186] E-mail to author (Mar. 28, 2018) (on file with author).

[187] E-mail from insurer to Author (Mar. 12, 2018) (on file with author); Telephone conversation with agent for insurer (Mar. 12, 2018) (on file with author).

to be confident that if my home was lost, I had enough coverage to rebuild it. Is this enough? If not then how much should that be?"[188]

Insurers D and G: Both had a moratorium on the address because of wildfire risk.[189]

Insurer E (telephone quote): The agent said Insurer E likely wouldn't differ much from the others because they all use the same software, and that if the applicant could stay with their current insurer (who wrote Guaranteed Replacement Coverage) then the applicant should. The agent said the replacement cost estimates the other insurers were quoting were "silly" low.[190]

Insurer F (telephone quote): The agent said Insurer F uses 360Value, which Insurer F referred to as the 'industry standard.' Because of the Fireline code of 8 – insurance would require two policies, one from Insurer F and one from the California FAIR Plan, and for this reason recommended the applicant stay with their current insurer. Nonetheless the agent quoted Full Replacement Coverage (at $237 per square feet) with a 25% extension. The agent said they were "comfortable" this was adequate. The written quote (sent by email) explicitly references 360Value, but also says the policyholder should pick a different replacement coverage in order to "feel" they have enough. Estimated Replacement Cost: $512,000.[191]

Insurer H (on-line and clarified through a transcribed on-line chat): The chat representative described Estimated Replacement Coverage was using 360Value. The chat representative also confirmed that if the website inputs were conservative, that this "essentially" guaranteed replacement coverage because the applicant would "have all the coverage [they] need." Estimated Replacement Cost: $554,000.[192]

Insurer I (on-line and by telephone): Insurer I writes through independent agents. The agent suggested that to have confidence that there was enough coverage to fully replace the home, there should be full

---

[188] E-mail from insurer to Author (Mar. 26, 2018) (on file with author).

[189] Telephone conversations with insurers D and G (Mar. 12, 2018) (on file with author).

[190] Telephone conversation with insurer E (Mar. 12, 2018) (on file with author).

[191] Telephone conversation with insurer E (Mar. 12, 2018) (on file with author).

[192] E-mail from insurer H to author (Mar. 12, 2018) (on file with author); Transcript of chat with insurer H (Mar. 12, 2018) (on file with author).

replacement coverage plus a 200% extension.[193] Ultimately, no coverage was quoted because of "claims history" in the previous three years.

Insurer J (in-person and by telephone): This is the Author's present insurer, through which the Author has Guaranteed Replacement Coverage. This has been the author's insurer for 20 years, and this was the first and only in-person inspection (of approximately 15 minutes) of the home in 20 years, and the only inspection by any of the contacted insurers. The inspection was not prompted by this research but was coincidental.[194] The estimate of replacement cost was done using software from "Marshall & Swift/Boeckh."[195] The estimated replacement cost from this inspection is $672,000, and the policy has been renewed as guaranteed replacement coverage.[196]

B. TEST 2 – REPLACEMENT COST ESTIMATING THE AUTHOR'S HOUSE

In the wake of the 2003 San Diego wildfires it was widely reported that with a disturbing frequency, shortcuts cut deeply low.[197] But that was a forensic *post hac* explanation of "what happened."

---

[193] Telephone conversation with insurer I (Mar. 12, 2018) (on file with author).

[194] Telephone conversation with insurer J (Mar. 12, 2018) (on file with author).

[195] Voicemail message from Allegra Christian (Mar. 21, 2018) (on file with author).

[196] *Id.*

[197] *See, e.g.*, Elliot Spagat, *Insurance calculator questioned*, WASHINGTON POST (July 24, 2004), http://www.carehelp.org/files/News/20040711_Homeowners_haunted_by_underinsurance.pdf; Jospeh B. Treatser, *Homeowners Come Up Short On Insurance*, NEW YORK TIMES (Aug. 31, 2004), http://www.nytimes.com/2004/08/31/business/homeowners-come-up-short-on-insurance.html; Jeanette Steele, *Coverage gap in rebuilding linked to cost calculators*, SAN DIEGO TRIBUNE (Aug. 22, 2004), http://legacy.sandiegouniontribune.com/news/fires/20040822-9999-1n22inssoft.html; *Company drops insurance calculator amid criticism*, BILLINGS GAZETTE (Nov. 18, 2004), http://billingsgazette.com/business/company-dropsinsurance-calculator-amid-criticism/article_293fc05e-ad31-5001-afea-f5ca544a4c91.html.

To test what actually happens in cost estimating (and the possibility that a lot has changed in the intervening fifteen years), the Author of this Article sought to run all three estimating software programs on his own house. Here are the results:

RCT: CoreLogic provided the Author with portal access to the software. Estimate using just the property address: Reconstruction cost without debris removal -- $565,017; with debris removal -- $587,235.[198] With input of detail by the homeowner, re-estimate done: Reconstruction cost without debris removal -- $658,045; with debris removal -- $683,834.[199]

Pronto/Mainstreet: e2Value provided the Author with portal access to the software. Estimate using just the property address: Reconstruction cost without debris removal -- $646,000; with debris removal -- $678,000.[200] Changing just a few of the assumptions in order to reflect the property more accurately (input by the homeowner) – the style of the house and the materials used for roofing – changed the estimate to $810,000 and $850,000 respectively.[201] Changing the "quality of construction" from "above average/upgraded" to "expensive/custom" (again by the homeowner) changes the numbers to $902,000 and $947,000.[202] A Mainstreet estimate done using "Residential Full," meaning inputting the most detail possible (by the homeowner) -- estimated replacement cost with debris removal: $1,134,000; without debris removal: $1,080,000.[203]

360Value: The quotes from Insurers A, F, and H all were explicitly based on homeowner input into 360Value. An expert on doing valuation using Verisk software was contacted and asked to do a valuation based on his in-person inspection. The expert responded that to generate a defensible, accurate valuation would require at least three separate visits (at an expense of $195 an hour) and about an additional $2,000 in costs for technology and support.[204] The expert indicated that he would expect the resulting figure to be materially higher than an estimate applying a dozen or so parameters from

[198] CoreLogic, Data entry report (on file with author).
[199] CoreLogic, Data entry report (on file with author).
[200] e2Value report (on file with author).
[201] e2Value report (on file with author).
[202] e2Value report (on file with author).
[203] e2Value report (on file with author).
[204] July 11, 2018 email from Sean Scott to Ken Klein on file with author.

the homeowner input into Verisk cost estimating software, which routinely omits components and understates components.[205]

V. RISK ALLOCATION

All of this adds up to pervasive, unintended, inadequate RCV coverage limits. As e2Value recognizes, "any discrepancy between estimated and actual replacement costs can translate into financial risk…."[206] The question then becomes, a risk to *whom*?

A. THE CONTRACTUAL LANDSCAPE

An insurance contract is, even from a theoretical economist's point of view, an unusual contract. An economist would posit that in any contract, both sides bear or retain some risk.[207] An insurance contract, however, literally is a contract buying and selling risk.[208] So, an insurance contract should quite explicitly spell out what risk each side bears or retains. If a homeowner buys what is represented as 'full' coverage, then that presents as an agreement that the only risk that the policyholder retains is the amount of the deductible. A policyholder may be oblivious either to a treacherous legal landscape or language within a lengthy and obtuse contract that seeks to reverse this intuitive understanding.[209]

But even in insurance contracts representing that the insured has full RCV, there often is wiggle language. The CDOI provides a tool that allows a homeowner to see exemplar insurance policies from various insurers.[210]

---

[205] July 13, 2018 email from Sean Scott to Ken Klein on file with author.

[206] e2Value, *supra* note 122.

[207] *See* Georges Dionne & Scott E. Harrington, *An Introduction to Insurance Economics*, FOUNDATIONS OF INSURANCE ECONOMICS: READINGS IN ECONOMICS AND FINANCE 2 (Georges Dionne & Scott E. Harrington eds., 1992) ("Risk is seldom completely shifted in any market.").

[208] *See id.* at 1-2 ("In the usual insurance example, risk averse individuals confronted with risk are willing to pay a fixed price to a less risk averse or more diversified insurer who offers to bear the risk at that price.").

[209] *See also* Klein, *supra* note 3, at 373-76 (discussing the special challenges of the often-obtuse language of insurance agreements).

[210] California Dept. Ins., *Homeowners Coverage Comparison Tool*, https://interactive.web.insurance.ca.gov/apex/f?p=143:16:0::NO(last visited April 2, 2018).

Using this tool, one can see that within the insurance agreement, "Farmers Smart Plan Home Policy California," is the language:

> The Coverage A (Dwelling) stated limit is the most we will pay if your dwelling sustains a loss. The actual cost to replace the dwelling at the time of loss may be different. We do not guarantee that the stated limit represents the actual cost to replace the dwelling.[211]

There are no similar clauses in posted insurance policies from other major home insurers. But similar language is quoted from an Allstate policy in a complaint file of the CDOI.[212]

And from occasional litigation files it is apparent that there are clauses that are not seen on the CDOI web site, because rather than reside in base insurance policies, they reside in renewal notices. In *Everett v. State Farm Gen. Ins. Co.*,[213] for example, the court quoted a clause that State Farm included with its insurance renewal notice:

> The State Farm replacement cost is an estimate replacement cost based on general information about your home. It is developed from models that use cost of construction materials and rates for homes like homes in the area. The actual cost to replace your home may be significantly different. State Farm does not guarantee that this figure will represent the actual cost to replace your home. You are responsible for selecting the appropriate amount of coverage and you may obtain an appraisal or contractor estimate which State Farm will consider and accept, if reasonable. Higher coverage amounts may be selected and will result in higher premiums.[214]

---

[211] Farmers Insurance, *Farmers Smart Plan Home Policy California* at 5.

[212] Administrative Rulemaking File for CAL. CODE REGS., tit.10, § 2695.183, *supra* note 4, at 163, 378-79 ("Allstate's estimated replacement cost...is...only an estimate.... The decision regarding the limit applicable to Coverage A...is your decision to make....").

[213] Everett v. State Farm Gen. Ins. Co., 162 Cal. App. 4th 649, 653 (2008).

[214] *Id*. at 816. Nearly identical language is found in a 2004 State Farm estimate now lodged in the public record. *See* Administrative Rulemaking File for CAL. CODE REGS., tit.10, § 2695.183, *supra* note 4, at 624. *Accord*

Additionally, a Complaint filed in California attached as an exhibit a form USAA sent to its insured at time of renewal stating:

> Our mission at USAA is to help protect your financial security. One way we do this is by helping you determine if you're adequately covered in the event of a loss. We can calculate the minimum rebuilding cost of your home based on your home characteristics, but only you can decide if this is enough coverage.[215]

There is no known compilation of renewal notice language (as opposed to base policies). It may be that variations of this contractual text are *very* prevalent in the industry, but primarily *only* in renewal notices. But that is speculation. What can be said with clarity is that just these four companies – Farmers, State Farm, Allstate, and USAA – measured by direct premium, represent 39.77% of all homeowner multi-peril insurance written in 2016.[216]

There also are 'meeting of the minds' challenges. No matter how clearly these clauses are written, there is some likelihood that policyholders are unaware of them. As one author of an insurance law treatise describes, "an insured relies not upon the text of the policies but upon the general description of the coverage provided by the insurer and its agents."[217] The insurance industry self-describes that homeowner are "fuzzy on the details" of their insurance policies.[218] In insurance-commissioned surveys, the point is confirmed -- according to "the results of a survey by Zogby International for MetLife Auto & Home," "[m]ore than two thirds (71 percent) of those

---

id. at vol. III, p. 799.

[215] Exh. A to Complaint and Demand for Jury Trial, *supra* note 134.

[216] National Association of Insurance Commissioners, *2016 Market Share Reports for Property/Casualty Groups and Companies by State and Countrywide*, 139 (2017), http://www.naic.org/prod_serv/MSR-PB-17.pdf.

[217] ROBERT H. JERRY, II, UNDERSTANDING INSURANCE LAW §32[b] (Mathew Bender, 2d ed. 1996); *accord* Thomas Holzheu & Ginger Turner, *The Natural Catastrophe Protection Gap: Measurement, Root Causes and Ways of Addressing Underinsurance for Extreme Events*, 43 GENEVA PAPERS ON RISK & INS. 37, 42 (2018).

[218] INS. INFO. INST., *supra* note 24, at 7. *Accord* Hassani, *supra* note 2, at 109-10.

surveyed believe insurance pays for the full cost to rebuild their property in the event of a major loss, such as a fire or other natural disaster."[219]

And then there are the possible parol evidence problems. As referenced earlier, State Departments of Insurance across the country advise homeowners to ask their insurer or agent for the amount of coverage necessary to replace a home.[220] Similarly, the National Association of Insurance Commissioners advises consumers, "Your insurance agent usually will help you decide how much dwelling coverage to buy when you get homeowners insurance," adding, "Your coverage should equal the full replacement cost of your home."[221]

These parol conversations occur with an indeterminable frequency. The CDOI asserts it has sometimes been "flooded" with homeowners reporting agents/brokers told them they had adequate coverage,[222] while the insurance industry calls those claims "hyperbole."[223] One example from the anecdotal work described above, however, may explain how these differing perceptions persist. In a transcribed chat, Insurer H – in response to the question, "Okay. I know you do not write Guaranteed Replacement Coverage (my old insurer did but I fear that I may no longer be able to renew

---

[219] *Homeowner Coverage Knowledge Gap Wide Among Consumers*, INSURANCE JOURNAL (Aug. 24, 2010), https://www.insurancejournal.com /news/national/2010/08/24/112704.htm.

[220] Texas Department of Insurance et al., *supra* note 69.

[221] National Association Insurance Commissioners, *A Consumer's Guide to Home Insurance*, 4 (2010), www.naic.org/documents/consumer_guide_home.pdf. *Accord* Collier & Ragin, *supra* note 62, at 1, 3.

[222] Appellant's Opening Brief, Ass'n. Cal. Ins. Cos. v. Jones, 2 Cal. 5th 376 (2017) (No. S226529) 2014 WL 508598, at *1; *see also* Appellant's Opening Brief on the Merits, Ass'n. Cal. Ins. Cos. v. Jones, 2 Cal. 5th 376 (2017) (No. S226529) 2015 WL 6114253, at *10. For an example of such a homeowner assertion, see what one homeowner wrote to the CDOI on September 2009: "We had a conversation with our agent … just after we completed a major remodel of our home.… The meeting took place at our home and our policy limits were reset as a result. During this conversation I made it clear that one of the reasons we were doing this was to ensure we were not in the position of the Cedar Fire people that ended up short on insurance. When I asked [the agent] if the amount he was recommending was sufficient to replace our house, he said yes." Administrative Rulemaking File for CAL. CODE REGS., tit.10, § 2695.183, *supra* note 4, at 906.

[223] Respondent's Brief, *supra* note 53, at *4-5.

in that form), but am I correct that if I do as you recommend then that is essentially what I have because I have all the coverage I need?" – answered: "Yes, that is correct."[224] Yet Insurer H – in a footnote to its written quote generated simultaneously with that transcribed chat – states:

> This represents an estimated minimum rebuilding cost…. Please keep this in mind when you determine sufficient coverage for your home. [Insurer H] cannot guarantee the rebuilding cost estimate will be sufficient in the event of a loss. Please remember it is your responsibility to…make sure your coverage is adequate to rebuild your home."[225]

In a telephone to call seeking to clarify this discrepancy, the insurer acknowledged that as to accurately estimating replacement cost, a homeowner is "not a builder, you're not gonna [sic] know that;" reassured that the insurer's estimates were "accurate over 90% of the time;" but noted the language was added to the written quote because it "was not a guarantee."[226]

Chubb Insurance's website provides another example of how insureds and insurers might come away with differing perceptions. The website says, "Chubb's in-house Risk Consultants can help determine the amount of coverage you need. …Using the information gathered during an in-home visit and incorporating the knowledge and experience Chubb has gained through thousands of interviews with building contractors each year, a Risk Consultant will estimate the replacement cost for your home."[227] Is that a representation that the homeowner can rely on the Chubb estimate, or is it not?

Similarly, the CDOI's Administrative Rulemaking File contains a document from 2004 where one insurance agency distributed to policyholders a 'FAQ' sheet that led with the question, "How do we know that the stated insurance amount is enough to cover our home or building?", and answered, "The dwelling amount is based on a current estimate of the replacement cost of the structure. It is not necessary to insure the land, the

---

[224] Transcript of chat with insurer H, *supra* note 192.

[225] Transcript of chat with insurer H, *supra* note 192.

[226] Telephone conversation with insurer H (Apr. 5, 2018) (on file with author).

[227] Chubb, *supra* note 13.

market value of the property, or the loan amount."[228] The document is silent on *whose* estimate is referred to.[229]

Based on compiling numerous anecdotal parol reports such as these, the CDOI survey concluded:

> In general, each insurer had its own replacement cost estimating tool and the value generated by this tool was considered (from the insurer's perspective) to be the minimum Coverage A limit for which the policy could be issued. Each insurer stated that the insured was responsible for making the limit selection based on his or her knowledge regarding the home, but was able to make use of the insurer's tool to assist with this selection. There were varying degrees of communication and disclosure to the insured regarding what the estimate generated by the insurer's tool represented, and regarding the insured's duty to determine the amount of coverage he or she determined to be appropriate.[230]

Then there are timing issues. As one academic center studying insurance notes, "Insurance is the only product for which consumers do not know what they are buying before they buy it. Insurance companies almost never provide copies of policy language or complete summaries of policy terms to prospective policyholders."[231]

Nonetheless, insurers still sometimes blame the policyholder for underinsurance.[232] Indeed, the first public comment offered in the "Homeowners Insurance Hearing" held by the CDOI in 2009 was: "In general, ACIC members believe that the responsibility for determining the level of coverage provided in a homeowner's insurance policy must be a decision that rests with the insured."[233]

---

[228] Administrative Rulemaking File for CAL. CODE REGS., tit.10, § 2695.183, *supra* note 4, at 329.

[229] Administrative Rulemaking File for CAL. CODE REGS., tit.10, § 2695.183, *supra* note 4, at 329.

[230] *Id.* at 1029.

[231] Rutgers Center for Risk and Responsibility, *Essential Protections for Policyholders*, 10 (2016), http://uphelp.org/sites/default/files/guides/epp_10-18-2016.pdf (last visited April 2, 2018).

[232] *See, e.g.*, Klein, *supra* note 3, at 364-65.

[233] Administrative Rulemaking File for CAL. CODE REGS., tit.10, § 2695.183, *supra* note 4, at 424-26, 1114. Similarly, a document Farmers

If one were to posit that the homeowner bears the primary responsibility for selecting adequate coverage limits, then the next question would be to ask precisely *how* the homeowner could discharge that responsibility? Because generally the homeowner does not *actually* have the knowledge or expertise to calculate the cost of rebuilding their home, and is almost never the one being asked to determine that cost.[234] Much more typically, as one homeowner wrote after losing her home to fire in 2007:

> When my agent wrote our policy, he asked me only a few questions …. I answered each every [sic] question that he asked of me. The fact that some characteristics were not included is because I was not asked. Since I am not in the business of insuring a home's replacement value, I had no idea what questions or what characteristics should be included.[235]

Insurance Group sent to insureds entitled, "Make sure you're not under-insured", that says among other things: We want to help you choose the amount of coverage that is right for you.…The information we have on record about your home is important because with each renewal offer, we use it to calculate a reconstruction cost estimate. You can use the estimate as a guide to help you choose the amount of coverage you want for your home. If you don't have enough coverage, you could be under-insured. If you don't have enough coverage, you could be under-insured. And if your house were totally destroyed, that could mean being unable to pay for complete reconstruction.… The reconstruction cost estimate can serve as a guide, but it is your responsibility to choose the Coverage A limit that is right for you.… You may choose Coverage A limit higher than the estimate, or you have the option to reduce the limit to an amount equal to the estimate.

[234] *See* Appellant's Opening Brief on the Merits, *supra* note 222, at *8 ("The Senate Banking, Finance and Insurance Committee…noted that homeowner' lack of knowledge about construction costs, and improperly trained insurance industry personnel estimating replacement costs, contributed to underinsurance. The Committee declared that it is "*critical* that initial policy limits be set accurately and updated regularly."). *Accord* note 226 *supra* and accompanying text. *See also* note 220.

[235] Administrative Rulemaking File for CAL. CODE REGS., tit.10, § 2695.183, *supra* note 4, at 105. *Accord id*. at 218 ("Not being experts about either the cost of new home building or home insurance, we accepted the policy as written by USAA."), at 723 ("My husband and I have no experience

As another wrote:

> I lost my cabin in the 2007 Slide Fire. I an [sic] underinsured because State Farm not doing their job [sic]. They denied my claim, with some nebulous nonsense. According to them, they do not insure for an amount, just an estimate. I am suppose [sic] to know what and how to insure? I'm suppose [sic] to be the expert? Are they or are they not in the insurance business? Do they know or know what they are doing? They advertise that they are the professionals and behind you, but you couldn't prove it my [sic] me after this past year.[236]

Yet producers also lack the time or expertise. Producers simply use the cost estimators given to them, and often apply shortcuts (doomed to understate coverage) embedded and promoted in the software (and which the compensation structures incentivize the agents to apply).[237]

There is little a homeowner can do to remedy this problem. Per I.I.I. literature written to homeowners, other than relying on an insurance agent, a homeowner could "call your local real estate agent [or] builders association …."[238] This recommendation is incongruous with other advice from I.I.I. Real estate agents are experts on home values. The I.I.I. emphasizes that there is a difference between the price of a home and the cost to rebuild a home.[239] Market value and replacement cost simply are distinct conceptually.[240] It seems fantastical to suppose that a real estate agent would

---

or expertise in any phase of construction of homes or costs and did not question the amounts [comprising the estimated replacement cost].").

[236] Administrative Rulemaking File for CAL. CODE REGS., tit.10, § 2695.183, *supra* note 4, at 822.

[237] *See infra* sections III.B.1.a & III.B.2.a, fns. 33 & 34 and accompanying text.

[238] INS. INFO. INST., *supra* note 71. *See also* Barry Zalma, *Uncovered: Who's Responsible for Setting Policy Limits?*, CLAIMS MAG., June 2017 at 22, 23.

[239] INS. INFO. INST., *supra* note 72, at 2 ("The amount of insurance you buy should be based on rebuilding costs, not the price of your home. The cost of rebuilding your house may be higher (or lower) than the price you paid for it or the price you could sell it for today.").

[240] *See, e.g.*, *Replacement Cost vs. Market Value*, STATE FARM MUT. AUTOMOBILE INS. CO., https://www.statefarm.com/simple-insights/planning/replacement-cost-vs-market-value. (last visited Jan. 8, 2019); James

– in a context where there are potential legal liability consequences to error – estimate rebuild costs of a home. It simply is not their core competency or expertise.

Builders similarly are a misfit to supporting a policyholder's need to determine of adequate coverage. The entire business model of Verisk is that they can sell that expertise to, among others, building contractors because builders too lack the knowledge, inclination, or expertise.[241] As one amici wrote to the California Supreme Court, "contractors are not in the business of providing free estimates for hypothetical construction projects." And if they were, they likely would do it poorly.[242]

The homeowner simply is not positioned to determine the adequacy of coverage. Nonetheless, the legal landscape often reaches a different conclusion.

B. THE REGULATORY LANDSCAPE

One former state Deputy Director of Insurance suggests that state Insurance Commissioners have the power to collect the data necessary to address underinsurance, have collected the information, but largely have done nothing with it.[243]

It is possible for insurance regulators to put a thumb on the scales of risk shifting. California regulators have done so. Effective June 27, 2011, the CDOI adopted a new regulation standardizing the components of an insurer's

---

Siebers, *Market Value vs. Replacement Cost*, CORELOGIC https://www.corelogic.com/blog/2016/03/market-value-vs-replacement-cost.aspx.

[241]*See, e.g.*, Xactware, *Xactware Webcast.: Introducing Restoration Manager: Helping Contractors Get a Read on Their Business*, https://www.xactware.com/en-us/resources/webcasts/upcoming-webcasts/introducing-restoration-manager---helping-contractors-get-a-bead-on-their-business/ (last visited Apr. 8, 2018); 360Value, *supra* note 93, at 8 ("Xactimate...is used by...80 percent of insurance repair contractors"); *Accord* Appellant's Reply Brief, Ass'n. of Cal. Ins. Cos., 235 Cal. App. 4th 1009 (2015) (No. S226529) 2014 WL 3014611, at *8 ("A contractor can bill the homeowner for cost overruns during construction, but the homeowner cannot receive coverage over the limits of a replacement cost policy.").

[242] Amicus Brief of United Policy Holders, *supra* note 81, at *16-17; Whatley, *supra* note 106, at 5, 7-8.

[243] Berry, *supra* note 15.

replacement cost estimate.[244] The regulation requires insurers write RCV utilizing cost estimating to account for several delineated features of the insured home:

(1) Cost of labor, building materials and supplies;
(2) Overhead and profit;
(3) Cost of demolition and debris removal;
(4) Cost of permits and architect's plans; and
(5) Consideration of components and features of the insured structure, including at least the following:
  (A) Type of foundation;
  (B) Type of frame;
  (C) Roofing materials and type of roof;
  (D) Siding materials and type of siding;
  (E) Whether the structure is located on a slope;
  (F) The square footage of the living space;
  (G) Geographic location of property;
  (H) Number of stories and any nonstandard wall heights;
  (I) Materials used in, and generic types of, interior features and finishes, such as, where applicable, the type of heating and air conditioning system, walls, flooring, ceiling, fireplaces, kitchen, and bath(s);
  (J) Age of the structure or the year it was built; and
  (K) Size and type of attached garage.[245]

Importantly, the regulation distinguishes between insurers and producers. One of the changes that insurance agents successfully lobbied for in the California regulations was to clarify that when producers were using tools that were provided to them by insurers, if the tools estimated in error, then that was on the insurer, not on the producer.[246]

But California's intervention by regulation may not be a panacea. Just as tobacco companies relied on the government-mandated health warnings on a package of cigarettes as a defense to a charge that smokers

---

[244] CAL. CODE REGS. tit. 10, § 2695.183 (2011).

[245] § 2695.183.

[246] Administrative Rulemaking File for CAL. CODE REGS., tit.10, § 2695.183, *supra* note 4, at 1489-96.

were not adequately warned, compliance with the insurance regulation might provide a defense to insurers if the resulting estimate is still too low.[247]

C. THE LEGISLATIVE LANDSCAPE

It is, of course, possible for a state to legislatively step into the underwriting landscape, rather than leaving the matter to courts or regulators. Fourteen states affirmatively prohibit the policyholder, an insurer, and/or an agent from knowingly agreeing to over-insure.[248] For example, Minnesota law provides, "No company shall knowingly issue any policy upon property in this state for an amount which … exceeds the replacement cost of the buildings …."[249]

Colorado law provides that before issuance or renewal of full replacement cost homeowner insurance (defined as the dwelling limit is equal to or greater than the estimated replacement cost of the residence) the insurer shall make available at least ten percent extended replacement cost coverage.[250]

Florida law provides, "prior to issuing a homeowner's insurance policy, the insurer must offer … a policy or endorsement providing … replacement costs to the dwelling…."[251]

Conversely, while it is an ever-changing landscape, roughly twenty states have valued policy laws requiring that in the event of a total loss an insurer must pay the coverage limit of the policy whether the actual replacement cost reaches (or exceeds) this value or not.[252]

---

[247] *See* Cipollone v. Liggett Grp., Inc., 505 U.S. 504, 520-21 (1992).

[248] ALASKA STAT. § 21.60.010 (2014); GA. CODE ANN. § 33-6-5(6)(A) (West 2011); HAW. REV. STAT. ANN. § 431:10E-102 (West 2005); KY. REV. STAT. ANN. § 304.20-260 (West 2006); MINN. STAT. ANN. § 65A.09 (West 2005); MISS. CODE ANN. § 83-13-5 (West 1999); NEB. REV. STAT. ANN. § 44-603 (West 2010); N.J. REV. STAT. ANN. § 17:36-5.19 (West 1994); N.C. GEN. STAT. ANN. § 58-43-5 (West 2009); OR. REV. STAT. ANN. § 742.200 (West 2015); S.C. CODE ANN. § 38-75-20 (2002); TENN. CODE ANN. § 56-7-801 (West 2000); WASH. REV. CODE ANN. § 48.27.010 (West 2010); WYO. STAT. ANN. § 26-23-101 (West 2011).

[249] MINN. STAT. ANN. § 65A.09(1) West (2005).

[250] COLO. REV. STAT. ANN. §10-4-1108(6)(a) (West 2013).

[251] FLA. STAT. ANN. § 627.7011 (West 2011).

[252] *See* Molk, *supra* note 11, at 362, 364, 386.

D. THE JURISPRUDENTIAL LANDSCAPE

A comprehensive review of caselaw broadly addressing coverage adequacy in contract and tort law is beyond the scope of a subsection within an article.[253] But there is a somewhat discrete set of published cases addressing the argument that coverage is ultimately the homeowner's responsibility.[254]

In *Everett v. State Farm Gen. Ins. Co.*,[255] Ms. Everett – whose San Bernardino, California home initially was insured with a stated dwelling replacement cost but had guaranteed replacement (read: unlimited) coverage – had for several years had full replacement (read: limited) coverage annually renewed with notices reminding her it was "her responsibility to insure her home with adequate coverage."[256] After her home burned down in 2003, she sued State Farm both in contract and tort alleging that even with a coverage limit extension she was underinsured.[257] The appellate court affirmed the trial court's entry of summary judgment for State Farm, holding the policy had limited dwelling replacement coverage in clear and unambiguous language, "nothing in the record suggests that the original policy limits were insufficient," and it was not State Farm's duty to maintain adequate limits.[258]

In *Bryce v. Unitrin Preferred Ins. Co.*,[259] after a 2006 fire destroyed the Bryce's home in Georgetown, Texas, the Bryces learned their 'replacement cost' insurance was "grossly inadequate."[260] For several years, the Bryces had been involved in a series of conversations about coverage and policy renewal, beginning when the Bryces changed insurers and opted to keep the prior insurer's coverage limits in place;[261] of these most notably the

---

[253] *See* Joshua Fox, Comment, *Softening the Short Shrift: Regulating Homeowners Insurance Limits as Causes of Underinsurance*, 46 CAL. W. L. REV. 369 (2010) (providing a broad summary of the case law).

[254] Hassani, *supra* note 2, at 81-83; *accord* Ramsay & Heffernan, *supra* note 169, at 2-4.

[255] Everett v. State Farm Gen. Ins. Co., 162 Cal. App. 4th 649 (2008).

[256] *Id.* at 652-53.

[257] *Id.* at 653-54.

[258] *Id.* at 657-61.

[259] *Bryce v. Unitrin Preferred Ins. Co.*, No. 03-08-00670-CV, 2010 WL 01253579 (Tex. Ct. App. Apr. 1, 2010).

[260] *Id.* at *1.

[261] *Id.* at *1-*3.

agent recalled recommending the Bryces consult with a builder on determining replacement cost, while the Bryces recalled being told by the agent that the insurance was adequate.[262] "After hearing the evidence, the jury returned a unanimous verdict that the Bryces' negligence alone proximately caused their home to be underinsured."[263] The appellate court affirmed.[264] The appellate court noted Texas law, "does not, as the Bryces contend, create a duty on the part of either an agent or an insurance carrier to monitor an insured's policy in order to ensure that the requested coverage is adequate."[265] Further, an insurer inspection of a home – per the Texas court – is for the benefit of the insurer, not the insured.[266]

In *Furtak v. Moffett*,[267] after a 1992 fire destroyed the Furtaks' Highland Park, Illinois home, the Furtaks found themselves with insurance of roughly 1/6th the appraised value of their home.[268] The Furtaks claimed that in 1975 when they purchased the home, they requested insurance agent "Moffett provide insurance that would fully cover their home against all loss, and Moffett offered them a policy that would fully cover their home even in the worst case scenario."[269] There was no home inspection and there was a notation that the home was being completely renovated and remodeled.[270] The insurance was renewed for the next 15 years, without inquiry from the agent or notice from the homeowner about the outcome of the renovations and remodeling.[271] At trial, the Furtaks conceded that under Illinois law it was their burden to know the contents of their policy, to draw any discrepancies to the insurer's attention, and that the insurer had no duty to review the adequacy of coverage; nonetheless, the Furtaks contended that the insurer – Farmers – had voluntarily undertaken a duty to determine adequacy of coverage of its insureds through a series of actions, but had failed to do so for the Furtaks.[272] The appellate court held, "The fact that defendants instituted procedures to determine whether their insureds were

---

[262] *Id.* at *2-*3.
[263] *Id.* at *4.
[264] *Id.* at *10.
[265] *Id.* at *5.
[266] *Id.* at *7-*8.
[267] *Furtak v. Moffett*, 671 N.E. 2d 827 (Ill. 1996).
[268] *Id.* at 829.
[269] *Id.*
[270] *Id.*
[271] *Id.*
[272] *Id.*

underinsured and Farmers encouraged their agents to inform their insureds that they should evaluate the adequacy of their coverage does not impose upon them a duty to warn plaintiffs of their inadequate insurance."[273] As to any breach of oral contract claim, the appellate court rejected it as contrary to the Illinois statute of frauds.[274]

In *Schanz v. New Hampshire Ins. Co.*, [275] a 1979 fire completely destroyed the plaintiffs' building in Saginaw, Michigan.[276] The building owners and their insurance agent agreed that an insurer – Aetna – appraised the building and set the replacement cost of the building.[277] The building owners and their insurance agent then used that appraisal to place insurance with the defendant insurer because it came at a cheaper premium than Aetna quoted.[278] The defendant insurer then did their own inspection and estimate – a higher replacement coverage was estimated – and plaintiffs insured to that new figure.[279] After the fire, the true replacement cost was over double any figure any insurer estimated.[280] On these rather dramatic facts, the plaintiffs sued asserting negligence, they won at trial, and the appellate court affirmed.[281] The appellate court affirmed the trial court's ruling that the defendant – having voluntarily undertaken to inspect the property knowing the plaintiffs would rely on the findings of that inspection – negligently caused the property to be underinsured.[282] In contrast to *Schanz*, in *Chemical Technology, Inc. v. Berkshire Agency, Inc.*,[283] the court confirmed that in Michigan, unless something changes the usual situation of agents taking orders from customers, generally, "insurance agents have no duty to advise the inured regarding the adequacy of insurance coverage."[284]

---

[273] *Id.* at 830.

[274] *Id.*

[275] *Schanz v. New Hampshire Ins. Co*., 418 N.W.2d 478 (Mich. 1988).

[276] *Id.* at 479.

[277] *Id.* at 480.

[278] *Id.*

[279] *Id.*

[280] *Id.*

[281] *Id.* at 481, 484.

[282] *Id.* at 482-83.

[283] *Chemical Technology, Inc. v. Berkshire Agency, Inc.*, No. 326394, 2016 WL 4008455, at *1 (Mich. Ct. App. July 26, 2016).

[284] *Id.* at *2 (quoting Harts v. Farmers Ins. Exch., 597 N.W.2d 47, 50 (1999)).

In *Peterson v. Big Bend Ins. Agency, Inc.*,[285] when the Petersons purchased homeowner insurance they "explained their desire to have their home insured for the full replacement value."[286] "The Petersons indicated they did not know what the cost of this coverage would be or how such a figure would be determined."[287] Their insurance agent used software identified as the "Boeckh Cost Guide" (per the court, "this software, or a similar program, is a standard in the insurance industry") to estimate the cost to replace the home in the event of a total loss.[288] This involved personal inspections of the exterior, as well as drawn diagrams of the home (and later describing some of the information in writing to the homeowner, but actually calculating replacement value differently than as described).[289] When their home was destroyed by fire, their coverage was less than 2/3rds of the true replacement value.[290] On these facts, the trial court found the defendant negligent for providing an estimate represented as calculated one way when in fact it was calculated another way.[291] The appellate court affirmed, but only because the agent did not use the Boeckh calculator – the court found that if the agent had done so then there would be no liability.[292]

No wonder, as one California lawyer and insurance consultant wrote in 2017:

> […]it is incumbent on the agent or broker to remind the applicant for insurance to set appropriate limits to avoid underinsurance…. When an insured loses everything in a catastrophe, he or she calls an insurance agent, insurance broker or insurance company to make a claim. When the claim is made, the insured is reminded of the limit

---

[285] *Peterson v. Big Bend Ins. Agency, Inc.*, 202 P.3d 372 (Wash. Ct. App. 2009).

[286] *Id.* at 374.

[287] *Id.* at 375.

[288] *Id.*

[289] *Id.*

[290] *Id.* at 374.

[291] *Id.* at 376.

[292] *Id.* at 377-78 (quoting, Gates v. Logan, 862 P.2d 134, 136 (Wash. Ct. App. 1993) ("Ordinarily the insured knows the extent of his personal assets and ability to pay increased premiums better than the insurance agent.") and Virgil R. Lee & Son, Inc., 754 P.2d 155, 157 (Wash. Ct. App. 1988) ("[I]t is the insured's responsibility to advise the agent of the insurance he wants, including the limits of the policy to be issued.")).

> of liability chosen, only to find it is inadequate to replace the house…. The insured will be angry and unwilling to accept the fact that the inadequate policy limit is due to his or her error. Suits are filed…only to find that the court will not cure the insured's mistake.[293]

Or as Professor Tom Baker writes, "insurance coverage litigation is simultaneously about abandonment and greed."[294]

So where does this leave the question of who bears the financial risk of any discrepancy between estimated and actual replacement costs? The answer is that it is mixed. But that with some frequency, the policyholder bears the risk.

An example from litigation concretely illustrates the matter. When – in the wake of the 2017 Northern California wildfires – a group of USAA insureds sued USAA and Xactware, USAA demurred (the California procedural device for a pre-answer attack on the basis of the failure to state a claim) asserting it was only responsible for the contracted for policy limits, while Xactware demurred asserting it had no legal privity with individual policyholders.[295] Both entities looked at the legal landscape and saw they could assert a plausible, possible safe harbor *even if* each knowingly understated the replacement cost of the insured homes.[296]

This is why a 2011 article concludes:

---

[293] Zalma *supra* note 238, at 23; a*ccord* Michael J. Geiger & Gregory J. Schwartz, *Phantom Insurance Coverage in the New Underinsurance Gambit*, 10 ENVTL. CL. J. 5 (1998).

[294] Tom Baker, *Sales Stories, Claims Stories, and Insurance Contract Damages*, 72 TEX. L. REV. 1395, 1396 (1994).

[295] Defendant United Services Automobile Association's Notice of Demurrer and Demurrer to Plaintiffs' Second Amended Complaint; Memorandum of Pints and Authorities in Support of Thereof, Bivin et al. v. United Services Auto. Ass'n et al., No. SCV261717 (Super. Ct. Cal. County of Sonoma, Apr. 5, 2018); Defendant Xactware Solutions, Inc.'s Notice of Demurrer and Demurrer to Plaintiffs' Second Amended Complaint; Memorandum of Pints and Authorities in Support Thereof, Bivin et al. v. United Services Auto. Ass'n et al., No. SCV261717 (Super. Ct. Cal. County of Sonoma, June 6, 2018).

[296] *Id.*

> Homeowner insurance policyholders are ill-equipped to determine the appropriate limits for their insurance policies. The current legal framework defining insurers' obligations to their insureds does not effectively account for this reality, in turn providing an incentive for insurers to sustain ambiguity and confusion regarding a duty to accurately assess replacement costs.[297]

VI. MORAL HAZARD-LIKE PROBLEMS ENCOURAGING PERVASIVE, UNWITTING UNDERINSURANCE

Insurers are neither charities nor churches. Insurers do not pay claims because insureds need the money, or because it is the 'right' thing to do.[298] Insurers pay claims because they legally are obligated to do so. And as for-profit businesses, if regulators, legislators, and courts permit insurers to increase profits by precisely navigating the intersection of coverage limits and replacement cost estimating, then one should expect insurers to do so.

But that still leaves hanging out there the question: If homeowners are willing to pay for full and adequate RCV and producers have incentives to sell full and adequate RCV, then why would an insurer either want to or knowingly tolerate the sale of nominally full but actually inadequate RCV? The short answer is an insurer may be rewarded for underinsuring and may be punished for over-insuring. Put another way, because the legal landscape protects insurers from the consequence of inadequate coverage, the aspects of cost estimating that result in nominally full but actually inadequate coverage turn out to be features rather than glitches.

A. UNDERINSURING CAN BE PROFITABLE FOR INSURERS

Altered incentives analogous to moral hazard concerns encourage an insurer to underinsure. There is no single, accepted definition of "moral hazard."[299] Krugman's definition – "any situation in which one person makes the decision about how much risk to take, while someone else bears the cost

---

[297] Fox, *supra* note 253, at 394.

[298] *See* Tom Baker, *Insuring Morality*, 29 ECON. & SOC'Y. 559 (2010) (discussing the narratives and counter-narratives of morality in insurance).

[299] David Rowell & Luke B. Connelly, *A History of the Term "Moral Hazard"*, 79 J. RISK & INS. 1051 (2012); *accord* Tom Baker, *On the Genealogy of Moral Hazard*, 75 TEX. L. REV. 237 (1996).

of things going badly"[300] – is a quite workable big tent to encapsulate the many iterations of the concept.

In insurance, there is much contemporary work on moral hazard.[301] In the context of predicting behaviors of insureds, simply stated, "Moral hazard refers…to the tendency of insurance protection to alter an individual's motive to prevent loss."[302] Molk writes, "Moral hazard is a dominant concern of insurance companies…."[303] But as Molk shows, at least in the context of homeowner insurance, there is considerable question whether the predictions the theory of moral hazard makes about policyholder behavior are confirmed by actual behavior.[304]

The theory of moral hazard actually seems to fare better in explaining actual behaviors of insurers.[305] For example, when a state

---

[300] *See* KRUGMAN, *supra* note 10, at 63; *Definition of 'Moral Hazard'*, *supra* note 10, ("Moral hazard is a situation in which one party gets involved in a risky event knowing that it is protected against the risk and the other party will incur the cost.").

[301] *See, e.g.*, Kenneth J. Arrow, *The Economics of Moral Hazard: Further Comment*, *in* ESSAYS IN THE THEORY OF RISK BEARING (Julius Margolis, ed.) (Markham 1971); Ralph A. Winter, *Optimal Insurance Under Moral Hazard*, *reprinted in* GEORGES DIONNE, HANDBOOK OF INSURANCE 155-183 (Georges Dionne ed., 2000) (describing how moral hazard leads to less than full insurance); Baker, *supra* note 293; Tom Baker, *Containing the Promise of Insurance: Adverse Selection and Risk Classification*, 9 CONN. INS. L.J. 371 (2003); Baker, *supra* note 298; John M. Marshall, *Moral Hazard*, 66 AM. ECON. REV. 880 (1976); J.A. Mirreles, *The Theory of Moral Hazard and Unobservable Behaviour: Part I*, 66 REV. ECON. STUDIES 3 (1999); Mark V. Pauly, *The Economics of Moral Hazard*, 58 AM. ECON. REV. 531 (1968); Steven Shavell, *On Moral Hazard and Insurance*, 92 QUART. J. ECON. 541 (1979).

[302] Shavell, *supra* note 301, at 541. Under this definition, the general presumption is that full insurance coverage encourages risky behavior and so an insurer should not offer full coverage, but that if the cost of monitoring insured's behavior is minimal, then coverage approaching full insurance is optimal. *Id*. at 541-42.

[303] Molk, *supra* note 11, at 349.

[304] *Id.* at 350-51, 392-93.

[305] *See, e.g.*, Neil Bhutta & Benjamin J. Keys, *Eyes Wide Shut? The Moral Hazard of Mortgage Insurers During the Housing Boom*, (Nat'l. Bureau of Econ. Research, Working Paper No. 24844, 2018),

guarantees life insurance proceeds in the event of insurer insolvency, life insurers more frequently hold highly leveraged portfolios composed of risky assets.[306] The same effect can be seen by banks in response to FDIC insurance: "It has been demonstrated both theoretically and empirically that deposit insurance for commercial banks and savings and loan associations (S&Ls) creates a moral hazard problem by shielding creditors from the consequences of risk taking."[307] Economists see similar behavior by property-casualty insurers in response to the likelihood of state and federal disaster recovery resources.[308] As Tom Baker has explored and explained, one should fully expect that an insurer will be the economically, ruthlessly opportunistic actor predicted by the theory of moral hazard.[309]

Replacement cost estimators do not give insurers control over the quantity of risk they underwrite, nor do they lead to insurers mis-pricing the risk. Rather, replacement cost estimators create an asymmetry of understanding between an insurer and a policyholder of quantity of risk being sold. Policyholders think they are buying truly full replacement coverage while insurers know the likelihood that the coverage limits could be inadequate. Economists might differ about whether this is a classic 'moral hazard problem.' But it unquestionably is an opportunity for an opportunistic, profit-maximizing motivated actor.

---

http://www.nber.org/papers/w24844 (documenting moral hazard behavior of private mortgage insurers).

[306] Elijah Brewer III, Thomas S. Mondschean, & Philip E. Strahan, *The Role of Monitoring in Reducing the Moral Hazard Problem Associated with Government Guarantees: Evidence From the Life Insurance Industry*, 64 J. RISK & INS. 301, 304, 320 (1997); Brian J. Hall & and James G. Bohn, *The Moral Hazard of Insuring the Insurers* (Nat'l Bureau of Econ. Research, Working Paper No. 5911, 1997), https://ssrn.com/abstract=225693.

[307] Brewer, Mondschean, Strahan, *supra* note 306, at 301-04.

[308] *See, e.g.*, Paul Hudson, W.J. Wouter Botzen, Jeffrey Czajkowski, & Heidi Kreibich, *Moral Hazard in Natural Disaster Insurance Markets: Empirical Evidence from Germany and the United States*, 93 LAND ECON. 179 (2017); Carolyn Kousky & Leonard Shabman, *The Hazard of the Moral Hazard – or Not*, NAT. HAZARDS OBSERVER (May 2013), https://hazards.colorado.edu/uploads/observer/2013/may13_observerweb.pdf; George L. Priest, *The Government, the Market, and the Problem of Catastrophic Loss*, 12 J. RISK & UNCERTAINTY 219 (1996).

[309] *See* Baker, *supra* note 298.

An insurer knows – through years of accreted experience – that costs estimators pervasively calculate full replacement cost profoundly low. Insurers perceive that the customer is a low-information, price elastic customer; i.e., a customer likely to be attracted to a low premium and unlikely to be sensitive to the risk attendant to it.[310] Most "underinsureds" will not ever sustain a total loss exposing the risk.[311] Should that risk materialize, some insureds will be litigation averse (for any host of reasons including, perhaps, learning of the uncertain legal landscape) and thus not challenge the claims adjustment; of those who do, many either will settle at below the uninsured portion of the loss or will simply lack the resources to see the dispute through; and of the subset who do see the dispute through, only some will recover the entirety of the uninsured portion of the loss.[312] Thus, if an insurer believes the net amount ultimately paid over stated coverage limits (including marginal additional Loss Adjusting Expenses) will be exceeded by the additional net premium captured by lowering full RCV coverage limits, then the insurer should underestimate replacement cost.[313] Or put another way, an insurer who thought that the insured bore the

---

[310] *See* Ramsay & Heffernan, *supra* note 169, at 10-11; a*ccord* Insurance Brokers and Agents of the West, *supra* note 68.

[311] *See, e.g.*, INS. INFO. INST., *supra* note 183 ("About one in 290 insured homes has a property damage claim related to fire and lightning."); *id.* at 183 ("In 2014, 5.46% of insured homes had a claim, according to ISO. Property damage, including theft, accounted for 95.9% of those claims." The average insurance claim is for less than $10,000); Klein, *supra* note 3, at 353-54 (in 2007, one-twentieth of one percent of U.S. homes had a disaster loss forcing relocation from the home).

[312] *See generally* Baker, *supra* note 294, at 1430-31 (describing some of the strategic behaviors of insurers to minimize the claims experience); Feinman, *supra* note 3, at 31-33, 80-85; Rutgers Center for Risk and Responsibility, *supra* note 231, at 37-44; a*ccord* Molk, *supra* note 11, at 46 (positing that one explanation of his data on valued policies is that "*insurers* understand the legal playing field and price their policies accordingly").

[313] Howard Kunreuther, *The Role of Insurance in Reducing Losses from Extreme Events: The Need for Public-Private Partnerships*, 40 GENEVA PAPERS ON RISK & INS. 741, 750-51 (2015) ("Insurance premiums should be based on risk to provide individuals with accurate signals as to the nature of the hazards they face and to encourage them to engage in cost-effective mitigation measures to reduce their vulnerability. Risk-based premiums should also reflect the cost of capital that insurers need to integrate into their

risk of understated coverage limits and who thought that this would capture more gross premium would not be troubled by, and indeed might be enthused by, an underwriting tool and process that understated full replacement cost.[314]

Indeed, the Commissioner of the CDOI defended its RCV regulation (requiring RCV calculations, if done, to include at least twelve delineated components) to the California Supreme Court, at least in part, on the

---

pricing to assure an adequate return to their investors."). The premise of insurance is risk-spreading among the pool of insureds –moral hazard as a theory of reducing insurance coverage should be inconsistent with this premise –but that is assuming that the premium has been calculated in an actuarially sound manner. Marshall, *supra* note 295, at 880. Premium priced accurately is loss risk plus underwriting and other transactions costs and profit. *See, e.g.*, Paul L. Joskow, *Cartels, Competition and Regulation in the Property-Liability Insurance Industry*, 4 BELL J. ECON. & MGMNT. 375, 377-78 (1973), reprinted IN FOUNDATIONS OF INSURANCE ECONOMICS: READINGS IN ECONOMICS AND FINANCE 469, 470-71 (Georges Dionne & Scott E. Harrington, eds., Kluwer 1991) (Georges Dionne & Scott E. Harrington, eds., Kluwer 1991) ("Insurance is generally a 'bad bet.' That is to say, the premium is generally greater than the expected property loss without insurance. The difference between premiums and losses over time is made up of underwriting and transaction costs and the profit of the insurance firms."). *Accord* Insurance Services Office, *supra* note 63, at 4 ("An insurer willing to pay the price of sufficient catastrophe insurance could have trouble competing for business."); "Documents for which print copy is practically available:" Whitepaper, e2Value, *How to Buy Data and Why Buy Data 2*, http://e2value.com/wp-content/uploads/2015/03/E2Value_WP.pdf. ("Discrepancies between the estimation in a home valuation and the ultimate cost of rebuilding can present financial risk to firms who don't get it right."); Roman Inderst & Marco Ottaviani, *Misselling through Agents*, 99 AM. ECON. REV. 883 (2009). *See also* Collier & Ragin, *supra* note 62, at 1 ("sellers have incentives to overstate a contract's benefits or to recommend suboptimal products"), citing Inderst and Ottaviani. *See also* Howard C. Mahler, *An Introduction to Underwriting Profit Models* (1987), https://www.casact.org/pubs/proceed/proceed85/85239.pdf.

[314] *See* Feinman, *supra* note 3, at 136-38; *accord* Bhutta & Keys, *supra* note 305, at 11.

assertion that insurers were affirmatively misleading homeowners into believing that homeowners had adequate replacement coverage:

> We must bear in mind that the estimate here is of *replacement cost,* which is defined to mean "the amount that it would cost the insured to repair, rebuild, or replace the thing lost or injured, without a deduction for physical depreciation, or the policy limit, whichever is less." …A consumer would reasonably believe that an estimate would have considered basic cost components, she would rely on that estimate to set the limit of liability on the policy, and she would be bound by that limit in the event of a loss. An incomplete estimate would result in a low estimate for the primary dwelling (Coverage A) and would mislead a consumer into believing that the coverage limit selected as a result of the incomplete estimate is sufficient when in fact it is not sufficient to rebuild a home. …an insurer would or should know that an estimate based on incomplete data is misleading.[315]

The California Supreme Court found, "The Commissioner could reasonably conclude that replacement cost estimates are likely to mislead the public about the actual cost of repair or replacement when they willfully omit cost components essential to repairing or rebuilding a dwelling."[316] The Court rejected the challenge to the regulation.[317]

One might find implausible this explanation of why an insurer might want to underinsure. But the fact remains that insurers routinely *do* underinsure, underinsure by very large margins, and have been doing so now for decades. The standard in the industry used to be guaranteed replacement coverage, but for the last almost thirty years it has been RCV with coverage limits.[318] And it bears keeping in mind that the RCV estimation tools claim to already price in inflation, building cost changes, local market cost variability, catastrophe risk, and demand surge. If full replacement coverage limits nonetheless *still* routinely are materially below actual, accurately

---

[315] Appellant's Opening Brief, *supra* note 222, at *12-13 (internal footnote omitted).

[316] Ass'n of Cal. Ins. Cos. v. Jones, 386 P.3d 1188, 1203 (Cal. 2017).

[317] *Id.* at 401.

[318] *See supra* Klein, note 3, at 364; Feinman, *supra* note 3, at 135-36.

estimated, full replacement costs (they are), then insurers know it and have known it for a while.[319]

A bit more needs to be said about one price inflator in particular – natural disaster. One might posit that what is occurring is the unanticipated consequence of natural catastrophes. But the insurance industry asserts it has solved this challenge: "Catastrophe models have been developed and improved over the past 25 years to more accurately assess the likelihood and damages resulting from disasters of different magnitudes and intensities. Today, insurers and reinsurers utilize the estimates from these models to determine risk-based premiums and how much coverage to offer in hazard-prone areas."[320] Today, the insurance industry in general, and Verisk and CoreLogic in particular, deeply study wildfire and other catastrophe risk,[321] and claim they now can expertly underwrite such risk even at the granularity forecasting risk to an individual house.[322] And indeed, contrary to intuitive

---

[319] In the public record of underinsurance complaints after wildfires in California in 2007, there are repeated references to insurers using Xactware, RCT, MSB, or generic 'cost estimators' – each of these is an instance where the resulting estimated RCV led to underinsurance. *See, e.g.*, Administrative Rulemaking File for CAL. CODE REGS., tit.10, § 2695.183, *supra* note 4, at 74, 146, 154, 186, 196, 227, 371, 417, 442, 464, 520, 620, 624, 678, 689, 699, 717, 745, 769, 834-35, 969, 974, 993. Guaranteed replacement coverage stopped being the 'norm" roughly twenty-five years ago. *See supra* Klein, note 3, at 364; Feinman, *supra* note 3, at 135-36. Insurers have had two and a half decades of experience with understated replacement costs from cost estimators.

[320] Kunreuther, *supra* note 313, at 750.

[321] *See* INS. INFO. INST., *supra* note 157; VERISK, *supra* note 157.

[322] *See, e.g.*, Scott G. Stephenson, *Resilience: Higher Ground in the Face of Disaster*, VERISK (2018), https://www.verisk.com/verisk-review/fall-2017/resilience-higher-ground-in-the-face-of-disaster/ ("advanced computer models can offer a view into scenarios for different perils—the major ones might include wind, flood, earthquake, and wildfire. Such models can give [insurers, emergency managers, and government officials] a basic understanding of potential losses they could experience or are likely to experience."); VERISK, *supra* note 93, at 6 ("Because many of the data elements needed for replacement cost estimates are the same elements needed for catastrophe modeling, 360Value is ideally suited to capture the detailed, property-specific data needed for effective catastrophe analysis. The point in the underwriting process when replacement cost is reviewed

expectations, catastrophic events do not, on average, have statistically significant relationships to homeowner insurance market outcomes.[323] Simply put, catastrophe loss already is priced into the premium, or at least so it is claimed. But more to the point, even if demand surge was inadequately accounted for in the algorithms, then 'extended' coverage riders would be sufficient to cover the additional risk, yet the CDOI found most of the time even then coverage was inadequate.

B. AN INSURER MAY BE PUNISHED FOR OVER-INSURING

While an insurer may be rewarded for underinsuring, an insurer also may be punished for over-insuring. Collier & Ragin found 11.7% of insureds chose to over-insure.[324]

Over-insurance is a valid concern for insurers. In valued policy states, in the event of a total loss an insurer is required to pay the full coverage limit even if that coverage limit exceeds the actual full replacement cost.[325] An insurer thus may (perhaps should) be worried that a policyholder would buy excessive insurance as a hedge to escape a financially perilous position in the wake depreciating home values.[326]

This is analogous to an "adverse selection problem."[327] "Adverse selection occurs in insurance markets when information is asymmetric; i.e.,

---

may also be an ideal opportunity to check on catastrophe risk. 360Value, the only replacement cost estimator that fully supports catastrophe risk management programs, can:...assess catastrophe risk on individual properties before the policy is underwritten using a built-in connection to AIR Worldwide catastrophe models.").

[323] Patricia Born & Robert W. Klein, *Catastrophe Risk and the Regulation of Property Insurance Markets*, 35 J. INS. REG. 1, 31 (2016).

[324] Collier & Ragin, *supra* note 19, at 12, Table 3.

[325] *See* Molk, *supra* note 11, at 17, 19.

[326] *See* Molk, *supra* note 11 (analyzing the theoretical concerns with valued policies and how the concerns are not borne out by actual behavior).

[327]*See generally* Georges Dionne, Neil Doherty, & Nathalie Fombaron, *Adverse Selection in Insurance Markets*, *reprinted in* GEORGES DIONNE, HANDBOOK OF INS. 225 (Georges Dionne et al. eds, 2000) ("Although in many situations principals face adverse selection and moral hazard problems simultaneously when they design contracts, these types of asymmetrical information have been given separate treatments so far in the economic literature on risk-sharing agreements…More recently, some authors have

when an insurer cannot observe an individual's risk at the time policies are issued and the individual has superior information about his or her risk."[328] An example of adverse selection in insurance is when the highest risk individuals disproportionately purchase coverage, thereby raising everyone's premiums and pricing the general population out of the market (a market failure); or put another way, "we tend to trust the people we shouldn't!"[329]

Perhaps because of valued policy states, a lot of work has focused on insured adverse selection problems.[330] And whether in a valued policy state or not, insurers have a variety of tools to address the concern. An insurer will engage in *ex ante* screening of applicants to raise premiums or deny coverage to an applicant who they expect to have a high claims experience (an insured apparently adversely selecting the insurer).[331] An insurer may, when permitted by state law, have an insurable interest requirement capping

---

attempted to integrate both information problems into a single model...such an integration of both information problems is warranted on empirical grounds.").

[328] Dionne & Harrington, *supra* note 207, at 18.

[329] *Information Economics – Moral Hazard and Adverse Selection*, TUTOR2U, https://www.tutor2u.net/economics/reference/information-economics-moral-hazard-and-adverse-selection (last visited Sep. 7, 2018).

[330] *See, e.g.*, Alma Cohen & Peter Siegelman, *Testing for Adverse Selection in Insurance Markets*, 77 J. RISK & INS. 39, 39-43 (2010).

[331]*See, e.g.*, Dionne & Harrington, *supra* note 207, at 20 ("Experience rating can be viewed as either a substitute or a compliment to both risk categorization and sorting contracts with self-selection constraints when adverse selection is present."); Robert Puelz & Arthur Snow, *Evidence on Adverse Selection: Equilibrium Signaling and Cross-Subsidization in the Insurance Market*, 102 J. POL ECON. 236, 237, 255 (1994) ("firms engage in screening activities by assigning each insurance applicant to a particular risk category"); *Home buyers haunted by past owners' claims,* INSURE.COM (July 6, 2017), https://www.insure.com/home-insurance/past-claims.html ("loss history reports alert insurers to properties that carry potentially more risk than they are willing to assume"). *See generally* Keith J. Crocker & Arthur Snow, *The Efficiency Effects of Categorical Discrimination in the Insurance Industry*, 94 J. POL ECON. 321 (1986), reprinted in FOUNDATIONS OF INSURANCE ECONOMICS: READINGS IN ECONOMICS AND FINANCE 444 (Georges Dionne & Scott E. Harrington eds., 1991). *Accord* Rutgers Center for Risk and Responsibility, *supra* note 231, at 22-23.

payouts at the actual loss.[332] Or an insurer may simply intentionally resist high coverage limits.[333] Regardless of the approach an insurer takes, however, an insurer's passivity in refining cost estimators in ways that would raise RCV coverage limits may be a predictable and understandable response to the pressures on an insurer to not over-insure.[334]

C. REPUTATIONAL CONCERNS AND MARKET MECHANISMS

A brief word needs to be said about reputational interests and market mechanisms. One could posit that because of concerns of harm to reputation, an insurer would not knowingly permit inadequate, unwitting coverage limits. This conjecture, however, is called into question by e2Value's market positioning strategy, and that strategy's lack of resulting market penetration, at least so far. The e2Value patent explicitly asserts that it is a cost estimating innovation that cures the prevalent inaccuracy problems of other estimators. This is the core of e2Value's marketing pitch to insurers. Thus far, e2Value has yet to achieve much of a beachhead in the cost estimating market. Apparently, the prevalence and depth of inaccurate and inadequate coverage limits has yet to be a dominating reputational concern among insurers.[335] Further, the prevalence of underinsurance is a recurrent news story in the wake of natural disaster, often punctuated by homeowners calling out insurers by name. But underinsurance persists unabated.

Similarly, one might expect a properly functioning competitive market to adjust through normal market mechanisms to punish an insurer who persistently set coverage limits materially inadequately. The most that can be said about this expectation is that while explanations as to why may vary, thus far the market has *not* evidenced any adjustment.

---

[332] *See* Molk, *supra* note 11, at 363.

[333] *See* Molk, *supra* note 11, at 391. *See also Definition of moral hazard*, FT.COM/LEXICON, http://lexicon.ft.com/Term?term=moral-hazard ("There are concerns that some individuals that take out large insurance policies to cover specific risks are likely to claim against such policies.... Insurance firms...use screening techniques to try and identify such customers and monitor their behavior.").

[334] Molk, *supra* note 11, at 386 n.140.

[335] Bhutta & Keys, *supra* note 305, at 33, 36.

VII. A PROPOSED REGULATORY RESOLUTION OF PERVASIVE UNDERINSURANCE

Homeowner insurance is an interesting market. It is dominated by low information, largely unengaged, nonetheless arguably highly price elastic customers, buying coverage that is complex to accurately underwrite and challenging to price shop.[336] In other words, most customers are to some degree or another apathetic about buying insurance, and to whatever degree a customer is price sensitive, they often are ill-positioned to do anything about it.

Simultaneously, insurers face their own challenge. Building a house is a complex problem. And precisely projecting a replacement cost at an indeterminate point in the future is an impossibility. If an insurer can shift risk of error, then one would expect insurers to do so.[337] And capping replacement coverage limits has indeed become a common and effective insurance strategy for insurers to shift risk to a homeowner and/or government authority.[338] That strategy works because the insurer is working within a legal landscape that separates risk from responsibility. Companies pursue business strategies that the laws (as interpreted) and regulations reward.[339]

And yet consider the resulting dilemma consumers of homeowner insurance finds themselves in: The ubiquitous consumer information of state insurance commissioners advises homeowners to be cautious and seek full

---

[336] Contrast this, for example, with automobile insurance – pricing the actual or replacement value of a car is straightforward, the likelihood of material error is small, and price comparison tools are ubiquitous.

[337] Santosh Anagol, Shawn Cole, & Shayak Sarkar, *Understanding the Advice of Commissions- Motivated Agents: Evidence from the Indian Life Insurance Market*, 99 REV. ECON. & STAT. 1 (2017) (commission structures caused agents to sell inappropriate life insurance to low information customers.).

[338] *See, e.g.*, J. Robert Hunter, *The Insurance Industry's Incredible Disappearing Weather Catastrophe Risk: How Insurers Have Shifted Risk and Costs Associated with Weather Catastrophes to Consumers and Taxpayers*, CONSUMER FEDERATION OF AMERICA, Feb. 17, 2012, at 4-6, 9-11.

[339] *Accord* Baker, *supra* note 294, at 1401 ("All that an insurance company has to sell is its promise to pay...the better an insurance company is at avoiding that promise, the more money it makes.").

replacement coverage, and further advises that if the homeowner is unsure how much that is, then the homeowner should ask their insurer or agent.[340] Many insurers or agents, however, will only describe an amount as a 'minimum' and will assert that the ultimate responsibility for adequate insurance is on the homeowner. The legal landscape frequently enforces this language. The problem is dizzying.

But there is a solution. Fundamentally what is occurring is that the information and expertise that form the basis of an informed, estimated replacement cost is remote from the responsibility if that estimate is profoundly in error.

There are a host of ways one might modify the legal landscape to close the resulting protection gap.[341] But fundamentally, any solution will fail that assumes either that adequate coverage is susceptible of consistent, accurate calculation, or that broadly and ubiquitously consumers will become informed buyers. Facts on the ground repeatedly expose those approaches as overly Pollyannaish.

Indeed, the CDOI – in defending its regulation defining how to estimate replacement cost – detailed (albeit inadvertently) many of the reasons that its solution could fail to remedy the problem of underinsurance:

> The Regulation does not affect underwriting. It does not specify, require, or otherwise mandate…which risks they decide to insure against, what policy limits they wish to insure, or what price to charge for a policy. It does not require insurers to estimate replacement cost or recommend a policy limit, does not prevent insurers from including additional factors in determining the estimate, does not prohibit an insurer from setting a minimum or maximum amount of coverage or any amount of coverage that is different from the estimate of replacement cost, and does not prohibit a consumer from obtaining his or her own estimate.[342]

A more likely to succeed solution would re-couple risk and responsibility by requiring an insurer essentially to quote guaranteed replacement coverage and allowing the insurer to underwrite and price that coverage in anyway it chooses, so long as the rate is approved by the DOI. If the policyholder chooses to reject that coverage, then the policyholder

---

[340] See *supra* text accompanying note 69.

[341] *See, e.g.*, Holzheu & Turner, *supra* note 217, at 56-62.

[342] Appellant's Reply Brief, Ass'n. of Cal. Ins. Cos., 235 Cal. App. 4th 1009 (internal citations omitted).

bears the risk of underinsurance. If the policyholder accepts that coverage, then the insurer bears the risk of underinsurance. That legislation might read something like this:

> (a) For every policy of residential property insurance that is newly issued or renewed in this state, an insurer shall offer insurance for the full replacement of the insured property.
> (b) If the insured purchases the policy or renewal described in section (a), then in the event that the policy coverage limit is not sufficient to replace the insured property, the insurer shall be liable for the actual replacement cost.
> (c) If the insured does not purchase the policy or renewal described in section (a), then in the event that the policy coverage limit is not sufficient to replace the insured property, the insurer shall not be liable for the actual replacement cost.
> (d) This section shall not be deemed to limit or preclude an insurer and insured from agreeing to provide coverage for a policy limit that is greater or lesser than the estimate of replacement value provided in accordance with subdivision (a).

The advantages to a policyholder of this approach are patent. But there are advantages to insurers as well. This approach allows each insurer to model confidence levels and margins of error, and then decide what business strategy makes most sense to it. One insurer might be aggressive in pricing premium and calculating limits, determining that the realized volume of market share justifies the risk exposure of understated limits. Another insurer might come to a more conservative solution. And both approaches would be permitted without exposing policyholders or government resources.

Further, this will reconnect risk creation and risk allocation. The core challenge is that replacement cost estimators, as with any predictive tool, have margins of error. It is the seller of the software who sets the parameters and algorithms, and thus can make the estimator neutral, biased to a conservative estimate, or biased to an aggressive estimate. That is a matter of negotiation with an insurer and a marketing strategy by the software company. But the risk of error should be allocated between those two entities, rather than passed through to an unwitting consumer.

If this solution is adopted, then premiums may rise. And yet, one must query, why? The providers of replacement cost estimators claim their tools *already* precisely underwrite total replacement coverage, accounting appropriately for general inflation, historical trends in building costs,

localized market idiosyncrasies, demand surge pricing in the wake of mass loss, and the risk to a particular address of being part of a mass loss. If so, then prices should not move at all. Frankly, however, recent claims history in the wake of wildfire suggests that these product claims – at least at present – range more toward aspirations than descriptions.

If these are (at least for now) hollow promises, then yes, prices will rise, as they should. It is important to accurately price risk so long as this does not equate to price gouging. It is a core competency of Departments of Insurance. And the constant political debate surrounding flood insurance demonstrates the challenges of trying to artificially suppress price.[343] If the last 30 years stands for nothing else, it serves as stark proof that a world of unwitting underinsurance carries real and unnecessary cost.[344]

There will be a concern, of course, that a price elastic, ill-informed and/or disengaged consumer will decline (to their disadvantage) full replacement coverage. The experience of consumer buying decisions to date, however, suggests to the contrary – homeowners largely want full insurance and largely are willing to pay for it.

CONCLUSION

Natural disasters have exposed that literally millions of Americans, are unknowingly, profoundly, inadequately insured. This is not only a private problem, but a public one, as government frequently is the resource of last resort when homeowners become homeless. The problem of unintended, significant, widespread underinsurance has been ongoing for decades. But it is solvable. The solution is to combine the known product of guaranteed

---

[343] *See generally* Molk, *supra* note 11, at 5 n.16; Anthony Cappelletti, *National Flood Insurance Program: Reauthorization 2017*, SOCIETY OF ACTUARIES (June 2017), https://www.soa.org/News-and-Publications/Newsletters/General-Insurance/2017/june/National-Flood-Insurance-Program--Reauthorization-2017.aspx; Carolyn Kousky & Leonard Shabman, *How and Why the NFIP Differs from a Private Insurance Company*, RESOURCES FOR THE FUTURE (2014), http://www.rff.org/files/sharepoint/WorkImages/Download/RFF-DP-14-37.pdf.

[344] A separate and perhaps more profound concern is that some areas will have such high fire risk that insurers will refuse to write insurance quotes at all. *See, e.g.*, Jackie Botts, *As Fire Seasons Intensify, California Homeowners Struggle to Stay Insured*, PAC. STANDARD (Aug. 15, 2018), https://psmag.com/environment/as-fire-seasons-intensify-california-homeowners-struggle-to-stay-insured.

replacement coverage, on the one hand, with preserving the business flexibility of insurers to idiosyncratically tailor products to consumers, on the other hand. To paraphrase an apocryphal old advice column, this solution falls into that special category of appropriate called "high time."

EXPECTED BAD MORAL LUCK

YEHONATAN SHIMAN*

TABLE OF CONTENTS

I. INTRODUCTION……118
II. NON-COMPLIANCE……..….120
A. UNDERSTANDING THE LEGAL AND THEORETICAL FRAMEWORK……..121
B. INTERNATIONAL NON-COMPLIANCE……122
1. Intentional Infliction of Harm.….…..……123
2. Intentional Risk-taking……..123
C. UNINTENTIONAL NON-COMPLIANCE……..…126
1. The Objective Standard……..…126
2. Perfect Compliance……...127
3. Res Ipsa Loquitur – The Presumption of Negligence……128
4. Bad Moral Luck……128
III. THE EXPECTED OR INTENDED HARM CLAUSE……129
A. DISTINGUISHING NON-COMPLIANCE IN INSURANCE POLICIES……130
B. EXCLUDING COVERAGE FOR EXPECTED OR INTENDED HARM……133
C. AN IMPERFECT INTERPRETATION ……134
1. Assessing Subjective Expectation ……137
2. Substantial Probability…….…..……139
IV. OPTIMAL INTERPRETATION ……144
A. DETERMINING WHAT IS "BEST"?……..….145
B. BURDEN OF PROOF – BEST EFFORTS AS A DEFENSE……147
C. DISTINGUISHING "BEST EFFORTS" FROM SECOND ORDER PRECAUTIONS ……148
D. APPLICATION OF THE BEST EFFORTS TEST……150

---

* *Yehonatan Shiman is an Associate at Gornitzky & Co. and an Adjunct Faculty member at Ono Academic College School of Law.*

For discussing these ideas and challenging me, I thank Michael Gilbert, Kenneth Abraham, Andrew Hayashi, Mila Versteeg, Sharon Cop, Natasha Pereira, Nadia Pereira, and the participants of the University of Virginia S.J.D. Colloquium. For excellent comments and edits, I thank the Connecticut Insurance Law Journal, especially Kyle Roseman, Francis Arevalo, and Jennifer Bush.

E. BEST EFFORTS TEST AND THE INSURTECH LANDSCAPE……153
V. CONCLUSION…….…...155

I. INTRODUCTION

After a long renovation process, your house is finally ready. Unfortunately, several weeks after its completion you, notice water leaking from the second floor, and a few days later a pipe bursts damaging a large portion of the house. As a legally informed homeowner, you sue the contractor for damages and repair costs. The court rules in your favor, declaring that the contractor's services were negligently performed. You hire a new contractor.

This example captures how people think about their legal options in these situations. In many cases, the sued party will rely on her insurance company for coverage against the claim. Assuming the contractor attempted to do her best work, but for a variety of reasons fell short, should her negligence be covered? Most people would answer in the affirmative. What if the contractor intentionally damaged the homeowner's plumbing? Most people would agree the insurance company should not bear the cost of the contractor's intentional infliction of harm. However, what if the contractor intentionally used cheap materials knowing this choice would increase her profits but also increase the leakage probability? In this case, the answer is less clear.

Courts have struggled to determine under what circumstances the injured, such as the contractor, should be covered and when her actions forfeit coverage.[1] This determination is governed, *inter alia*, by the "expected or intended harm clause," a liability insurance policy provision that excludes coverage for expected or intended harm.[2] Courts in different jurisdictions vary in their interpretation of this clause ranging from a broad construction that *any* expectation of harm bars coverage to a narrow one where only the *intention* to inflict harm bars recovery. *Wausau Underwriters Ins. Co. v. United Plastics Grp., Inc.*,[3] highlights this difference. In this case, the insured, United Plastic Group Inc. (UPG), manufactured a defective part

---

[1] *See* FISCHER, WIDISS & KEETON, *infra* note 53 at 435–37. *See also* the relevant discussion in Section III.C.1.

[2] *See* FISCHER, WIDISS & KEETON, *infra* note 53 at 421–24. *See also* the relevant discussion in Section III.

[3] Wausau Underwriters Ins. Co. v. United Plastics Grp., Inc., 512 F.3d 953 (7th Cir. 2008).

for its water heaters by using a significantly lower molding temperature. As a result, the water heaters ruptured in customers' homes causing $26.5 million in property damage. In its opinion, the court noted: "[s]uppose UPG thought that 0.1 percent of the heaters would fail; instead 15 percent did. Is the difference in magnitude enough to show that the harm to the customers that occurred was 'expected'?"[4]

To answer this question, we must look to how jurisdictions construe the expected or intended harm clause because this choice affects injurer behavior. The central difficulty is defining "expected" harm, which can lead to over- and under-inclusive outcomes—an unfavorable result. In response, injurers and insurance companies may alter their actions to avoid exposure to liability. As one court described this relationship:

> [B]oth [the] insured and insurer have an incentive, at the contracting stage, to rule out [expected or intended harm]. If a policy allows recovery for discharges that expectedly or intentionally generate liability, policyholders will be tempted (at the margin) to engage in harm-generating (or reckless) behavior, i.e., will be subject to 'moral hazard.' To the extent that the moral hazard is not constrained, total compensable losses will be increased by a number of reasonably avoidable losses, and premiums, of course, will rise with them.[5]

This Article provides a novel analysis of the incentives created by different interpretations of the expected or intended harm clause. Moreover, this interpretive decision has ramifications on the insurance system. Given the connection between courts' interpretative decisions, party incentives, and the insurance industry, this Article recommends that courts look to the injurer's efforts to comply with the standard of care to distinguish unintentional behavior from intentional negligent risk-taking. To achieve this aim, this Article suggests that courts should employ a "best effort" defense, which removes liability if the injurer can prove she exercised her best efforts to comply with the standard of care. This approach differs from previous doctrines and scholarship because it subjectively evaluates the injurer based on personalized information now available through technological advancements. With more information available during the underwriting process, insurers can create tailored standards of care for their policyholders. Courts can then use this personalized rubric to more

---

[4] *Id.* at 961.

[5] Charter Oil Co. v. Am. Employers' Ins. Co., 69 F.3d 1160, 1166 (D.C. Cir. 1995).

accurately measure the injurer's *ex post* behavior. This article will examine the benefits of the advanced underwriting process and its mechanics, including information acquisition and burdens of proof. The result is a personalized insurance policy that can provide more favorable outcomes in insurance coverage disputes.

Part II of this Article will summarize the three categories of negligent behavior—intentional infliction of harm, intentional negligent risk-taking, and unintentional non-compliance—any one of which may be implicated in an insurance dispute. Part III will review the expected or intended harm clause and how courts have decided to interpret it. From these observations, we can trace how current legal doctrine may result in flawed applications of this clause which negatively impacts insurer and injurer incentives. Part IV offers a new way of looking at this problem by introducing the "best efforts" defense to safeguard policyholders against imperfect applications of the expected or intended harm clause exclusion. This section will elaborate on how and why this defense is feasible in today's legal system. Finally, Part V concludes this discussion.

II. NON-COMPLIANCE

Liability insurance disputes often begin with a compensable harm to a third party. In most cases, either negligence or strict liability will determine whether the defendant's harm, caused by the injurer, is legally compensable.[6] Harm is legally compensable when the injurer fails to comply with the appropriate liability regime.[7] For strict liability, harm is compensable regardless of whether the injurer took precautions.[8] Under a negligence regime, harm is compensable if the injurer failed to take legally mandated precautions.[9] Non-compliance—the failure to take legally mandated precautions—materializes for a variety of reasons. Distinguishing between

---

[6] Although the scope of this article focuses on harm caused by negligence, further scholarship can apply this discussion to other liability regimes. Regardless of the governing liability rule, harm is legally compensable when the injurer caused it while failing to comply with the standard of care.

[7] KENNETH S. ABRAHAM, THE FORMS AND FUNCTIONS OF TORT LAW 188 (4th ed. 2012) ("[S]trict liability is in effect activity-based, whereas negligence liability is act-based").

[8] *Id.*

[9] *Id.* at 51–52.

them is noteworthy for two reasons. First, insurance policies often determine coverage based on the type of non-compliance. There are two types of non-compliance: (1) expected or intended (intentional non-compliance) and (2) inadvertent (unintentional non-compliance).[10] The expected or intended harm clause explicitly bars coverage for the first category, while coverage for the latter depends on how courts interpret this clause. Since these categories inform the scope of insurance, any mechanism that enhances our ability to distinguish between them will strengthen injurers' confidence in their level of coverage. Second, and perhaps more importantly, organizing non-compliance into these two categories allows scholars to quantify when courts misclassify the harm. This observation is important to gauge how consistently courts can accurately identify non-compliance type, which directly impacts coverage. Before examining non-compliance under the negligence standard, we will briefly review the standard of care under this liability regime.

A. UNDERSTANDING THE LEGAL AND THEORETICAL FRAMEWORK

Negligence is the failure to exercise reasonable care that causes compensable harm.[11] In order to assess whether an individual acted negligently, the court must engage in a two-step analysis. First, the court must define "reasonable care," a standard derived from asking what a reasonably prudent person would do in the same situation.[12] The court may adjust the standard after evaluating evidence so that the level of care is sensitive to the case's particular circumstances.[13] Second, the court measures the defendant's behavior against this standard.[14] Failure to comply with this standard informs the finding of liability.

Different schools of thought articulate various rationales for why individuals do or do not comply with the standard of care. Under an economic analysis of tort law,[15] compliance depends on how much the

---

[10] *See* discussion *infra* Section III.C.

[11] MARK A. GEISTFELD, TORT LAW: ESSENTIALS 51; KENNETH S. ABRAHAM, *supra* note 7 at 58-59; RICHARD A. EPSTEIN, TORTS 109–10 (1999).

[12] Kenneth S. Abraham, *The Trouble with Negligence*, 54 VAND. L. REV. 1187, 1190–91 (2001).

[13] *Id.*

[14] *Id.*

[15] For the purpose of this Essay an in-depth analysis of victims'

defendant internalizes the accident costs. The more an injurer internalizes the cost of her harm, the more likely she is to comply with the standard of care. In this way, tort law aims to achieve efficient incentives by pricing non-compliance appropriately. To elaborate, both victims and injurers take efficient precaution when negligent behavior costs more than complying with the standard of care. Negligence law creates efficient compliance incentives when the standard of care is aligned with the efficient precaution.[16] We can achieve this outcome by reconceptualizing the Hand Formula[17] into marginal terms where a defendant is negligent when the marginal cost of increasing her precaution is lower than the benefit gained from reducing the expected harm.[18] Put differently, negligence law requires the injurer to take all efficient precautions.[19]

Although this theoretical account explains injurers' incentives to comply with the standard of care, non-compliance frequently occurs. Evaluating these cases provide limited explanation of non-compliance because individuals fail to conform with the standard of care for a variety of reasons. The following section explores these explanations.

B. INTENTIONAL NON-COMPLIANCE

Why do rational injurers knowingly and intentionally fail to comply with the standard of care? An injurer may fail to meet the standard of care because she enjoys inflicting harm on the victim or, alternatively, because she does not fully internalize the magnitude of her harm. Most would agree that the former injurer should receive harsher treatment than the former given the harm's intentional nature. As such, it is important to differentiate between intentional infliction of harm (when the injurer intends to harm the

---

precautions is unnecessary as we focus on the injurer interaction with its insurance, however, it is important to note that any comprehensive economic analysis of tort law will require incentivizing both injurers and victims to behave efficiently.

[16] ROBERT COOTER & THOMAS ULEN, LAW & ECONOMICS 205–06 (6th ed. 2012).

[17] U.S. v. Carroll Towing Co., 159 F.2d 169, 173–74 (2d Cir. 1947).

[18] COOTER & ULEN, *supra* note 16, at 213–15.

[19] Mark F. Grady, *A New Positive Economic Theory of Negligence*, 92 YALE L.J. 799 (1983); Mark F. Grady, *Untaken Precautions*, 18 J. LEG. STUD. 139 (1989).

victim) and intentional negligent risk-taking (when the injurer engages in risky behavior, but does not intend to cause harm).

1. Intentional Infliction of Harm

Some injurers intend for their behavior to cause harm. This article refers to such injuries as "intentional infliction of harm" where the injurer's activity is aimed at causing harm. Most criminal activity falls within this category. Moreover, these intentional cases differ from calculated risk or gross negligence because of the injurer's deliberateness. In economic terms,[20] the intentional injurer generates some value or enjoyment from harming the victim.[21] In these cases, the defendant takes no precaution to prevent the accident but purposefully acts to increase its probability.[22]

2. Intentional Risk-taking

Unlike intentional infliction of harm, an injurer's negligent conduct can also be characterized as "intentional negligent risk-taking," where the injurer engages in risky behavior that violates the standard of care but does not explicitly intend to cause harm. Put differently, the injurer's activity may foreseeably harm the victim, but such harm is not the objective. The

---

[20] RICHARD A. POSNER, ECONOMIC ANALYSIS OF LAW 239–45 (9th ed. 2014); THOMAS J. MICELI, THE ECONOMIC APPROACH TO LAW 74–75 (2004); WILLIAM M. LANDES & RICHARD A. POSNER, THE ECONOMIC STRUCTURE OF TORT LAW 149–60 (1987); COOTER & ULEN, *supra* note 11, at 188 (classifying intentional torts as a criminal activity); William M. Landes & Richard A. Posner, *An Economic Theory of Intentional Torts*, 1 INT. REV. L. ECON. 127, 127–39 (1981).

[21] In his discussions of the economic analysis of torts, Shavell does not cover intentional in the accident law analysis. *See* STEVEN SHAVELL, ECONOMIC ANALYSIS OF ACCIDENT LAW 1 (1987) [hereinafter: ACCIDENT LAW]; STEVEN SHAVELL, ECONOMIC ANALYSIS OF LAW (1st ed. 2004) (ignoring intentional torts in his analysis); STEVEN SHAVELL, FOUNDATIONS OF ECONOMIC ANALYSIS OF LAW (2004) (ignoring intentional torts in his analysis). One can infer, according to Shavell and also intuitively, that intentional torts are not accidents.

[22] As a matter of fact, when an injurer intentionally inflicts harm, the precaution cost becomes negative when stated in the terms of the Hand Formula. The injurer does not invest in avoiding the harm, but instead invests her energy in harming the victim.

relationship between shareholders and management provides an example. A CEO may participate in high-risk corporate activity without meaning to harm her shareholders; nonetheless, this activity may ultimately reduce the shareholders' assets.

Injurers may become intentionally negligent risk-takers for several reasons. First, some injurers enjoy risk-taking because it generates a danger-induced exhilaration rooted in the potential for harm rather than a victim's suffering. We can think of street racing as an example where drivers are attracted to the high-risk environment, rather than a desire to hit pedestrians or other vehicles. Likewise, injurers may take risks to achieve a competitive edge. This can be seen when cheerleaders hope to elevate their performances with difficult stunts, individuals pursue high-stakes gambling, or CEOs engage in highly leveraged investments. In these examples, risky activity attracts ambitious individuals because it can generate considerable rewards and profits.

In addition to an injurer's preference for risky activity, negligent risk-taking can also occur because of imperfections in the legal system. Such deficiencies are problematic because they prevent injurers from fully internalizing their accident costs. Several institutional factors explain this externalization, which as noted above, increases the likelihood of non-compliance. First, there may be judicial mistakes in setting liability. When courts systematically set the standard of care too low, the injurer is incentivized to align her level of care with the court's lowered standard.[23] Second, inaccurately computed damages can also lead to distorted party incentives. When courts consistently undervalue harm, the injurer is incentivized to lower her precautions since she will not be responsible for the total accident costs.[24] Third, collective action problems motivate injurers

---

[23] Steven Shavell, *Liability for Accidents*, 1 HANDBOOK OF L. ECON. 139, 160-161 (2007); Mitchell A. Polinsky & Steven Shavell, *Punitive Damages: An Economic Analysis*, 111 HARV. L. REV. 869, 892 (1997); COOTER & ULEN, *supra* note 11, at 220–22.

[24] COOTER & ULEN, *supra* note 11, at 257–61; Louis Kaplow & Steven Shavell, *Accuracy in the Assessment of Damages*, 39 J.L. ECON. 191 (1996); Ariel Porat, *Misalignments in Tort Law*, 121 YALE L.J. 82, 135–36 (2011); SHAVELL, *supra* note 16, at 165; Yehonatan Shiman, Reasonably Subjective & Subjectively Reasonable: Examining Subjectivity in Negligence: Victims, Injurers, & Courts 8–51 (May 2018) (unpublished Ph.D. dissertation, University of Virginia School of Law) (on file with author). (Pages 8-51).

to lower their precautions[25] because victims may not litigate harms when costs exceed the recovery.[26] Fourth, an injurer can be "judgment-proof" meaning she cannot practically be accountable because she cannot compensate the victim. The judgment-proof defendant's[27] resources limit her expected costs[28] thereby allowing her to engage in tortious behavior when the expected benefits exceed these potential costs.[29]

Finally, injurers benefit when courts ignore excessive victim precautions in calculating liability or damages, even though these behaviors lower the accident's probability.[30] When victims take excessive precaution to safeguard against harm, their action reduces the accident costs below the

---

[25] Steven Shavell, *Liability for Harm versus Regulation of Safety*, 13 J. LEG. STUD. 357 (1984); COOTER & ULEN, *supra* note 11, at 257–61.

[26] David Gilo, Ehud Guttel & Erez Yuval, *Negligence, Strict Liability, and Collective Action*, 42 J. LEGAL STUD. 69, 70 (2013); MANCUR OLSON, THE LOGIC OF COLLECTIVE ACTION; PUBLIC GOODS AND THE THEORY OF GROUPS (Harvard Univ. Press 2nd ed. 1971); William B. Rubenstein, *Why Enable Litigation: A Positive Externalities Theory of the Small Claims Class Action*, 74 UMKC L. REV. 709, 712 (2006).

[27] Steven Shavell, *The Social Versus the Private Incentive to Bring Suit in a Costly Legal System*, 11 J. LEGAL STUD. 333 (1982); Steven Shavell, *The Judgment Proof Problem*, 6 INT'L REV. L. & ECON. 45 (1986).

[28] Lynn M. LoPucki, *The Death of Liability*, 106 YALE L. J. 1 (1996).

[29] Amanda Edwards, *Medical Malpractice Non-Economic Damages Caps*, 43 HARV. J. ON LEGIS. 213, 217 (2006); David A. Hyman et al., *Estimating the Effect of Damages Caps in Medical Malpractice Cases: Evidence from Texas*, 1 J. LEGAL ANALYSIS 355 (2009); Greg Pogarsky & Linda Babcock, *Damages Caps, Motivated Anchoring, and Bargaining Impasse*, 30 J. LEGAL STUD. 143, 146 (2001); Catherine M. Sharkey, *Unintended Consequences of Medical Malpractice Damages Caps*, 80 N.Y.U. L. REV. 391, 402 (2005).

[30] Scholars have examined how precaution levels can affect the total accident cost such as how one party's precaution costs may change the other party's precaution costs. *See* Dhammika Dharmapala & Sandra A. Hoffmann, *Bilateral Accidents with Intrinsically Interdependent Costs of Precaution*, 34 J. LEGAL STUD. 239, 246 (2005). *See also* Alan J. Meese, *The Externality of Victim Care*, 68 CHICAGO. L. REV. 1201, 1211–15 (2001) (Alternatively, precaution costs can affect the total accident costs when the injurer fails to internalize the victim's precaution costs).

cost of precaution.[31] As victims take more precautions, an accident is less likely to materialize, thus reducing the injurer's internalized accident costs. Such scenarios arise when victims protect items with high subjective value.[32] Items are highly valued when they are irreplaceable, or when the law does not provide full recovery. Taken together, these institutional reasons illustrate why injurers may engage in intentional risk-taking since they will not internalize the full cost of their harm.

C. UNINTENTIONAL NON-COMPLIANCE

In addition to intentional risk-taking, courts can also find injurers negligent for "unintentional non-compliance," episodes where the injurer tried to comply with the standard of care but failed.[33] Various features in negligence law contribute to unintentional non-compliance, including an unreachable standard of care,[34] unintentional lapses of attention,[35] and the *res ipsa loquitur* doctrine.[36] The following sections examine these cases.

1. The Objective Standard

As noted above, tort law establishes an objective standard of care based on the reasonably prudent person.[37] This reasonable person standard

---

[31] Shiman, *supra* note 24.

[32] Shiman, *supra* note 24.

[33] Abraham, *supra* note 6; Mark F. Grady, *Res Ipsa Loquitor and Compliance Error*, 142 U. PA. L. REV. 887 (1994); Robert Cooter & Ariel Porat, *Lapses of Attention in Medical Malpractice and Road Accidents*, 15 THEOR. INQ. L. 329 (2014); Omri Ben-Shahar & Ariel Porat, *Personalizing Negligence Law*, 91 N.Y.U. L. REV. 627 (2016).

[34] Kenneth S. Abraham, *Strict Liability in Negligence*, 61 DEPAUL L. REV. 271 (2011); Ben-Shahar & Porat, *supra* note 33.

[35] Grady, *supra* note 33; Cooter & Porat, *supra* note 33; Abraham, *supra* note 34.

[36] Grady, *supra* note 33.

[37] RESTATEMENT (THIRD) OF TORTS: LIAB. FOR PHYSICAL & EMOTIONAL HARM § 3 (AM. LAW INST. 2010). Other elements that determine liability are also evaluated from an objective perspective. For example, the foreseeability of the accident is determined objectively rather than subjectively. The question for the jury is not whether the defendant foresaw the plaintiff, but rather whether the defendant should have foreseen the plaintiff and the risk of the accident.

does not consider a defendant's specific capabilities[38] thereby leading to circumstances where the standard is too low for some injurers and too high for others.[39] While this misalignment does not disadvantage injurers in the former category, its impact can be substantial for the latter. Unintentional non-compliance results when injurers cannot achieve the reasonable person standard. For example, a physician is still expected to act like a "reasonable practitioner" even if she lacks some knowledge or skill to satisfy this standard in a particular circumstance.[40] As such, the objective standard condemns injurers who experience capacity limitations that fall below the reasonable person's abilities. Non-compliance with the standard of care can result from physical, mental, or emotional constraints.

2. Perfect Compliance

Unintentional non-compliance can also occur when the court expects conformity with the standard of care in *every* instance. Liability occurs under a "perfect compliance" regime when injurers cannot meet this rigorous requirement[41] due to random errors or lapses.[42] Individuals are prone to lapses either from limited capacity, attention span, or multi-tasking over extended periods of time. For example, Amy may be an excellent driver who generally takes precautions yet causes an accident in the few seconds she glances at her speedometer. Thus, even cautious drivers can negligently cause an accident because of a lapse.[43] As such, demand for perfect

---

[38] Abraham, *supra* note 33, at 283. There are a few limited exceptions to this rule, including when courts allow evidence of limited capacity to be presented. *See* Ben-Shahar & Porat, *supra* note 33, at 637–41; ABRAHAM, *supra* note 7, at 64–67.

[39] Ben-Shahar & Porat, *supra* note 33.

[40] Note however that asymmetry exists when a high level of skill or knowledge may raise the required precaution by the defendant.

[41] William M. Landes & Richard A. Posner, *The Positive Economic Theory of Tort*, 15 GA. LAW REV. 851, 880 (1980).

[42] *Id.*at 879–80; Grady, *supra* note 33, at 894–906; Abraham, *supra* note 34, at 288–89.

[43] Peter A. Diamond, *Single Activity Accidents*, 3 J. LEG. STUD. 107, 123–25 (1974). We can think about compliance error as the distinction between two orders of negligence. *See* Cooter & Porat, *supra* note 33, at 330–31. The first order is the decision itself, such as driving at the speed limit. The second order is the attempt to maintain a precise precaution within

compliance with the standard of care is another example of unintentional non-compliance.

3. Res Ipsa Loquitur – The Presumption of Negligence

Finally, unintentional non-compliance can emerge from *res ipsa loquitur* ("the thing speaks for itself"), which assigns liability when the defendant's negligence is the likely consequence of the harm, even if it cannot be proven.[44] To illustrate, if a driver and a pedestrian collide, *res ipsa loquitur* presumes the former was the faulty party. The court can invoke *res ipsa loquitur* when the following conditions are fulfilled: (1) the accident is typically caused by a common type of defendant, (2) the defendant assumed full control of the instrument that caused the accident, and (3) the injury does not result from the plaintiff's voluntary action or contributory behavior.[45]

Unlike compliance errors and limited capacity, *res ipsa loquitur* enables defendants to be found negligent due to an overriding presumption even when they perfectly comply with the legal standard. From the defendant's perspective, *res ipsa loquitur* essentially creates a version of strict liability[46] by casting liability without finding legal fault as traditionally defined.[47] This outcome leads injurers to internalize error costs. Error costs are instances where, courts find injurers liable despite compliance because of the negligence presumption. Error costs, therefore, provide another reason why injurers need insurance to cover unintentional non-compliance episodes.

---

the first order, such as maintaining a precise speed limit. Similarly, the goalkeeper's decision to jump right is a first order decision, and the quality of his attempt to block the ball is a second order decision.

[44] RESTATEMENT (THIRD) OF TORTS: LIAB. FOR PHYSICAL & EMOTIONAL HARM § 17.

[45] ABRAHAM, *supra* note 7, at 107.

[46] Grady, *supra* note 33, at 892–94; GEISTFELD, *supra* note 11, at 237–38.

[47] ARIEL PORAT & ALEX STEIN, TORT LIABILITY UNDER UNCERTAINTY 95–97 (2001); Stephen G. Gilles, *Negligence, Strict Liability, and the Cheapest Cost-Avoider*, 78 VA. L. REV. 1291, 1303–13 (1992).

4. Bad Moral Luck

Unintentional non-compliance occurs when an injurer cannot meet the objective standard, fails to exercise perfect compliance, or is presumed negligent under *res ipsa loquitor*. These factors all involve circumstances where compliance is beyond the injurer's physical control, making non-compliance an involuntary behavior. When an injurer's uncontrollable moments of non-compliance cause harm, we can conceptualize this condition as "bad moral luck."[48]

To demonstrate, a driver following the speed limit may nonetheless accelerate when she drives downhill. She will suffer "bad moral luck" if a pedestrian crosses her path at the exact moment she deviates from the standard of care. Thus, "bad moral luck" occurs when the injurer causes harm during her period of unintentional non-compliance.[49] Conversely, injurers experience "good moral luck" when their non-compliance does not trigger any harmful consequences.

III. THE EXPECTED OR INTENDED HARM CLAUSE

Given the possibility of bad moral luck, the expected or intended harm clause gives courts a tool to assign different protections to unintentional non-compliance and intentional negligent risk-taking. When harm is expected or intended, courts can use this contractual clause to bar

---

[48] This article refers to bad moral luck in the sense of compliance luck and the personal characteristics of the injurer. This formulation mirrors the natural lottery concept. *See* JOHN RAWLS, A THEORY OF JUSTICE 101 (1971). Another type of moral luck, which is not discussed in this article, is casual moral luck. For a discussion of this manifestation of moral luck see generally Kasper Lippert-Rasmussen, *Justice and Bad Luck*, *in* THE STANFORD ENCYCLOPEDIA OF PHILOSOPHY 1 (Edward N. Zalta ed., 2014), https://plato.stanford.edu/archives/sum2014/entries/justice-bad-luck/ (last visited May 9, 2017); John C. P. Goldberg & Benjamin C. Zipursky, *Tort Law and Moral Luck*, 92 CORNELL L. REV. 1123, 1143–49 (2006). OLIVER WENDELL HOLMES, JR., THE COMMON LAW 108 (Revised ed. 1991); Jeremy Waldron, *Moments of Carelessness and Massive Loss*, *in* PHILOSOPHICAL FOUNDATIONS OF TORT LAW 387, 387–88 (David G. Owen ed., 1995).

[49] Tom Baker, *Liability Insurance, Moral Luck, and Auto Accidents Moral and Legal Luck*, 9 THEOR. INQ. L. 165, 168 (2008).

coverage.[50] Conversely, courts can find that unintentional non-compliance does not forfeit insurance protection.[51]

A. DISTINGUISHING NON-COMPLIANCE IN INSURANCE POLICIES

Insurance is a contract between two parties in which the injurer transfers her risk to an insurance company for a premium. Examples of liability insurance include automobile, commercial liability, homeowner, and renter insurance policies. In many cases, an insurance company requires its policyholder to conform to certain safety measures in order to maintain coverage or price. For example, homeowner insurers offer discounts when policyholders install smoke detectors.[52] By dictating the coverage terms, the insurance company monitors individuals to ensure they take appropriate

---

[50] FISCHER, WIDISS & KEETON, *infra* note 53, at 424–26 (reviewing various judicial different "approaches to assessing whether liability coverage exists for a consequences that the tortfeasor allegedly did not intend").

[51] FISCHER, WIDISS & KEETON, *infra* note 53, at 424–25 (the second approach presented by the authors). *See also infra* notes 76–78 and accompanying text.

[52] Ben-Shahar & Logue, *Outsourcing regulation*, *infra* note 53, at 224.

safety measures.[53] Thus, liability insurance serves as a safety regulator.[54]

Insurance plays a pivotal role in the American tort system[55] and thus merits attention for any understanding of injurer incentives. A quantitative study showed that in 2010 liability insurance was the greatest cost associated with tort cases ($172.9 billion) while self-insurance[56] accounted for a smaller amount ($61.9 billion).[57] Another study showed that plaintiff attorneys typically sue defendants for their insurance policy limits rather than for their personal assets' value.[58] As such, an insurance policy's scope and

---

[53] JAMES M. FISCHER, ALAN I. WIDISS & ROBERT E. KEETON, INSURANCE LAW: A GUIDE TO FUNDAMENTAL PRINCIPLES, LEGAL DOCTRINES, AND COMMERCIAL PRACTICES 463–65 (2nd ed. 2016); Kenneth S. Abraham, *Four Conceptions of Insurance*, 161 PA. L. REV. 653, 683–91 (2012); Omri Ben-Shahar & Kyle D. Logue, *Outsourcing Regulation: How Insurance Reduces Moral Hazard*, [hereinafter: *Outsourcing regulation*] 111 MICH. L. REV. 197 (2012); Omri Ben-Shahar & Kyle D. Logue, *How Insurance Substitutes for Regulation*, 36 REGULATION 36 (2013) [hereinafter: *How Insurance Substitutes for Regulation*]. Tom Baker, *Liability Insurance as Tort Regulation: Six Ways That Liability Insurance Shapes Tort Law in Action*, 12 CONN. INSUR. LAW J. 1–16 (2005); but see Tom Baker & Sean J. Griffith, *The Missing Monitor in Corporate Governance: The Directors' & (and) Officers' Liability Insurer*, 95 GEO L. J. 1795 (2006); Tom Baker & Sean J. Griffith, *Predicting Corporate Governance Risk: Evidence from the Directors' & (and) Officers' Liability Insurance Market*, 74 CHIC. L. REV. 487 (2007).

[54] Abraham, *supra* note 53, at 683–91; Ben-Shahar & Logue, *How Insurance Substitutes for Regulation*, *supra* note 53; Ben-Shahar & Logue, *Outsourcing regulation*, *supra* note 53.

[55] Baker, *supra* note 53; Kathryn Zeller et al., *Physicians' Insurance Limits and Malpractice Payments: Evidence from Texas Closed Claims, 1990-2003 Current Research on Medical Malpractice Liability*, 36 J. LEG. STUD. S9–S46 (2007); *see e.g*. Ellen S. Pryor, *Stories We Tell: Intentional Harm and the Quest for Insurance Funding*, 75 TEX. L. REV. 172 (1996) (arguing that the plaintiff can engage in strategic pleading based on the policy's exclusions).

[56] This includes high deductibles and captive insurance programs. TOWERS WATSON, U.S. TORT COST TRENDS – 2011 UPDATE 10 (2012).

[57] *Id.* at 14.

[58] Tom Baker, *Blood Money, New Money, and the Moral Economy of Tort Law in Action*, 35 LAW & SOC'Y REV. 275, 281 (2001). ("[I]f the

limitations, particularly liability insurance, has rippling effects for injurer behavior and tort litigation.[59]

Central to this structure is how insurance companies differentiate coverage between intentionally inflicted harm, intentional negligent risk-taking, and unintentional non-compliance. Insurers, policyholders, and society all benefit when coverage includes unintentional non-compliance but rejects the former two categories. A fairness argument supports this distinction: it seems improper to bar coverage for injurers who purchase insurance to protect against unintentionally caused harm. Policyholders obtain insurance because they seek coverage for unintentional non-compliance, including uncontrollable accidents that cause substantial harm. In contractual terms, obtaining coverage for unintentional behavior is within the injurer's reasonable expectation. By contrast, denying coverage for intentional negligent risk-taking makes sense since this approach eliminates moral hazard problems that would emerge if insurance companies subsidized intentional risk-taking. Once again, an injurer who intentionally engages in risk-taking may expect her coverage to be challenged if her deliberate intentions are revealed.

Another important consideration is efficiency. Unintentionally non-compliant policyholders pose an ordinary risk on average since they consistently attempt to meet the standard of care but occasionally fall short. This description captures all individuals since human error prevents perfect compliance. Assuming unintentional non-compliance is random, then under a normal distribution all policyholders impose the same risk on average. Therefore, unintentional non-compliance operates within the ordinary insurance framework in which harm results from lapses or limited capacity, not from a lack of precaution. In this way, allowing coverage for unintentional non-compliance will not distort injurer incentives since the policyholder continues to internalize her accident costs as she tries to comply with the standard of care. The same cannot be said for intentional negligent risk-taking. When insurance covers intentional negligent risk-taking, the injurer externalizes some of the accident costs to her insurer, leading to a moral hazard problem. With the insurance company subsidizing her negligent risk-taking, the injurer will continue to take inefficient precautions against potential harms.

Efficiency also demands barring coverage for intentional negligent risk-taking because this conduct raises costs to insurers and other

---

respondents are accurate, plaintiffs prefer not to purse blood money in an ordinary negligence case").

[59] ABRAHAM, *supra* note 7, at 281–83.

policyholders. For unintentional non-compliance, an insurer can balance high-risk activity through its policy terms or the average risk pool. Once insurers agree to cover individuals with a high-lapse potential, they can mitigate their risk by adjusting ratings, increasing deductibles and requesting higher premiums. Conversely, intentional negligent risk-taking is more challenging to assess during the underwriting process because policyholders will not disclose their intentions.[60] As a result, insurers cannot discriminately impose stricter coverage terms for these individuals since they cannot accurately identify them. Moral hazard also increases the risk pool because intentional risk takers transfer the costs of their risk-taking to other compliant policyholders in the pool.[61]

Following these assumptions about insurers and injurers, there is both a need and a benefit to policies differentiating between types of non-compliance. The expected or intended harm clause seeks to provide this needed filter.

B. EXCLUDING COVERAGE FOR EXPECTED OR INTENDED HARM

Commercial General Liability (CGL) is "the first line of coverage that businesses in [the United Sates] use to insure against liability."[62] A standard CGL insurance policy provides coverage for bodily injury or property damages that result from "an occurrence."[63] An insurance policy

---

[60] We can also ask whether individuals who have a high tendency of lapsing will disclose this information during the underwriting process. Intuitively, it seems unlikely because this honesty will lead to higher premiums. Therefore, as will be discussed further in Section III.C.2, injurers who know and do not disclose their high-lapsing behavior, essentially engage in intentional negligent risk taking. To see why, recall that the intentional risk taker chooses her activity *because* she can externalize the harm to the insurer and only bears the premium costs. In a similar manner, the injurer who suffers from high-lapses and uses insurance to mitigate her exposure to the risk is intentionally negligent. Absent her insurance, this individual would not have engaged in the same activity.

[61] *See* Charter Oil Co. v. Am. Emp'rs Ins. Co., 69 F.3d 1160, 1166 (D.C. Cir. 1995) (arguing to a similar effect).

[62] Kenneth S. Abraham, *The Rise and Fall of Commercial Liability Insurance*, 87 Va. L. Rev. 85, 85 (2001).

[63] INSURANCE SERVICES OFFICE, COMMERCIAL GENERAL LIABILITY – COVERAGE FORM CG 00 01 04 13, at 1 (2012) [hereinafter COMMERCIAL

generally defines occurrence as "an accident, including continuous or repeated exposure to substantially the same general harmful conditions."[64] Through its broad scope, this language accounts for harm caused by sudden and unexpected events as well as harm caused by a slow and gradual injury.[65] It is important to note that the policy leaves "accident" undefined despite using the term six additional times.[66] Although a definition is not clearly provided, "accident" can be inferred to encompass an event that is neither expected nor intended. This presumed meaning is grounded in the fact that insurance policies explicitly exclude expected or intended harm, noting that coverage does not apply to "[b]odily injury or property damage expected or intended from the standpoint of the insured."[67]

By contractually excluding expected or intended harm, insurance policies cabin the type of risk an individual can transfer to her insurer.[68] By limiting coverage to unanticipated harm, the injurer bears the costs for any "expected" or "intended" accident. This responsibility differs from universal coverage, which would enable injurers to externalize all their costs for non-compliance. Determining when an accident is "expected" or "intended" presents a difficult inquiry that courts approach differently. This varied

---

GENERAL LIABILITY].

[64] *Id*. at 15.

[65] FISCHER, WIDISS & KEETON, *supra* note 53, at 422 (internal quotations omitted).

[66] COMMERCIAL GENERAL LIABILITY *supra* note 63; *See, e.g*., State Farm Fire & Cas. Co. v. CTC Dev. Corp., 720 So. 2d 1072, 1075 (Fla. 1998) (discussing the definition of accident).

[67] COMMERCIAL GENERAL LIABILITY, *supra* note 63, at 2. Other insurance policies that provide liability insurance, such as homeowners and renters insurance also contain a similar expected and intended exclusion. *See, e.g.*, INSURANCE SERVICES OFFICE, HOMEOWNERS 3 – SPECIAL FORM - HO 00 03 10 00 (1999).

[68] For example, exclusions such as "Knowing Violation of Rights of Another," "Material Published With Knowledge of Falsity," "Criminal Acts," "Contractual Liability," "Quality or Performance of Goods – Failure to Conform to Statements," "Wrong Description of Prices," and "Infringement of Copyright, Patent, Trademark or Trade Secret" attempt to mitigate the insurance company's exposure to intentional negligent risk-taking by the insured that would be transferred to the insurance company. *See* COMMERCIAL GENERAL LIABILITY, *supra* note 63, at Coverage B-Exclusions.

response is problematic because it can lead to inconsistent outcomes. The subsequent section discusses these challenges in judicial interpretation.

C. AN IMPERFECT INTERPRETATION

Some jurisdictions interpret the expected or intended clause to cover only intentionally inflicted harm. As one court articulated in *Snyder v. Nelson*, "it is against public policy for a tortfeasor to insure against liability for intentionally inflicted injury or damage." [69] Under this approach, both intentional negligent risk-taking and unintentional non-compliance receive insurance coverage. However, measuring intentions is difficult with the line between intentional infliction of harm and intentionally negligent risk-taking often blurred.

Should coverage forfeiture be limited to intentionally inflicted harm or should intentional negligent risk-taking also be barred? One might assume that the shared '*intentional*' element leads to an affirmative answer. However, intentional risk-taking is also aligned with unintentional non-compliance in that both behaviors have similar outcomes: their activities *do not intend* the resulting harm. Given this commonality, it is not clear that intentional negligent risk-taking is more like intentionally inflicting harm than unintentional non-compliance. As such, courts should determine where intentional risk-taking falls on the spectrum between intentional infliction of harm, a socially unacceptable activity, and unintentional non-compliance, a behavior deserving coverage. By using different "expected" harm definitions, courts create coverage uncertainty for behavior falling outside intentionally inflicted harm. Such unpredictability impacts injurer incentives because there is a possibility she will be responsible for the total accident cost.

An intuitive approach to "expected" harm is understanding it in terms of tort law where "expected" often equates to "foreseeable." When an injurer anticipates her conduct will generate some likelihood of harm, then coverage should be denied if such harm materializes. Most courts reject this unforgiving approach as seen in *Carter Lake v. Aetna Cas. & Sur. Co.*[70]:

> [A]n injury is not caused by accident because the injury is reasonably foreseeable would mean that only in a rare instance would the comprehensive general liability policy be of any benefit

[69] 278 Or. 409, 564 P.2d 681 (1977).
[70] 604 F.2d 1052 (8th Cir. 1979).

> to [the defendant]. Enforcement of the policy in this manner would afford such minimal coverage as to be patently disproportionate to the premiums paid and would be inconsistent with the reasonable expectations of an insured purchasing the policy.[71]

Instead, the court focused on the magnitude of the injurer's risk-taking and did not bar coverage simply because the harm was foreseeable. The court elaborated:

> [T]he word 'expected' denotes that the actor knew or should have known that there was a substantial probability that certain consequences will result from his actions. If the insured knew or should have known that there was a substantial probability that certain results would follow his acts or omissions then there has not been an occurrence or accident as defined in this type of policy when such results actually come to pass. The results cease to be expected and coverage is present as the probability that the consequences will follow decreases and becomes less than a substantial probability.[72]

In *Carter Lake*, the court offered a common construction for "expected" harm where coverage is excluded if (1) the injurer had knowledge that her conduct created a (2) substantial probability of harm.[73] To satisfy the first prong, insurers must show that the injurer knew (subjective) or should have known (objective) her actions risked harm. Under the *Carter Lake* test, meeting either the subjective or objective standard satisfies this prong. However, *Carter Lake* is not a universal approach. Most jurisdictions employ similar prongs in their "expected" harm analysis,[74] but limit the first inquiry to a strictly subjective standard.[75] For

---

[71] *Id.* at 1058.

[72] *Id.* at 1058–59.

[73] *See* discussion *infra* Section III.C.2.

[74] *See, e.g.*, Johnson v. Am. United Life Ins. Co., 716 F.3d 813, 882-27 (4th Cir. 2013); Carney v. Vill. of Darien, 60 F.3d 1273, 1280 (7th Cir. 1995); Wickman v. Nw. Nat'l Ins. Co., 908 F.2d 1077, 1088 (1st Cir.1990); Hartford Roman Catholic Diocesan, Corp. v. Interstate Fire & Cas. Co., 199 F. Supp. 3d 559, 594-96 (D. Conn. 2016); Cas. & Sur. Co. v. Waisanen, 653 F. Supp. 825, 830-31 (D.S.D. 1987).

[75] U.S. Fid. & Guar. Co. v. Armstrong, 479 So. 2d 1164, 1167 (Ala. 1985) ("[T]he legal standard to determine whether the injury was either

example, in *Johnstown v. Bankers Standard Ins. Co.*,[76] the court found the injurer forfeited recovery if she "intended the damages, or if it [could] be said that the damages were, in a broader sense, 'intended' by the insured because [she] knew that the damages would flow directly and immediately from its intentional act."[77] Many courts adopt this narrower formulation of the "expected" harm analysis.[78] The following section discusses how a court' decision to adopt the broad *Carter Lake* approach or the narrow *Johnstown* approach impacts coverage for unintentional non-compliance and intentional negligent risk-taking.

1. Assessing Subjective Expectation

Whether employing *Carter Lake*'s broad test or *Johnstown*'s narrow one, courts must evaluate an injurer's harm expectation. Two elements are critical for an accurate analysis: (1) ascertaining the injurer's knowledge, and (2) measuring the quality of her knowledge.[79] Both these inquires present

---

expected or intended . . . is a purely subjective standard."); Fire Ins. Exch. v. Berray, 694 P.2d 191, 194 (Ariz. 1984) (the legal standard should be "from the standpoint of the insured"); Great Am. Ins. Co. v. Gaspard, 608 So. 2d 981, 985 (La. 1992) ("[T]he subjective intent of the insured is the key and not what the average or ordinary reasonable person would expect or intend."); Shell Oil Co. v. Winterthur Swiss Ins. Co., 15 Cal. Rptr. 2d 815, 861 (Cal. Ct. App. 1993) (rejecting the subjective "should have known" test).

[76] 877 F.2d 1146 (2d Cir. 1989).

[77] *Id.* at 1150 (internal citation omitted).

[78] Westfield Ins. Co. v. Tech Dry In., 336 F.3d 503 (6th Cir. 2003); Stonewall Ins. Co. v. Asbestos Claims Mgmt. Corp., 73 F.3d 1178 (2d Cir. 1995); Am. Home Assurance Co. v. Safeway Steel Prods. Co., 743 S.W.2d 693 (Tex. App. 1987); Quaker State Mint-Lude, Inc. v. Fireman's Fund Ins. Co., 868 F. Supp. 1278 (D. Utah 1994).

[79] Another challenge to a narrower subjective test is redundancy as the policy language already excludes harm that is either expected or intended through the Expected or Intended Harm Clause. Some courts have ruled that insurance policy provisions should be interpreted so that every word has a distinct meaning. *See* Galli v. Metz, 973 F.2d 145, 149 (2d Cir. 1992) (applying N.Y. law); Bay State Ins. Co. v. Wilson, 451 N.E.2d 880, 882 (Ill. 1983); Klapp v. United Ins. Grp. Agency, Inc., 663 N.W.2d 447, 453 (Mich. 2003); Balandran v. Safeco Ins. Co. of Am., 972 S.W.2d 738, 741 (Tex. 1998). If the test for expected harm is subjective intent, then the insurance

hurdles for courts. Often it is unclear whether harm resulted from negligent risk-taking or unintentional non-compliance. To illustrate, assume a manufacturer disposes harmful waste knowing her improper disposal will cause permanent contamination. If she disposes the waste improperly, is her behavior a calculated risk or a human error despite aiming for perfect compliance? When subjective intent is inferred from objective evidence (i.e. improper waste disposal, or warnings about the potential of hazard),[80] it is almost impossible to determine if the manufacturer intended to take the risk or whether she suffered from bad moral luck.

In these instances, the choice between using the *Carter Lake* test or the *Johnstown* test determines the scope of coverage. Courts adopting the *Johnstown* approach require the insured to prove the manufacturer *knew* about the risk when she acted. Under this standard, unintentional non-compliance is covered because the manufacturer's harm was neither expected nor intended, but resulted from involuntary behavior. Conversely, the broad *Carter Lake* approach requires proof that the manufacturer *should have known*[81] about the risk—a much lower evidentiary bar that can be

---

policy could have easily precluded intended harm. This contractual interpretation is not necessarily as problematic as it may appear at first glance. Having laid the foundations for how to distinguish between different types of non-compliance in Part II, we can attribute the term "intended" to "intentional infliction of harm" and the word "expected" to "intentional negligent risk-taking." Under this word association, unintentional non-compliance is inapplicable to either of these categories and remains covered by the policy. Even once incorporating "intent" into the narrower subjective test, this term may still have a unique and distinguishable meaning from "intended harm."

[80] The court in *Walnut Grove Partners., L.P. v. Am. Family Mut. Ins. Co.*, 479 F.3d 949 (8th Cir. 2007) concluded that a notice of mold established an expectation that harm would occur. In *Carney*, *supra* note 74, the court ruled that prior allegations against officer misconduct established an expectation by his employer.

[81] Objective approach supports barring recovery, for example, for blatantly foolish behavior, which is sometimes referred to as the "Damn Fool Doctrine." FISCHER, WIDISS & KEETON, *supra* note 53, at 440–42; Tenn. Farmers Mut. Ins. Co. v. Evans, 814 S.W.2d 49 (Tenn. 1991); Metro. Prop. & Cas. Ins. Co. v. Buckner, 302 S.W.3d 288 (Tenn. Ct. App. 2009). The "Damn Fool" doctrine can be conceptualized as a variation of an objective measure to establish subjective expectations regarding an

inferred as a matter of law.[82] With a reduced burden of proof, courts may find the expected or intended harm clause excludes coverage for both intentionally negligent risk-taking and unintentional non-compliance. As a result, the court's decision to evaluate "knowledge" under a subjective or objective test impacts whether courts will find unintentional non-compliance excluded from coverage. If devised broadly, a subjective test prohibits coverage, whereas a narrow interpretation under perfect information allows coverage for bad moral luck.

The second challenge in dealing with subjective intent is gauging the precision of the injurer's knowledge, i.e. how accurately did the injurer anticipate the materialized harm. The injurer may forecast a specific harm from her actions but a different harm actually occurs. For instance, the manufacturer expects her improper waste disposal to pollute the soil, but it unexpectedly expands to pollute the next town's water reservoirs. Additionally, the injurer may expect her actions to produce a certain magnitude of harm; yet, the actualized harm is substantially greater. Again, improper waste disposal may contaminate a larger area because of rain and run-off. An injurer's mistake in assessing her harm's type and magnitude *ex ante* complicates the question of whether it was "expected." Courts must determine whether these miscalculations negate an injurer's expectation of harm. The court's choice of interpretive approach often informs this outcome.

Under a broad *Carter Lake* test, an injurer's harm miscalculation is unimportant since liability can be found under an objective standard. Because the resulting harm is measured against what a reasonable person would have anticipated, the injurer's error is irrelevant. As such, both intentional negligent risk-taking and unintentional non-compliance will be excluded from coverage under an objective standard so long as the reasonable person could anticipate the harm's magnitude and type. Conversely, the narrower *Johnstown* test prioritizes the injurer's predictions as a critical factor in evaluating "expected" harm. This interpretation's advantage is that it covers unintentional non-compliance, which by nature yields less anticipated harms since the objective is compliance with the standard of care. However, the *Johnstown* approach can be over-inclusive and sweep in intentional negligent risk-taking. If intentionally negligent risk-

---

individual's intention to cause harm.

[82] Auto-Owners Ins. Co. v. Harvey, 842 N.E.2d 1279 (Ind. 2006); Am. Bumper & Mfg. Co. v. Nat'l Union Fire Ins. Co., 683 N.W.2d 161 (Mich. Ct. App. 2004).

takers cause harm that is different in-kind or proportion to their initial aims, then by definition their harm was "unexpected", and they receive coverage.

As seen through this discussion, the court's interpretive approach informs the scope of coverage. Whether the court decides to adopt a broad objective test or a narrow subjective test results in comparable unintentional non-compliance being excluded from coverage in some cases but not others. By focusing on the injurer's knowledge at the time of the accident, a narrow subjective test under perfect information distinguishes unintentional non-compliance and intentional negligent risk-taking. Conversely, a broad objective test cannot attain this same filtering and so excludes coverage for the former behavior. While the narrow subjective test seems superior in evaluating the extent of the injurer's "knowledge" (whether she is or is not aware of her activity's possible harm), it is less apt at measuring the accuracy of her knowledge (the certainty of her risk). Under a subjective test, any harm that diverges from the injurer's expectation is "unexpected." Therefore, a narrow subjective test allows coverage for intentional negligent risk-taking when the actualized harm differs. For these reasons, assessing an injurer's harm expectation is important in the coverage analysis, but may lead to imperfect outcomes in some instances.

2. Substantial Probability

In addition to determining "knowledge," courts must also determine the second prong in the "expected" harm subjective analysis: whether the injurer's conduct created a substantial probability of harm. To satisfy this prong, the *Carter Lake* court, like many others,[83] requires a substantial probability that the injurer's harm will materialize. While no court has explicitly quantified the "substantial probability" threshold,[84] we can assume this test demands a higher likelihood than a 50-50% probability. Courts use the "substantial probability" inquiry to gauge an injurer's awareness regarding the likelihood that her harm may occur. In other words, the answer to this inquiry is articulated as a percentage—for instance, Amy is 60% confident that her risk-taking could cause harm. The advantages of the "substantial probability" approach are two-fold. First, it provides flexibility

[83] *Wickman v. Nw. Nat'l Ins. Co.*, 908 F.2d 1077 (1st Cir. 1990); *Carney*, 60 F.3d 1273; *Hartford Roman Catholic Diocesan, Corp. v. Interstate Fire & Cas. Co.*, 199 F. Supp. 3d 559 (D. Conn. 2016); *Honeycomb Sys., Inc. v. Admiral Ins. Co.*, 567 F. Supp. 1400 (D. Me. 1983).

[84] See all the above cases in this part, none defines substantial probability numerically.

to cover unintentional non-compliance since injurers aim for the standard of care yet fail. Absent atypical situations, unintentionally non-compliant injurers take precautions that are close to the legal standard so it is less likely that their conduct will trigger a substantial probability of harm. Second, as a supplement to the "knowledge" requirement, the "substantial probability" inquiry also filters out intentional negligent risk-taking from coverage. If an injurer knows her conduct will impose a high probability of risk, then such harm is expected. To this extent, awareness of a risk's substantial probability necessarily implies knowledge and, therefore, cannot be unintentional.

Despite advantages in filtering injurer behavior, the "substantial probability" probe also presents difficulties. First, it remains unclear what percentage constitutes a "substantial probability," with any determination appearing arbitrary. Does the probability need to be a high threshold like 90% or is a number above 51% sufficient? Second, probability is hard to precisely evaluate because of its speculative nature. Third, this test may exclude beneficial behavior when there is a substantial probability of harm. Fourth, and relatedly, the "substantial probability" test may also suspend coverage for small-magnitude harm, while providing insurance for high-magnitude and costly harm as long as there is a low probability of occurrence.

Although the "substantial probability" analysis seems to conflict with the aims of the expected or intended harm clause, four important factors mitigate these concerns: (1) injurer awareness of unintentional non-compliance; (2) specialty policies; (3) the common law of torts; and (4) restorative efforts. Regarding the first element, when an injurer knows there exists a substantial probability of her harm materializing, then pursuing this activity reveals a deliberate and informed decision. A rational injurer will only participate in an activity when the benefits outweigh the costs. The possibility of losing coverage increases an activity's cost, thereby making it less likely that the injurer will externalize this cost to her insurer. When injurers anticipate their small lapses could produce a substantial probability of harm, then coverage forfeiture will dissuade them from engaging in the activity. Given this effect, insurance policies can exclude injurer behavior that generates a substantial probability of harm as compared to the average policyholder pool even when such harm is unintended.[85]

This arrangement has merit because it mitigates adverse selection and moral hazard problems.[86] When the injurer knows she is likely to deviate

---

[85] Baker, *supra* note 49.

[86] *W. Cas. & Sur. Co. v. W. World Ins. Co., Inc.*, 769 F.2d 381, 385 (7th

significantly from the standard of care or her activity is dangerous, she can exploit this information asymmetry by purchasing insurance and expecting coverage. While some may challenge the assumption that injurers know their own deviation frequencies and magnitudes, it is important to emphasize that injurers are best positioned to acquire information about their own lapses. Although injurers cannot predict their every non-compliance, they know the risk of lapsing and should be incentivized to acquire this information.

Another factor that can provide coverage for unintentional non-compliance is a specialized insurance policy. This tool allows insurers to pool injurers whose slight deviations generate a high probability of harm, thus distributing the risk and providing coverage for these episodes. Medical malpractice and auto-insurance are examples of these policies.[87] Through this insurance structure, policyholders, who may have otherwise been barred from coverage because of their probable harm-generating activity, could still receive coverage. To illustrate, assume a surgeon performs a lifesaving treatment on a patient knowing that this procedure has a high probability of failure and can trigger harmful side effects. Absent a specialized policy that provides coverage for expected harm, the surgeon's conduct will be barred from insurance protection when reviewed under the expected or intended harm clause because she is aware of her high harm-generating probability.

The third vehicle to address significant lapses is through the common law of torts, which excuses certain non-compliant injurers from liability. Negligence law carves out groups that are expected to take fewer

---

Cir. 1985) (suggesting that purchasing insurance can incentivize the insured to "take more risks than before because he bears less of the cost of his conduct."); Gary T. Schwartz, *The Ethics and the Economics of Tort Liability Insurance,* 75 CORNELL L. REV. 313, 338 n.117 (1990) ("'Moral hazard' is sometimes distinguished from 'morale hazard,' the former referring to deliberate acts like arson, the latter to the mere relaxation of the defendant's discipline of carefulness."); George L. Priest, *The Current Insurance Crisis and Modern Tort Law*, 96 YALE L.J. 1521, 1547 (1987) ("Ex ante moral hazard is the reduction in precautions taken by the insured to prevent the loss, because of the existence of insurance").

[87] These specialized policies are also characterized by certain governmental regulation. These regulations create external incentives for insurers to provide insurance for policyholders that can potentially cause great harm. Examples include tort reform and the cap on medical malpractice damages and the requirement for mandatory Automobile Insurance Policy. See ABRAHAM, *supra* note 7, at 281–95.

precautions.[88] Children, the elderly, and individuals with disabilities, for example, are consistently assessed against a lower standard of care.[89] In the context of coverage forfeiture, negligence doctrines protect these individuals so that even highly probable risk-generating behavior may not be classified as negligent. This exception occurs when the injurer is part of a recognized sub-group that has traditionally been evaluated under a lower standard, and she meets this standard notwithstanding her harm's high probability. In this way, negligence law shields certain groups from suspended coverage since their liability threshold is already set at an exceptionally high standard.

Finally, coverage may be regained from conduct with a substantial probability of harm if the injurer took actions to mitigate her risk. Several courts advance this idea by allowing recovery if the defendant attempted to reduce her risk. For example, in *Potomac Ins. of Ill. v. Jonson Huang*,[90] the court found that when the defendant "took proactive measures to repair and replace the leaky windows in a sincere attempt to avoid recurrent incidents of the same nature…[he] fully hoped and expected that its remedial efforts would prevent subsequent incidents of the same nature."[91] By reducing the likelihood of occurrence or recurrence, preventative measures insulate the injurer from expecting subsequent accidents. As a result, when an injurer knows her conduct has a substantial probability of causing harm and she takes measures to lessen it, then the risk's manifestation should legally be considered "unexpected."

While the aforementioned approaches may reduce the adverse effects of the "substantial probability" test, insurance companies can offer a superior solution. Foremost, insurers can adjust their policy language away from expected harm—a "substantial probability" inquiry— and towards assessing the magnitude of harm—a "substantial risk" examination. Under this new focus, courts can determine that an injurer's conduct was "expected" when her action produced a substantial *risk* of harm regardless of its occurrence probability.

Although colloquially similar, "substantial probability" and "substantial risk" evaluate different factors, and thus result in disparate outcomes. Unlike "substantial probability" which measures chance, "substantial risk" concerns the degree of risk. We can conceptualize this

---

[88] Ben-Shahar & Porat, *supra* note 33, at 636–41.

[89] ABRAHAM, *supra* note 7, at 64–67.

[90] Potomac Ins. of Ill. v. Jonson Huang, No. 00-4013-JPO, 2002 U.S. Dist. LEXIS 4710, at *25 (D. Kan. Mar. 1, 2002).

[91] *See also Lone Star Steakhouse & Saloon, Inc., v. Liberty Mut. Ins. Grp.*, 343 F. Supp. 2d 989 (D. Kan. 2004).

distinction in economic terms, where substantial risk is the probability of harm multiplied by the accident cost. This is its main advantage: a "substantial risk" approach provides courts with a calculation for measuring probability. For example, a 5% marginal increase in probability (from 2% to 7%) for $2 billion in environmental damages can be a substantial risk even though generally a 7% probability of harm may seem low. Absent this "substantial risk" computation, courts are left with arbitrary line-drawing. The arbitrariness problem is not present in a "substantial risk" examination since courts can weigh the resulting harm against the activity's benefits.

While "substantial risk" solves the computation problem, this approach has limitations and may fail to differentiate unintentional non-compliance and intentional negligent risk-taking when unintentional activities generate substantial risks. One way to conceptualize this outcome is by grouping "risk" into three categories: compliance, ordinary, and substantial. An injurer who conforms with the standard of care only imposes a compliance risk—a risk injurers can legally inflict without being liable for the resulting harm. However, both ordinary and substantial risk suggest some deviation from the standard of care. In order for an injurer's harm to be expected, a "substantial risk" examination requires her risk be substantial in magnitude, not just likelihood.

One disadvantage of the "substantial risk" approach is that it ignores activities that diverge from the typical correlation that increased precautions reduce accident costs. In fact, small lapses may lead to an enormous increase in an accident's probability or the risk level. For example, assume that physicians lapse randomly when analyzing their patients' test results. A physician's slight misreading may have larger implications in the future if her mistake prevents an early cancer diagnosis. When courts use "substantial risk" to estimate a harm's "substantial probability," then unintentional non-complaint injurers are barred from coverage when small lapses produce a large increase in risk.

In sum, courts currently use the "substantial probability" test to determine whether coverage should be barred when the injurer knew about her risk. This test provides a good mechanism to infer knowledge since courts can cite to an injurer's awareness of substantial probability as evidence that her harm was expected. However, despite this advantage, this test lacks a reliable computation method for courts to determine what degree of certainty amounts to a "substantial probability." This shortcoming can sometimes be mitigated through injurer awareness of unintentional non-compliance, specialty policies, the common law of torts, and restorative efforts. Yet such solutions are not guaranteed. In response, insurers may be wise to adopt a different assessment approach by drafting their insurance

policies to bar coverage for harm with a "substantial risk" rather than harm with a substantial probability of occurring. This shift in evaluation is better aligned with efficiency considerations because it provides courts a more reliable computation to measure expected harm. Although offering important advantages when compared to the "substantial probability" test, the "substantial risk" test has its own imperfections, which can lead courts to bar coverage for unintentional non-compliance since the "substantial risk" knowledge requirement is also vulnerable to misclassification. This outcome is described further in Section III.C.1.

IV. OPTIMAL INTERPRETATION

The expected or intended harm clause allows insurance companies to differentiate between bad moral luck and intentional negligent risk-taking. Due to interpretive imperfection, courts undermine this aim when assessing subjective expectation and substantial probability. To mitigate this problem, this article recommends adding a best efforts component[92] to the "expected" harm analysis where injurers are evaluated according to their personal abilities. By rejecting the *Carter Lake* objective approach and refining the *Johnstown* subjective standard, the best efforts test provides a more reliable way to distinguish intentional non-compliance. With an enhanced mechanism for identifying "expected" harm, courts can more consistently interpret the expected and intended harm clause to exclude coverage for intentional negligent risk-taking, without also barring unintentional non-compliance. At this core, the best efforts test shifts the inquiry from a knowledge-oriented analysis (what did the injurer know?) to a behavior-oriented analysis (how did the injurer act?). The following sections detail this test's advantages, the need for shifting the burden of proof, and possible criticisms.

---

[92] The best efforts test suggested in this article is similar to the Second Order Precaution defense that has been suggested in the context of negligence law. *See* Cooter & Porat, *supra* note 33; However, the Second Order Precautions defense raises certain problems in the context of negligence, such as the problem of proving causation, which the authors note, *id.* at 355–56. There is no causation problem in the insurance policy context. Additionally, there is no problem of costing shifting to the victim, a party that usually cannot contract with the injurer, rather to the insurer a party that have contracted with the insurer. Hence, inefficiencies in cost shifting could be solved contractually between the parties.

A. DETERMINING WHAT IS "BEST"?

A critical component of the best efforts test is how to measure "best." While an injurer's actual efforts provide insight into intentionality, this criterion can be over-inclusive because it also captures minimal risk-taking that appears unintentional. To avoid this problem, the legal test must ensure that an injurer's efforts represent her *best* precautionary measures, not just her *actual* precautionary measures. Defining "best" implicates both practicality and fairness concerns. Regarding practicality, injurers must be able to meet the standard of care notwithstanding their imperfections. In terms of fairness, only efforts that surpass a higher threshold should qualify as "best" compared to any generic effort.

In applying a best efforts test, courts should evaluate an injurer's negligent behavior against her ordinary conduct in order to establish a subjective standard of care. To accomplish this analysis, courts must examine the injurer's behavior over an extended period of time before the accident—an approach which deviates from traditional tort doctrine by considering previous compliance. For instance, an injurer with a speeding infraction would be assessed against her past driving record. A medical malpractice claim would invite examination into the physician's records. Pollution would trigger research into a factory's historical handling of its toxins. By evaluating an injurer's previous actions, courts can learn a great deal about her ordinary behavior and see how her negligent conduct compares. If an injurer maintains a strong record of previous compliance, then it is more likely her harm resulted from unintentional non-compliance. The inverse is also true where frequent substantial deviations suggest intentional negligent risk-taking. Revisiting *Carter Lake* assume the municipality provided evidence of: (1) their timely response to previous complaints; and (2) a record of answered complaints. If the court believes, the municipality's behavior did not fall substantially below its ordinary conduct, then such conduct does not indicate a lack of "best" efforts, and thus a defense should stand as the case does not constitute intentional negligent risk-taking, and vice versa.

A likely criticism to the best efforts test is that it incentivizes injurers to reduce their ordinary precautions, so their subjective standard is also lowered. While a valid concern, mitigating factors within the insurance industry counteract this problem, especially premiums. Insurance policies undergo an underwriting process in which the insurance company determines the injurer's level of risk. Lowering one's best efforts standard to qualify for *ex-post* coverage can increase the insurance premium *ex ante*. In fact, in some cases, applicants with high ordinary risk may not be able to

obtain insurance at all. To counteract higher premiums, injurers will show they do not pose a risky investment and have exceptional "best efforts." Having presented this narrative to capitalize on lower premiums, the injurer will be foreclosed from later arguing that her best efforts comport to a lower standard. Given these counterbalancing factors, an injurer's best efforts will correlate to the standard initially presented and captured by the policy premium.

Another criticism of the best efforts test is that it incentivizes insurance companies to require timely updates of injurer behavior. While a potential administrative inconvenience, this byproduct is not necessarily a disadvantage. If the injurer and insurer both know that "best efforts" includes behavior captured by the policy and premium, then each party will be incentivized to provide the other with periodic information. Injurers will be motived to submit their information because a record of compliance safeguards against "expected" harm claims. Similarly, insurers have an interest in receiving this information, which would normally not be shared, so they can update their policy terms and premiums.

Thus far, we have examined the best efforts test through the injurer's representations, but policy warranties also serve as a reliable "best" effort proxy since they reveal the injurer's guarantees. No legal rule prevents parties from incorporating the injurer's subjective standard of behavior into the insurance policy as a form of warranty. For example, an insurer may require a factory to pledge its compliance with its own rules regarding hazardous material handling. In response, the factory is incentivized to create rules that are not too strict to facilitate easy compliance but also not too lenient, which will increase the premium price. As such, when insurance policies use a subjective standard, they provide courts a better rubric to measure the injurer's conduct.

B. BURDEN OF PROOF – BEST EFFORTS AS A DEFENSE

In order to bar coverage, the insurance company bears the burden of proof.[93] To satisfy its burden, the insurer must prove that the injurer had (1)

---

[93] Johanna Hjalmarsson, *The Standard of Proof in Civil Cases: An Insurance Fraud Perspective*, 17 INT'L J. EVIDENCE & PROOF 47, 48 (2013); William C. Hoffman, *Common Law of Reinsurance Loss Settlement Clauses: A Comparative Analysis of the Judicial Rule Enforcing the Reinsurer's Contractual Obligation to Indemnify the Reinsured for Settlements*, 28 TORT & INS. L.J. 659, 698–99 (1993).

subjective knowledge that there was (2) a substantial probability of harm.[94] Once the insurer satisfies these two elements, the best efforts test can be used as a defense, rather than an independent claim. The best efforts test is optimally situated as a defense for several reasons. First, this test assesses the injurer's culpability, competence, and behavior—all information within the injurer's possession.[95] As such, it is efficient to assign the injurer the burden of proof because her superior access to this information and high level of reliability makes her the cheapest information gatherer.[96] Moreover, as the above discussion revealed, the underwriting process discourages injurers from lying about their best efforts because their premiums reflect their capacities.

Second, assigning the burden of proof to the insurance company creates a conflict of interest. Rational injurers will not provide best efforts evidence when it is lacking because they will lose coverage. If the insurance company fails to satisfy its burden of proof because of insufficient evidence, then coverage will be granted regardless of whether the injurer exercised her best efforts. In this way, the injurer is incentivized to keep deficient best effort evidence secret since she benefits when the insurance company cannot prove this element. This result bolsters the broad subjective test's over-inclusiveness because any mitigating effect becomes marginal.

Third, employing a best efforts defense lowers litigation costs. A defense is triggered when courts rule that the expected or intended harm clause exclusion applies. As such, in cases where the court finds no exclusion, the best efforts test is superfluous because failure to meet the first two conditions—subjective knowledge and substantial probability—is fatal. Conversely, when the injurer believes she has a strong best efforts defense, then parties can litigate this question first. If the court finds for the injurer, then the "expected" harm inquiry becomes secondary since the injurer took her best precautions. For these reasons, a best efforts defense is optimal because the injurer possesses the necessary information and is incentivized to use it in her defense. Moreover, this defense saves litigation costs because

---

[94] *Compare* with the current requirement for substantial probability *supra* Part III.C.2.

[95] Ben-Shahar & Porat, *supra* note 33.

[96] Similar argument made in the context of contractual disclosure, *see* Anthony T. Kronman, *Mistake, Disclosure, Information, and the Law of Contracts*, 7 J. LEG. STUD. 1, 4 (1978) ("[A] court concerned with economic efficiency should impose the risk on the better information gatherer").

it is only implicated when the exclusion applies at which point it can be litigated first.

C. DISTINGUISHING "BEST EFFORTS" FROM SECOND ORDER PRECAUTIONS

This article's best efforts test parallels Robert Cooter and Ariel Porat's Second Order Precautions defense in negligence law.[97] Cooter and Porat recommend that First Order Precautions, those actually taken by the defendant and affect the likelihood of accident, should be distinguished from Second Order Precautions, "behavior that changes the probability distribution over first-order precaution."[98] It is important to distinguish the best efforts test from Second Order Precautions because while they may seem to overlap they maintain material differences.

First, Second Order Precautions are used to determine negligence and, therefore, affect litigation between injurers and victims.[99] Conversely, the best efforts test applies to disputes between injurers and insurers, so it does not directly impact victims and their precaution incentives. Second, self-control grounds Second Order Precautions, which injurers can continue managing even if they lapse when taking First Order Precautions.[100] Employing Cooter and Porat's hypothetical,[101] a driver might not always control her speed, but she can always glance at her speedometer. Straying from Second Order Precautions, the best efforts test takes a broader approach assuming that injurers can lapse when controlling their speed *and* when deciding how frequently to consult their speedometer. In this way, both actions are unintentional lapses under the best efforts test.

Third, Second Order Precautions presume an individual's capacities, which *de facto* applies an objective standard.[102] The best efforts test rejects this objective standard in favor of a personalized rubric constructed from the injurer's characteristics and competencies. Under an objective analysis, evidence of the injurer's best efforts is marginally significant because the standard is measured against the reasonable person. For instance, an injurer's

---

[97] *See* Cooter & Porat, *supra* note 33.

[98] *See* Cooter & Porat, *supra* note 33, at 330.

[99] *See* Cooter & Porat, *supra* note 33, at 330–31.

[100] *See* Cooter & Porat, *supra* note 33, at 345–48.

[101] *See* Cooter & Porat, *supra* note 33, at 330.

[102] *See* Cooter & Porat, *supra* note 33, at 347 (suggesting the second-order precaution defense will be based on reasonableness).

exceptional driving record has no bearing on a speeding case. Similarly, a factory that pollutes hazardous chemicals beyond the legally permitted limit cannot introduce evidence of prior compliance. These outcomes are undesirable because they treat defendants as intentional negligent risk-takers when their harm could also plausibly result from unintentional non-compliance. As such, this objective approach underutilizes valuable information that the best efforts test prioritizes.[103] Relevant inquiries under the best efforts test include: does the driver speed regularly, and if so, what is her degree of deviation? Did the factory comply with its own internal rules? All these questions try to assess whether the injurer's non-compliance was unintentional by measuring her conduct against her ordinary behavior. Constant deviations or repeated high-risk activities indicate intentional non-compliance whereas infrequent episodes or small deviations suggest unintentional non-compliance.

Finally, the best efforts test does not face the same evidentiary hurdles as Second Order Precautions.[104] Since the latter is a defense within negligence law, it often confronts problems with proving causation.[105] In some cases, it is almost impossible to prove that Second Order Precautions could have prevented an accident. To illustrate, a driver looking at her speedometer takes a Second Order Precaution because her action reduces her distribution of lapses. However, proving that another glance at the speedometer would have prevented her accident is a herculean task given its hypothetical nature.[106] Within the insurance context, where the best efforts test operates, this causation problem does not exist. The expected or intended harm clause renders additional precautions irrelevant since it is the injurer's intention that matters most. Thus, although the best efforts test seems to overlap with Second Order Precautions, they diverge significantly. While Second Order Precautions provide a theoretical framework from which the best efforts test borrows, the latter is further tailored to meet the efficiency concerns within insurance.

D. APPLICATION OF THE BEST EFFORTS TEST

To evaluate the best efforts test's force, it is important to consider how courts would apply it in interpreting the expected or intended harm clause. When an injurer's expectation is interpreted narrowly so to require

---

[103] Ben-Shahar & Porat, *supra* note 33.
[104] Cooter & Porat, *supra* note 33, at 356.
[105] *Id*.
[106] *Id*.

actual knowledge of a substantial probability of risk, then the best efforts test is insignificant. There is no need to assess an individual's best efforts if courts exclude coverage only for intentional actions. Thus, if an injurer intended to engage in negligent behavior, then she did not exercise her best efforts to conform with the standard of care.

While inapplicable in these scenarios, the best efforts test becomes valuable for courts engaging in a broad subjective analysis where the injurer possesses knowledge of harm but lacks the capacity to avoid it. This test also proves beneficial in cases where objective evidence leads courts to infer subjective (constructive) knowledge as a matter of law.[107] Thus, the central inquiry grounding the best efforts test under a subjective analysis is whether the injurer exercised sufficient care to yield the lowest accident cost given her idiosyncratic characteristics.

A review of *Harleysville Worcester Ins. Co. v. Paramount Concrete*[108] reveals how the best efforts test would operate. In *Harleysville Worcester*, a concrete factory faced charges for producing defective concrete that caused severe damage to the pools in which it was used. In its opinion, the court concluded that the factory "lacked an effective quality control system, its management lacked experience with concrete, and its batch man did not feel adequately trained. Those issues point to severe deficiencies in Paramount's operations and were enough for the jury to find that it acted recklessly."[109] However, the court ruled, that even if the jury found the company's behavior reckless, the harm was not "expected" under a subjective standard of injurer intent. It continued, "But [the plaintiffs] d[id] not prove that the relevant individuals at Paramount *actually knew, much less intended*, that the shotcrete was so defective it could cause harm." Such language highlights the court's reliance on a narrow subjective test where harm is "expected" if the injurer intends or has knowledge of an accident's possibility.

However, if the *Harleysville Worcester* court adopted a broad subjective interpretation, then the factory's incompetence could satisfy the subjective knowledge requirement for "expected" harm. To this extent, the factory's management knew it lacked the necessary knowledge about its product and maintained inferior quality-control technology compared to the rest of the industry. Using a broad *Carter Lake* approach, the court could

---

[107] *See supra* note 82.

[108] *Harleysville Worcester Ins. Co. v. Paramount Concrete*, 123 F. Supp. 3d 282 (D. Conn. 2015).

[109] *Id*. at 300 (internal quotations omitted).

reasonably conclude that the factory's management knew or should have known about the risk their product imposed.

If this outcome occurred, then the best efforts test would trigger, thereby allowing the factory to present evidence that the management team exercised its best efforts given their limited expertise and resources. Having examined the factory's best efforts evidence, the court could decide that the harm was "unexpected" and thus entitled to coverage. Courts would not be able to achieve this outcome if they applied a *Carter Lake* construction of knowledge and conducted a "substantial probability" inquiry because the factory's best efforts would be irrelevant in these assessments.

Similar to the *Harleysville Worcester* counterfactual, *Carter Lake* would also result in a different outcome if we applied the best efforts test. Unlike the former, the *Carter Lake* municipality was aware of their failing sewage system and knew, or should have known, that there was a substantial probability for a second flood.[110] Despite this knowledge and the foreseeable probability of a heightened flood risk, the municipality did not act to prevent future accidents.[111] The municipality's conduct clearly illustrates a failure to exercise its best efforts. With no evidence of alternative precautions, the court would find the municipality's harm "expected" and thus not a result of unintentional non-compliance. Once identified as "expected" harm, the municipality's conduct would be excluded from coverage.

The best efforts test does not distort the outcome in *Carter Lake*. The municipality forfeited its insurance coverage by engaging in intentional negligent risk-taking because it failed to take efforts to mitigate their risk.[112]

---

[110] *Carter Lake v. Aetna Cas. & Sur. Co.*, 604 F.2d 1052, 1059 (8th Cir. 1979) ("the probability of an identical equipment failure and consequential flooding of the [plaintiff's] basement on a particular day was relatively slight, about 2% With hindsight. However, there was clearly a substantial probability of another backup at some time caused by an identical equipment failure if the equipment was not replaced or an alarm system installed").

[111] *Id.* ("Nevertheless, Carter Lake took the calculated risk that such backup would not occur,and elected to continue operations without correcting its methods").

[112] *Id.* ("Once the city was alerted to the problem, its cause, and the likelihood of reoccurrence, it could not ignore the problem and then look to Aetna to reimburse it for the liability incurred by reason of such inaction. [internal citation omitted] Once the city was alerted to the problem, its cause, and the likelihood of reoccurrence, it could not ignore the problem and then look to Aetna to reimburse it for the liability incurred by reason of such

Had the municipality engaged in good-faith yet unsuccessful efforts to prevent the accident, it is likely the court would have found the harm "unexpected." In fact, courts have often found no expectation of harm when injurers attempt to take sufficient care, even if those precautions are insufficient.[113] For example, in *Aetna CA's. & Sur. Co. v. Dow Chem. Co.*,[114] the court, as a matter of law, found that the injurer did not expect the magnitude of contamination despite knowing the disposed materials' hazardous nature. Instead, the court held that the injurer took sufficiently reasonable precautions to mitigate the possible harm.[115] In other words, the injurer exercised her best efforts to lessen the risk; therefore, shifting the inquiry from an examination of knowledge to an examination of behavior. *Aetna* suggests that, in certain cases, some courts cannot adequately assess knowledge and so turn to examining the injurer's behavior. As such, this case illustrates how examining conduct can be superior to evaluating knowledge. This article recommends that by adding this third prong—the best efforts test—courts can more consistently interpret the expected or intended harm clause to exclude intentional negligent risk-taking but not unintentional non-compliance. Ultimately, the best efforts test achieves more efficient outcomes.

The best efforts test is also operative under the court's "substantial probability" inquiry. A behavior-based examination can reveal the probability of harm an injurer imposes over time given her idiosyncratic characteristics. When an injurer's behavior creates a sudden unexplained increase in the probability of harm, her conduct will be classified as "expected" in comparison to her smaller deviations. Inversely, when the injurer's harm-generating behavior aligns with her ordinary deviations and this risk is incorporated in her insurance policy, then the injurer may keep her coverage under the best efforts test despite her conduct's "substantial probability" since this is the risk she was underwritten.

Alternatively, if insurers decide to adopt the more efficient "substantial risk" test, the best efforts test still offers relief for the misclassification problem. Under this recommended approach, the insurance company could underwrite the injurer for a certain risk range. Over time, the risk will increase and decrease due to the injurer's limited cognitive capacity

---

inaction").

[113] *See supra* notes 90–91 and accompanying text. *See also* FISCHER, WIDISS & KEETON, *supra* note 53at 442–43.

[114] Aetna Cas. & Sur. Co. v. Dow Chem. Co., 28 F. Supp. 2d 421 (E.D. Mich. 1998).

[115] *Id*. at 434.

to constantly comply with the standard of care. Any sudden unexplained or unexcused deviation triggered by the injurer's risky behavior would provide evidence that the injurer did not exercise her best efforts. Conversely, when a substantial risk materializes but remains within the risk range incorporated into the underwriting process, then the injurer's conduct can be covered. In this way, whether insurers continue to use a "substantial probability" inquiry or shift to a "substantial risk" approach, the best efforts test offers a good mechanism to address the activity misclassification problem which occurs under both tests.

E. BEST EFFORTS TEST AND THE INSURTECH LANDSCAPE

Acquiring the injurer's behavior information demands a significant investment in the underwriting process and an ongoing examination, requirements that may seem impractical. However, like many other commercial vendors, the insurance industry is experiencing radical innovations in technology which may improve such information gathering both in accuracy and efficiency. These technological changes within the insurance industry have led to the emergence of a new market—InsurTech.

In recent years, the traditional insurance industry has transformed as new insurers emerge and incumbent companies offer innovative services. In particular, these actors and services aim to incorporate technological advancements into various aspects of the insurance industry. For example, some web-based insurance providers sell policies for accidents that have not traditionally been protected in the insurance market, such as a flight delay policy or a cracked screen policy.[116] These new policies signal insurers' enhanced abilities to assess risk and offer better coverage against high-risk behaviors and events. One way providers achieve this service is by engaging in an advanced underwriting process,[117] such as the Big-Data-based underwriting procedure.[118] Other insurers incorporate behavioral economics[119] into the underwriting process to structure policies and set

---

[116] Don Weinland & Oliver Ralph, *ZhongAn launches InsurTech concept to world*, FINANCIAL TIMES (Sept. 25, 2017), https://www.ft.com/content/c9d10ada-9eb1-11e7-8cd4-932067fbf946 (In addition to these examples, ZhongAn also offers a shipping return policy).

[117] *Id.*

[118] *Id.* (For example, updating the policy premium according to current weather reports).

[119] Lemonade, *Lemonade Launches Insurance API*, PR NEWSWIRE (Oct.

premiums through Artificial Intelligence (AI).[120] These advanced underwriting procedures rely on information gathered through mass-data[121] collections from smart-phones, web searches, wearable sensors,[122] and meta-data, among others to make better-informed decisions about an applicant's risk level.[123] Access to this information's quantity and quality better positions insurance companies to assess risk, set representations and warranties, as well as mitigate exposure to moral hazard and fraud.

Although insurers employ different approaches, these changes to the insurance industry maintain a commonality: they seek to reduce information asymmetry between providers and injurers. By efficiently collecting information about policyholders or applicants,[124] providers can strategically adjust their premiums and design more personalized insurance policies. Currently, these advancements are most active in health and automobile insurance,[125] but we can expect growth beyond these industries due to the numerous advantages specialization offers.

In the context of the expected or intended harm clause, we can expect a few changes to occur simultaneously or consecutively. First, as more

---

10, 2017), https://www.prnewswire.com/news-releases/lemonade-launches-insurance-api-650210233.html.

[120] Jemima Kelly & Carolyn Cohn, *Insurers Hope InsurTech Will "Nudge" Customers to Less Risky Behaviors*, INS. J. (Sept. 19, 2017), http://www.insurancejournal.com/news/national/2017/09/19/464718.htm.

[121] Shanique Hall, *How Artificial Intelligence is Changing the Insurance Industry*, CIPR NEWSLETTER 2, 6 (Aug. 2017), http://states.naic.org/cipr_newsletter_archive/vol22.pdf.

[122] Elizabeth Gurdus, *UnitedHealthcare and Fitbit to pay users up to $1,500 to use devices*, CNBC (Jan. 5, 2017), https://www.cnbc.com/2017/01/05/unitedhealthcare-and-fitbit-to-pay-users-up-to-1500-to-use-devices.html.

[123] Kelly & Cohn, *supra* note 120 (For example, Telematics devices in care which are "black boxes in cars which enable insurers to check customers' driving and reward safer habits."). *See also* Tyler Tappendorf, *Five InsurTech Trends and What They Mean for Microinsurance*, MICROFINANCE GATEWAY (Feb. 2017), https://www.microfinancegateway.org/blog/2017/feb/five-insuretech-trends-and-what-they-mean-microinsurance.

[124] Russ Banham, *Investing in the InsurTech Toolbox*, RISK MGMT. (June 1, 2017), http://www.rmmagazine.com/2017/06/01/investing-in-the-insurtech-toolbox/.

[125] See *supra* notes 120–123 and accompanying text.

information about the injurer is available, unintentional non-compliance will be more predictable. Insurers will know promptly, through constant data collection, when a policyholder fails to meet an objective standard, thus transforming the underwriting process from a preliminary step to an ongoing examination.[126] Access to this information will also impact the best efforts test as judges shift from a theoretical exercise of determining "best" efforts to a more technical regression analysis.

Second, this enhanced approach will also enable insurers to more easily and accurately evaluate an injurer's risk-taking intentions. With access to the injurer's private records, providers can create a baseline of their policyholder's ordinary behavior. Using this metric, providers can observe an injurer's conduct for deviations with frequent episodes suggesting intentional negligent risk-taking and prior compliance indicating unintentional incompliance. [127]

V. CONCLUSION

Negligent defendants do not comply with the standard of care for one of two reasons. First, an injurer may wish to engage in intentional negligent risk-taking even if she is capable of meeting the standard. In this case, she has taken a calculated risk that an accident will not occur and has proceeded under this probability. Second, injurers may act negligently despite exercising their best efforts because of lapses, failures to meet the objective standard, and *res ipsa loquitor*. This article classifies the latter category as unintentional non-compliance.[128] When insurance policies can

---

[126] Hall, *supra* note 121, at 6. Gurdus, *supra* note 122.

[127] As policies become more individualized, the expected or intended harm clause will slowly lose its applicability since insurers will prefer specific contractual provisions to general "basket" clauses. For a review of personally tailored policies *see* Matt Cullen, *InsureTech Firms Look to Disrupt, but not to Overtake Incumbents*, LSE BUS. REV. (Jun. 14, 2016), http://blogs.lse.ac.uk/businessreview/2016/06/14/insuretech-firms-look-to-disrupt-but-not-to-overtakeincumbents/.

[128] This article does not conceptualize intentional negligent risk-taking as bad moral luck because under those circumstances the decision to engage in negligence is deliberate. The fortuitous element is the accident – the materialization of the risk. Hence, in my view, intentional risk-takers suffer from bad luck generally rather than bad *moral* luck.

bar coverage for the first injurer but not the latter, then we achieve an optimal result.

One mechanism that insurance policies can use to distinguish these two injurer-types is the expected or intended harm clause, which bars coverage when an injurer expects her conduct will cause harm. Courts disagree on what constitutes "expected" or "intended" harm.[129] Some jurisdictions require that the injurer has a subjective expectation[130] that harm has a substantial probability of occurring while other require an objective one.[131] These two approaches represent the most common interpretations of the expected or intended harm clause exclusion. Most courts also require that the accident's probability be particularly high.[132]

Both these approaches have limitations, imperfections, and tradeoffs. On the one hand, an explicit knowledge inquiry solves the problem of bad moral luck but allows coverage for intentional negligent risk-taking when subjective awareness evidence is difficult to obtain.[133] On the other hand, when courts require a subjective expectation of harm, bad moral luck may be barred from coverage.[134] Given human error, it is inevitable that injurers will sometimes engage in unintentional non-compliance that cannot be mitigated.[135] The substantial probability test, which bars coverage for accidents with a high probability of expected harm may help alleviate this problem but will not resolve it.[136]

The best efforts test provides a valuable tool for courts to efficiently distinguish between intentional and unintentional non-compliance. Formulating this test as a defense correctly incentivizes parties to supply important information as evidence, which ultimately saves litigation costs. This test also faces its own limitations and constraints. First, information about the injurer's best efforts may not be available. Second, the study of lapses and limited cognitive capacity is still evolving, leaving many questions unanswered in this area. Nevertheless, as legal and behavioral research continues to develop, we can gain additional insights into addressing these problems in tort law. Finally, further research may also

---

[129] *See supra* Part III.C.

[130] *See supra* note 75.

[131] *See supra* notes 70 and 74.

[132] *See supra* notes 74–75. *See also* FISCHER, WIDISS & KEETON, *supra* note 53 at 435–37.

[133] See *supra* Part III.C.1.

[134] See *supra* Part III.C.1.

[135] See *supra* Part III.C.1.

[136] See *supra* Part III.C.2.

prove beneficial in determining whether applying the best efforts test is justified from an efficiency or fairness perspective in other areas of the law, including contracts, criminal law, and administrative law. In these fields, using the best efforts test to assess the injurer's capability may yield different and superior results than those produced by the objective tests currently employed.

CONTRACT AND CLAIM IN INSURANCE LAW

JAY M. FEINMAN*

ABSTRACT

This article offers a new perspective on insurance law by examining and combining two basic features of insurance and insurance law: the nature of the insurance contract and the fact that most insurance law issues concern a disputed claim. Insurance law scholars are fond of reconceptualizing their subject. Insurance policies and insurance law have been likened to a means of public utility regulation, a product warranty, a social institution, or, perhaps mostly simply, a thing. This article represents another conceptualization of the subject, and one that may be less foreign to the subject and closer to the reality of the formation and performance of insurance relationships.

Every insurance policy is a contract between the policyholder and the insurer. Fundamentally, however, almost every insurance law problem, dispute, or doctrine is really about paying or not paying claims. These two features—contract and claim—are at the heart of most insurance law disputes. The significance of insurance as contract is generally recognized, but the centrality of claims, less so. The article examines each of them separately and then combines them. Doing so provides a perspective on a large number of insurance law issues, and that perspective should change the courts' approach to a number of issues and doctrines. The focus is on personal lines, particularly first-party insurance, but the analysis also has implications in other settings.

The article first presents the contract and claim analysis. It then applies the analysis to several common issues in insurance law. The illustrations come from three different points in the life of an insurance policy. The first concerns a formation issue: when an insurer may use misstatements by a policyholder in the application process to avoid coverage. The second, and most general, addresses interpretation issues that concern the insurer's performance of the insurance contract. The third concerns issues of policyholder and insurer performance after a claim is filed—the false swearing rule and the law of insurance bad faith. All three reinforce the

---

*Distinguished Professor of Law, Rutgers Law School; Co-Director, Rutgers Center for Risk and Responsibility. My thanks to James Davey, Rick Swedloff, and participants in the Insurance Fraud Symposium at the University of Southampton School of Law for their comments.

insight that every doctrinal issue involves a conception of the insurance contract and arises because of a disputed claim. The discussion demonstrates that courts sometimes use similar analysis, describes those tendencies, suggests why they are incomplete, and uses the contract and claim analysis to make them explicit and more comprehensive. Other courts take quite different approaches; contrasting those approaches with the contract and claim analysis demonstrates what they get wrong. The result is both a demonstration of the usefulness of the article's analysis and a beginning catalog of how it can reshape insurance law doctrine.

TABLE OF CONTENTS

I. THE CONTRACT AND CLAIM ANALYSIS...……161
A. CONTRACT.……161
1. Formation ……163
2. Performance ……166
B. CLAIM……169
C. CONTRACT AND CLAIM COMBINED..……173
II. APPLICATIONS OF THE CONTRACT AND CLAIM ANALYSIS.……174
A. AT FORMATION: REPRESENTATIONS AND WARRANTIES ….175
B. DURING PERFORMANCE: INTERPRETATION AND REASONABLE EXPECTATIONS ...……180
C. AT THE POINT OF CLAIM: FALSE SWEARING AND BAD FAITH…….…187
1. False Swearing …….…187
2. Bad Faith ……..193
CONCLUSION ……196

This article offers a new perspective on insurance law by examining and combining two basic features of insurance and insurance law: the nature of the insurance contract and the fact that most insurance law issues concern a disputed claim.

Every insurance policy is a contract between the policyholder and the insurer. As such, many of the disputes between policyholders and insurers come to court framed as contract disputes. Many disputes are about rules and principles of interpretation. How is the policy term of "an occurrence" applied? When should policy language be read in accordance with the reasonable expectations of a policyholder and how are those expectations created? Other doctrines fill gaps in policy language or limit pure application of policy language. When does estoppel or waiver permit

an insurer's actions to trump policy language? Is anti-concurrent causation language void as against public policy because of a conflict with the doctrine of efficient proximate cause?

Fundamentally, however, almost every insurance law problem, dispute, or doctrine is really about paying or not paying claims. The rules of insurance policy interpretation determine whether facts giving rise to a claim are within policy language. Estoppel and waiver are asserted by a policyholder to prevent an insurer from denying a claim otherwise excluded from the terms of the policy. The doctrine of reasonable expectations, void as against public policy, and more rules and principles of insurance law become relevant and are given effect only because a policyholder disputes an insurer's denial of its obligation to pay a claim.

These two features—contract and claim—are entailed in most insurance law disputes. The significance of insurance as contract is generally recognized, but the centrality of claims, less so. The article examines each of them separately and then combines them. Doing so provides a perspective on a large number of insurance law issues, and that perspective should change the courts' approach to a number of issues and doctrines. The focus is on personal lines, particularly first-party insurance, but the analysis also has implications in other settings.

I. THE CONTRACT AND CLAIM ANALYSIS

A. CONTRACT

The non-controversial starting point is that an insurance policy is a contract. The policy is created by a voluntary market transaction between the insurer and the policyholder, but like every other contract, it is made enforceable and regulated by law. Law regulates insurance policies through statutes, administrative regulations, and judicial decisions. It does so with two aims.[1]

The first aim is to improve the contracting process itself. This aim is concerned with improving the conditions of the many individual transactions through which insurance is bought and sold, thereby improving the insurance market as a whole. It defines the rules of contract formation, attempts to cure

[1] This structure is roughly parallel to Abraham's "two fundamental questions" of insurance law: the enforcement of policy language (to which I would add enforcement of a contractual obligation not clearly specified in the policy) and "'public law' values." Kenneth S. Abraham, *Four Conceptions of Insurance*, 161 U. PA. L. REV. 653, 656 (2013).

deficiencies in the process of assent, and addresses impediments to full and fair contracting such as moral hazard and adverse selection that potentially undermine the market for insurance.

The second aim is to advance public policies that are less immediately tied to the contracting process. There are a broad range of such policies including, for example, preventing discrimination in the underwriting process[2] and providing compensation for tort victims through liability insurance.[3]

This simple framing poses several complex questions. First, if an insurance policy is a contract, and what kind of contract is it, and what are the implications of that question for insurance law? Second, how should insurance contracts be regulated? This article mostly puts aside the second form of regulation, in service of external public policies, but that still leaves a lot of ground in which law can structure and intervene in insurance relationships.

The most obvious and universally recognized feature of the insurance policy as a contract is that it is a standard form contract, or a contract of adhesion.[4] The features that define the policy as this type of contract are:

1. The contract is embodied in the written policy documents.
2. The policy is drafted by the insurer.
3. The policyholder is unlikely or unable to read or understand the terms, a fact known to the insurer.
4. The insurer enters into many such policies.
5. The policyholder enters into few such transactions.
6. Except for a few terms such as policy limits, deductible, and a small number of endorsements, the contract is take-it-or-leave-

---

[2] *E.g.*, NAT'L ASS'N OF INS. COMM'RS, MODEL UNFAIR TRADE PRACTICES ACT §4.G (2004), http://www.naic.org/store/free/MDL-880.pdf.

[3] *See* Odolecki v. Hartford Accident & Indem. Co., 264 A.2d 38, 42 (N.J. 1970).

[4] The discussion focuses on personal lines and other insurance sold to less commercially sophisticated and empowered insureds largely on a take-it-or-leave-it basis. The practice of contracting for commercial lines covers a wide span, from transactions that largely track the model of adhesion contract described in the text to individually negotiated manuscript policies. The contract and claim analysis is most relevant in cases that resemble that model but it also informs other situations.

it.[5]

7. The policyholder's principal obligation is to pay the premium.
8. The insurer's obligations are conditional on loss and are more extensive than the policyholder's if there is a loss.

Features 1 through 6 are common to all form contracts and features 7 and 8 are distinctive to insurance contracts but certainly not limited to them.

That an insurance policy is a standard form contract does not suggest that it is unenforceable or that its terms should be disregarded. One of the central questions of modern contract law is how to regard such contracts.[6] But because an insurance policy is a form contract, it is problematic to treat the policy as if it embodied the agreement of a detailed bargain between equal and informed parties, and the law needs to inquire more deeply into the nature of the insurance relation beyond the four corners of the policy.

With that as a noncontroversial starting point, think about the insurance policy as a contract which, like every other contract, has two key moments: formation and performance. At each of these moments, consider separately the position of the insurer and the policyholder.

1. Formation

An insurance policy is a product of an insurer's actuarial classification of risks and calculation of their probability and extent; a drafting process to express those risks in the language of the policy; and the underwriting of a particular policyholder under the classified, expressed risks based on information provided by the policyholder and information available to the insurer from its own and external sources. At the point of formation, therefore, for the insurer the policy represents an effort to embody the substantial terms of the relationship between it and the policyholder. That is, in the language of relational contract theory,[7] the insurance relationship for

---

[5] Todd D. Rakoff, *Contracts of Adhesion: An Essay in Reconstruction*, 96 HARV. L. REV. 1173, 1177 (1983).

[6] *See generally* NANCY S. KIM, WRAP CONTRACTS: FOUNDATIONS AND RAMIFICATIONS (2013); MARGARET J. RADIN, BOILERPRINT: THE FINE PRINT, VANISHING RIGHTS, AND THE RULE OF LAW (2013); Friedrich Kessler, *Contracts of Adhesion—Some Thoughts About Freedom of Contract*, 43 COLUM. L. REV. 629 (1943); Rakoff, *supra* note 5.

[7] Ian R. Macneil, *Restatement Second of Contracts and Presentation*, 60 VA. L. REV. 589, 610 (1974).

the insurer is substantially presentiated in the policy, with the terms of future performance delineated at the moment of formation.

Of course, the written policy, as complex and detailed as it may be, necessarily is incomplete. It does not include every conceivable element of the parties' relationship, and what it does state may be vague, ambiguous, or otherwise uncertain of application. Therefore, the express policy terms are supplemented and explained by industry understandings, regulatory requirements, and judicial interpretations, all of which are within the insurer's knowledge and expertise and none of which are within the policyholder's knowledge or expertise. If there is a loss, the insurer expects to pay what is owed, with "what is owed" defined by the terms of the policy as understood by surrounding industry, regulatory, and legal norms.

Even with the insurer's knowledge and expertise, of course, uncertainty will remain about application of the policy to particular circumstances. But the insurer's uncertainty is reduced because of an essential feature of the policy: it is one among many such policies. For the insurer, the policy has value precisely because it is part of a large pool of policies that insure similar but non-correlated risks. At the point of formation, the insurer anticipates the possibility of loss. The possibility of loss for an individual policy is trivial; what matters is the individual loss as part of a portfolio of risk.

Like all form contracts, an insurance policy serves "to stabilize [the insurer's] external market relationships . . . and to serve the needs of a hierarchical and internally segmented structure."[8] Externally, standardization by contract reduces the transaction costs of contracting and aids the insurer in calculating and controlling risks. The particular form of external control that is most valuable for the insurer is the limiting and defining of underwriting risk, often in terms favorable to the insurer. In this way, it allows profitable risk spreading. Internally, standard terms are elements of organizational coordination and control, again reducing costs by making operations more predictable. One of the important features of an insurer's bureaucracy is the use of policy terms, among other systems, to limit the discretion of sales and claims personnel and to structure their interactions with policyholders.

At the point of formation, the policyholder is in a different situation. The insurance policy involves minimal planning by the policyholder, typically focusing on price, policy limits, deductible, a vague sense of the insurer's reputation, convenience, and perhaps a few items of coverage.

---

[8] Rakoff, *supra* note 5, at 1220.

Indeed, often the policyholder is unable to agree to (or even have access to) the terms of the policy; personal lines insurers almost never provide a copy of the policy prior to purchase.[9] An intermediary, an agent or broker, can provide the policyholder better understanding of the content of the policy at the time of formation, but it is rare that the content will be provided in great detail, certainly in personal lines and often even in commercial lines.[10] The policyholder engages at most in what Karl Llewellyn called "blanket assent":

> What has in fact been assented to, specifically, are the few dickered terms, and the broad type of the transaction, and but one thing more. That one thing more is a blanket assent (not a specific assent) to any not unreasonable or indecent terms the seller may have on his form, which do not alter or eviscerate the reasonable meaning of the dickered terms."[11]

The policyholder, rather than agreeing to the detailed terms, invests in a relationship of security,[12] a relationship that is formally created by the policy but that is socially constructed and promoted by insurers as a group.[13] The reasonable policyholder understands that relationship does not guarantee coverage for every conceivable loss. For example, certain risks that are highly correlated to many policyholders or those that pose excessive problems of moral hazard, may be excluded, for example. With those exceptions, however, the policyholder has a legitimate expectation of broad

---

[9] *See* Jay M. Feinman, *The Regulation of Insurance Claim Practices*, 5 U.C. IRVINE. L. REV. 1319, 1321-23 (2015).

[10] Daniel Schwarcz & Peter Siegelman, *Insurance Agents in the Twenty-First Century: The Problem of Biased Advice*, Daniel Schwarcz & Peter Siegelman EDS, RESEARCH HANDBOOK ON THE ECONOMICS OF INSURANCE LAW 36 (2015) (arguing that insurance agents can and often do fail to effectively serve consumers' interests).

[11] KARL N. LLEWELLYN, THE COMMON LAW TRADITION: DECIDING APPEALS 370 (1960). *See* Rakoff, *supra*, at 1206.

[12] "The final and perhaps most significant characteristic of insurance contracts, differentiating them from ordinary, negotiated commercial contracts, is the increasing tendency of the public to look upon the insurance policy not as a contract but as a special form of chattel. The typical applicant buys 'protection' much as he buys groceries." 7 WILLISTON ON CONTRACTS 34 (Walter H.E. Jaeger eds., 1957).

[13] The ubiquity of insurance company advertising and the familiarity of insurance company slogans — "Nationwide is on your side," sung to its well-known jingle — illustrate.

coverage.[14]

For the policyholder the insurance policy has value prior to loss because it provides this expectation of security. If a loss occurs, it is likely to be unique and potentially catastrophic; the policyholder, unlike the insurer, does not maintain a portfolio of risk for substantial losses in any meaningful sense. The policyholder's expectation is that if there is a loss the relationship of reasonable security will be realized. That expectation involves both vague ideas about the extent of coverage and perhaps a few specific terms and a general belief that there will be a reasonable process of adjusting the loss.

At the moment of formation, therefore, the insurer and the policyholder have different understandings of the policy and the insurance relation, so the policy serves different functions for each of them. That suggests a starting point for further analysis: it is an error to assume that the policy presentiates the terms of the parties' agreement, so it is an error to invest total weight or even too much weight on the express terms as precisely defining their rights and duties. Terms are a viable starting point but problematic as an ending point.

2. Performance

Now consider the essential moment of performance in an insurance contract—when a loss potentially within coverage occurs and the policyholder files a claim. As in any contract, there are risks of dispute over the performance due and of eventual nonperformance.

Two potential sources of failure to perform in other contracts are absent in insurance contracts: unavoidable breach, where a party is unable to perform, and efficient breach, where a party chooses to breach and compensate its contracting partner to take advantage of a better opportunity. Instead, a failure to perform may arise from a coverage dispute that arises because of disagreement about some mix of the interpretation of policy language, the facts of the claim, and controlling law. Or a dispute may be about one of the parties' performance obligations at the point of claim, such as an insurer's obligations in processing a claim or a policyholder's duty of cooperation. These disputes reflect features of the formation process such as the policy's incompleteness, leading to disputes over the performance owed, and the asymmetries of agreement due to the policy's status as a form contract, reflected in the parties' different expectations about the policy at

[14] Mark Geistfeld, *Interpreting the Rules of Insurance Contract Interpretation*, 68 RUTGERS U. L. REV. 371, 386-91 (2015).

the time of formation. Often this will be caused by a relational expectation of coverage by the policyholder that the insurer believes is inconsistent with the express terms of the written policy.

The sources of these disputes vary. Some reflect good faith disputes about the interpretation of policy terms, the facts giving rise to the claim, or uncertain or undecided issues of applicable law. Others may arise from a careless failure to adhere to policy requirements or even deliberate advantage-seeking behavior. At least the last two sources can be seen as agency problems; each party has a degree of discretion in its performance which raises the risk that it will not respect its contractual commitment and instead will act in its own interest.[15] Agency problems create the potential for opportunistic behavior. Opportunism can be defined narrowly—Williamson's famous "self-interest seeking with guile"[16]—or broadly, to include "any contractual conduct by one party contrary to the other party's reasonable expectations."[17]

As with formation, consider separately the position of the insurer and the policyholder as to their risks and their means of controlling those risks.

For the insurer, the insurance policy represents one element of a portfolio of potential losses that are the basis of its business. The risk for the insurer at the point of claim is that its planning will be upset either by an unanticipated gap in the policy as applied to a claim or by an action of the policyholder. A gap arises because of the incompleteness of the policy in addressing all possible states of affairs, a discrepancy between the policyholder's understanding of the coverage and the terms of the policy as interpreted by the insurer, or action of the policyholder that impacts the insurer's risk allocation. The policyholder's action may occur at the time of formation, by misrepresenting a material fact upon which the insurer underwrites the policy. The action may occur subsequent to formation but before the loss, by engaging in risky behavior inconsistent with its obligations under the policy that causes or contributes to the loss. Or the

---

[15] *See The Regulation of Insurance Claim Practices*, *supra* note 9, at 1323-25.

[16] Oliver E. Williamson, *Opportunism and Its Critics*, 14 MANAGERIAL & DECISION ECON. 97, 97 (1993).

[17] George M. Cohen, *The Negligence-Opportunism Tradeoff in Contract Law*, 20 HOFSTRA L. REV. 941, 957 (1992). *See also, The Regulation of Insurance Claim Practices*, *supra* note 9, at 1325-26. For a survey of "the opportunism tradition," see Cohen, *supra*, at 953- 61.

action may occur after the loss, such as negligently or intentionally misrepresenting information about the cause or severity of loss.

The insurer can attempt to control these risks at the time of formation, prior to the loss, or after the loss. It can address the gap by clarifying and extending the language of the policy and prospectively considering the interpretation and gap-filling functions of the law as supplements to the written policy.[18] To avoid discrepancies between the policyholder's and the insurer's understanding, the insurer can be clearer and more forthcoming in the marketing of the policy. To control the policyholder's behavior and therefore to reduce the problem of policyholder agency, the insurer can engage in extensive information-gathering and underwriting practices. Policy terms, limits, and deductibles aim to reduce the insured's moral hazard and provide the basis for defenses to coverage. After a loss, it can engage in extensive investigation, information gathering, and information sharing to ascertain facts. Most importantly, it can deny a claim in whole or part; doing so, or even expressly or implicitly threatening to do so, increases a policyholder's cost of pursuing the claim and therefore increases the cost of nonperformance and diminishes the value of the claim.

For the policyholder, one risk is that its inchoate expectation of coverage and security will be disappointed by the insurer's assertion of contrary policy terms at the point of claim. Another risk occurs because the insurer's duties with respect to processing the claim are poorly defined in the policy; the policyholder therefore is at risk that the insurer will fail to conform to the policyholder's expectations.

The policyholder has very limited means to control those risks. It can attempt to become better informed about the terms of the policy at the time of formation, but that usually does not happen in part because the burden of doing so is disproportionate to the anticipated return. Because the policy is an adhesion contract, the policyholder cannot include terms that reduce the ambiguity or the insurer's agency. If a loss is significant, the policyholder is dependent on the success of the claim. Unlike other contracts, it cannot procure a substitute and sue for the added expense because insurance is unavailable for a loss that already has occurred. The last resort is litigation, which is expensive, protracted, and often not fully compensatory.

In short, both parties are subject to agency problems that extend to opportunism. The problems cannot be eliminated, but the consequences of them for the policyholder are much more severe and the insurer has a much

[18] Macneil, *supra* note 7, at 606.

greater opportunity to control the risk posed by the policyholder than vice versa.

B. CLAIM

The discussion so far has focused on the insurance policy as contract. It described the policy as a form contract and considered the parties' situation in regard to the contract at the point of formation and the point of performance. Now consider the second point from a different perspective: the dynamics of the claim process. The insurance claim process exhibits common features that distinguish insurance contracts as a group from other types of contract. These features concern the advantages each party possesses in the claim process and the means the other party has in responding to those advantages.

The insurer initially is at a disadvantage relative to the policyholder in the claim process because the policyholder controls most of the information relevant to the claim. The insurer depends on the policyholder to provide the information completely and accurately in order for it to evaluate coverage and the extent of the loss. Typically, the insurer responds to this disadvantage by not relying exclusively on information provided by the policyholder. It may send an adjuster to assess the loss, and it has formal mechanisms to obtain information, such as requiring a Proof of Loss or Examination Under Oath, and informal mechanisms to enforce the policyholder's duty of cooperation, such as the leverage created by sequential performance.

In a number of other respects, the dynamics of the claim process put the policyholder at a disadvantage relative to the insurer.

First, the gap in knowledge about the terms of the policy between the insurer and the policyholder at the time of formation is mirrored at the time of claim. The policy description of the terms of coverage and the insurer's obligations are both technical and incomplete, so the policyholder is unable to fully understand what it is owed. In many cases, the policyholder's expectations about the relation vest the insurer with expertise, so the insurer's determination is effectively final even if it is objectively questionable. Therefore, even if a claim is incorrectly denied or the insurer otherwise fails to meet its obligations, the policyholder is either unlikely to perceive the failure or unable to do anything about it.[19]

---

[19] This is an example of the flatness of the grievance pyramid. *See* William L.F. Felstiner, Richard L. Abel & Austin Sarat, *The Emergence and*

Second, the insurance relation combines sequential performance with the lack of substitute performances.[20] The insured renders its principal performance first—paying the premium. In the event of a loss, the insured cannot withhold its performance to provide an incentive for the company to fully perform its own obligation in the claim process. Moreover, unlike in many contracts, the policyholder cannot procure an adequate substitute performance, sue for any added cost, and, at least in concept, be made whole by the provision of damages; no insurer will sell insurance to compensate for a loss that has already occurred.[21]

Third, the insurer's duties in the claim process are not fully specified in the policy or elsewhere even in cases in which the policy terms clearly provide coverage. A typical HO-3 homeowners policy, for example, only requires the company to pay claims within sixty days of agreement or adjudication and to participate in appraisal; otherwise, it delineates no duties concerning processing of a claim.[22] Even when a statute appears to narrowly specify a duty, the specification is usually qualified by a vague term such as "good faith."[23] Indeed, it would be hard to specify the insurer's duties because they necessarily rest on vague concepts such as promptness and

---

Transformation of Disputes: Naming, Blaming, Claiming, 15 L. & SOC. REV. 631 (1980).

[20] Jay M. Feinman, *The Insurance Relationship as Relational Contract and the "Fairly Debatable" Rule for First-Party Bad Faith*, 46 SAN DIEGO L. REV. 553, 558-59 (2009).

[21] "[A] breach in the employment context does not place the employee in the same economic dilemma that an insured faces when an insurer in bad faith refuses to pay a claim or to accept a settlement offer within policy limits. When an insurer takes such actions, the insured cannot turn to the marketplace to find another insurance company willing to pay for the loss already incurred." Foley v. Interactive Data Corp., 765 P.2d 373, 396 (Cal. 1988).

[22] INS. SERVS. OFFICE, INC., HOMEOWNERS 3—SPECIAL FORM, 1, 15 (1999), http://www.iii.org/sites/default/files/docs/pdf/HO3_sample.pdf. The homeowner, by contrast, is subject to eight specified duties, including prompt notice, cooperation in investigation, and submission of proof of loss. *Id*. at 13.

[23] In Tennessee, for example, an insurer is subject to a statutory penalty if it fails to pay a claim within sixty days of a demand by the policyholder, but only if "the refusal to pay the loss was not in good faith." TENN. CODE ANN. §56-7-105.

reasonableness.[24]

Fourth, even if the insurer's obligations are relatively clear, legal enforcement of the insurer's duties is difficult and often impossible to obtain. For small claims, hiring a lawyer or a public adjuster likely is not worth the expense or within the policyholder's means. For all claims, the insured's remedy is limited to the recovery of the benefits due under the policy and perhaps interest at the statutory rate. That remedy does not give the insured the promised benefits until the litigation is concluded, perhaps years later, during which time the insured is likely to have suffered financial and emotional hardship and therefore to have lost the security for which it contracted.[25]

Fifth, all of the problems described above are exacerbated by the likelihood of the policyholder's emotional and financial vulnerability following the loss. The purpose of the insurance is to provide funds to repair, rebuild, or otherwise compensate, which would otherwise be unavailable at the time of loss. In a large number of cases, the policyholder's need for settlement of the claim provides its own incentive.

The dynamics of the claim process presents agency problems; each party has a degree of discretion in its performance which raises the risk that it will not respect its contractual commitment and instead will act in its own interest. Agency problems create the potential for opportunistic behavior. Policyholder opportunism includes misrepresentation at the time of application or the time of loss, the most egregious version of which is fraud. Insurer opportunism may take the form of profiting from pre-loss behavior; examples would include establishing the basis for a misrepresentation defense or drafting unexpectedly limiting policy language. Or it may occur after the loss, by delaying or denying payment of a valid claim in whole or part. The opportunism may be intentional and systematic, or it may be merely negligent.

For the policyholder, insurance presents a classic case of potential opportunism. One party has fully performed and has substantial sunk costs,

---

[24] As expressed in the Model Unfair Claims Settlement Practices Act, for example, a company must "adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies." MODEL UNFAIR CLAIMS SETTLEMENT PRACTICES ACT §4.C (NAT'L ASS'N OF INS. COMM'RS 1997).

[25] "Although the insured is not without remedies if he disagrees with the insurer, the very invocation of those remedies detracts significantly from the protection or security which was the object of the transaction." Rawlings v. Apodaca v. Apodaca, 726 P.2d 565, 570 (Ariz. 1986).

the policyholder has paid its premium and invested in a relation of security, and the other party's performance comes later and is not well-defined. The insurer has to pay if there is a loss covered by the policy and has to observe "reasonable" claim practices in doing so. The benefit to the insurer from opportunistic behavior, of course is that it increases its profits by reducing its claim costs and increasing the assets available to it to invest.

Because of the dynamics of the claim process described above, there are fewer effective checks on insurer opportunism than on policyholder opportunism. Litigation by the policyholder is unlikely in many cases and impossible in others. Because the insurer is managing a portfolio of such cases, paying damages, even extracontractual damages, in a portion of the cases does not outweigh the benefits of opportunism in a larger number of other cases. Because empirical data on claim practices is not publicly available,[26] an individual insurer's reputation is established by advertising and other intangible means, and consumer choice is more focused on price than quality, the market does not effectively deter opportunistic behavior. Nor do regulators effectively monitor market conduct.[27]

Today the extent to which insurers act opportunistically is controversial. Insurers and industry representatives acknowledge that occasional mistakes are made but deny that there is systematic abuse. Industry critics argue that companies have increasingly viewed the claims process as a profit center.[28] For present purposes, it is only necessary to observe that opportunism can be broadly defined[29] and the potential for opportunism is inherent.

---

[26] The NAIC Market Conduct Surveillance Model Law § 7 and the National Conference of Insurance Legislators' Market Conduct Annual Statement Model Act § 8 provide that claims data reported to or collected by insurance commissioners are privileged and confidential. For adoptions, *see e.g.*, Ariz. Ann. Rev. Stat. § 20-158; Haw. Rev. Stat. Ann. § 431:2D-107; Ohio Rev. Code Ann. § 3916; R.I. Gen. Laws Ann. § 27-71-8; Ann. Rev. Code of Wash. § 48.37.080.

[27] *See* Feinman, *supra* note 9, at 1326-40.

[28] *See generally* JAY M. FEINMAN, DELAY, DENY, DEFEND: WHY INSURANCE COMPANIES DON'T PAY CLAIMS AND WHAT YOU CAN DO ABOUT IT (2010).

[29] *See* Cohen, *supra* note 17, at 957.

C. CONTRACT AND CLAIM COMBINED

Now consider together the insurance policy as a form contract and the dynamics of the claim process. The insurance policy is a standard form contract, or an adhesion contract. The policy takes on different functions at the point of formation for the policyholder and the insurer. At the point of performance, each is subject to different risks and possesses different means of controlling those risks. Seen differently, the point of performance involves claim dynamics that both increase the risks, which may be seen as agency bleeding into opportunism, and provide means of responding to the risks. In the claim process, the risks and responses put the policyholder at a systematic disadvantage relative to the insurer.

This analysis suggests that courts should further the regulatory role of law in improving the contracting process, not in the sense of improving formation *ex ante* but in the sense of realizing the parties' legitimate expectations.[30] The analysis contributes to that goal in several ways.

The contract and claim analysis clarifies the nature of the insurance policy as a contract. There is a tendency to regard the policy as the core of the relationship and everything else as peripheral to its construction. Therefore, the terms are the starting point and given great weight. Everything else—expectations created outside the written policy, public policies, measures against opportunism—necessarily carry less weight and have to struggle against the written terms. The two parts of the contract and claim analysis work against that construction. The contract is not constituted only by the written policy, and the differing conceptions of the contract by the policyholder and the insurer at the point of formation also needs to be considered.

Moreover, the problems of claim dynamics are also relevant to the resolution of disputes, even disputes about what are traditionally seen as formation or interpretation issues. The risks of agency and opportunism are broadly relevant, as is the relative advantage of the insurer in the claim process. This provides a perspective through which insurance law issues should be seen. In considering insurance law issues across a range of doctrines, courts should be sensitive to the nature of the contract relation as described here and the importance of claim process dynamics. This is

---

[30] "Legitimate" expectations, of course, are not just those of individual parties but reflect conceptions of reasonableness for policyholders and insurers as a whole. As Corbin proclaimed, "The Main Purpose of Contract Law Is the Realization of Reasonable Expectations Induced by Promises." ARTHUR LINTON CORBIN, CORBIN ON CONTRACTS §1 (1952).

something like the use of general principles or policy arguments to shape doctrine. Particular issues are approached through an established doctrinal framework—categories, rules, sub-rules, and exceptions, for example—but the application of the elements of the framework is shaped by purposes and policies. The contract and claim analysis serves as a lens through which the problems would be seen or a weighty element in the balancing process in which courts engage to shape and apply doctrine.

This does not suggest that insurers should lose every case. Surely there are cases in which policy language should be interpreted to deny coverage,[31] cases in which the insurer has observed fair claim practices, cases in which the policyholder has acted opportunistically, and more. This is obvious but it is worth stating to suggest the complexity of the analysis.

Nor should the contract and claim analysis be used on a case-by-case basis. Courts are ill equipped to consider in a particular case what the full context and expectations of the parties' contract were and whether an insurer has engaged in opportunistic behavior. Nor would it be worth the judicial resources to do so, because the more individualized the inquiry, the less impact it has on the pool of potential cases. And a case-by-case approach would undermine the general relevance of the resolution of particular disputes; certainty and predictability are important.

Finally, it could be possible to use the analysis to shape some insurance law doctrines but not others. For example, the next Part argues that the analysis supports the reasonableness standard for violation of claim practices ("bad faith") that is used by a minority of jurisdictions rather than the majority rule of "fairly debatable." It might be the case that the article's analysis is strongest on that issue but less persuasive on some other issue—for example, the rules about policyholder misrepresentation at the time of application that also are discussed later. In fact, the analysis in the article has sway across the entire field of insurance law.

II. APPLICATIONS OF THE CONTRACT AND CLAIM ANALYSIS

To illustrate and amplify the contract and claim analysis, this Part discusses several common issues in insurance law. The discussion demonstrates that courts sometimes use similar analysis, describes those tendencies, suggests why they are incomplete, and uses the contract and claim analysis to make them explicit and more comprehensive. Other courts take quite different approaches; contrasting those approaches with the

[31] *See infra* text accompanying notes 62–66.

contract and claim analysis demonstrates what they get wrong. The result is both a demonstration of the usefulness of this Article's analysis and a beginning catalog of how it can reshape insurance law doctrine.

The illustrations come from three different points in the life of an insurance policy. The first concerns a formation issue: when an insurer may use misstatements by a policyholder in the application process to avoid coverage. The second, and most general, addresses interpretation issues that concern the insurer's performance of the insurance contract. The third concerns issues of policyholder and insurer performance at the end-point of the relation, after a claim is filed—the false swearing rule and the regulation of the insurer's claim practices. All three reinforce the notion that every doctrinal issue involves a conception of the insurance contract and arises because of a disputed claim.

A. AT FORMATION: REPRESENTATIONS AND WARRANTIES

One area in which there is a developed body of law that illustrates the conflict between traditional concepts and the contract and claim approach is what Jerry and Richmond define as a "fundamental question: the extent to which courts [and legislatures] will allow insurers to utilize inaccuracies in information provided by the insured to deny coverage."[32]

Lord Mansfield established the early contours of this area by distinguishing between a representation and a warranty:

> There is a material distinction between a warranty and a representation. A representation may be equitably and substantially answered but a warranty must be strictly complied with…. A warranty in a policy of insurance is a condition or a contingency, and unless that be performed, there is no contract.[33]

This formulation and its subsequent elaboration set a framework for problems about inadequate or incorrect information provided by a policyholder. A warranty is "a statement or promise by the insured, set forth or incorporated in the policy, which if untrue or unfulfilled provides the insured with a defense to coverage."[34] A representation, in turn, is a statement that only provides a defense to coverage if it is false, material to

---

[32] ROBERT H. JERRY & DOUGLAS R. RICHMOND, UNDERSTANDING INSURANCE LAW 717 (5th ed. 2012).

[33] De Hahn v. Hartley (1786) 99 Eng. Rep. 1130, 1131; 1 T.R. 343, 345-346.

[34] JERRY & RICHMOND, *supra* note 32, at 718.

the risk, relied on by the insurer, and in some jurisdictions made with intent to deceive.[35]

The logic of this framework is traditionally contractual and reflects the insurer's conception of policy formation. The insurance policy is a contract, and the law's primary purpose is to enforce the legitimate expectations of the parties created by the contract. Where the parties have chosen to establish a statement or promise as a warranty, the disappointment of their planning by a breach provides a legitimate basis for nonperformance by the insurer. In the ordinary case, however, legitimate expectations distinguish between the essential and the peripheral. Therefore, the law does not convey the power to avoid a contract for every failure to conform to the information but only for the essential; that is the basis for the general contract doctrine that a contract can be avoided only for a misrepresentation that is false, material, relied upon, and intentionally made. But where the parties choose to do so, they can import a higher standard by making a statement a warranty, essentially designating it as material per se and removing the requirements of reliance and intent.

In addition to reflecting the insurer's approach to formation, the representations and warranties rules address the insurer's concern with policyholder agency at the point of formation. A potential policyholder has better information about its risk profile than the insurer. Where the information would demonstrate an increased risk, it is in the policyholder's interest to conceal or misrepresent the information in order to obtain coverage that might not otherwise be available or to obtain coverage at a lower premium. This is, of course, the problem of adverse selection. The insurer has some mechanisms to obtain or verify this information, but the mechanisms are limited, and the insurer must rely to a large extent on the policyholder's statement. Assuming that most potential policyholders give accurate information, it is not economical to invest the resources necessary to check on the policyholder at the point of formation; indeed, in some cases it will not be possible at all. At the point of claim, however, it often becomes economically justifiable and there may or may not be indicators of misrepresentation. In case of a loss and a subsequent claim, the insurer may assert that the policyholder failed to provide accurate information from which the insurer could perform appropriate underwriting as a basis for denying the claim. This cures the information asymmetry and allows the

[35] *Id.* at 721-22.

insurer to refuse the risk.[36]

But the warranty-representation distinction and its functions have turned out neither to be a strict rule nor easy to enforce. Instead, the rule is rife with exceptions which the Jerry and Richmond treatise helpfully categorizes.

First, to constitute a warranty the promise or statement must be included in the policy either expressly or by express incorporation by reference, and the inclusion must show that the parties intended the inclusion to operate as a true warranty. Courts strictly apply the requirements, so any ambiguity or technical failure will lead to the creation of a representation, with its less severe consequences,[37] or as a means of identifying insured property but neither warranty nor representation.[38]

Second, statements by the policyholder can be either affirmative, referring to a fact at the time the statement is made, or promissory, constituting a promise that state of facts will continue into the future. Courts will interpret statements as promissory to avoid the effect of a warranty.[39]

Third, even when finding a warranty, courts often will interpret it narrowly. A well-known example is *Vlastos v. Sumitomo Marine & Fire Ins. Co. (Europe) Ltd.*[40] An endorsement expressly incorporated into the policy stated, "[w]arranted that the 3rd floor is occupied as a Janitor's residence." The court held that this provision was indeed a warranty but because it did not unambiguously state that the janitor's occupancy was the exclusive use of the 3rd floor, the warranty was not breached by the partial occupancy of a massage parlor. In reaching its conclusion, the court relied on *contra proferentem*, extrinsic evidence to establish an ambiguity, "the context of the remainder of the policy, and of the alleged purposes of the warranty," all factors removed from the strict warranty-representation distinction.

Fourth, "a court might interpret the warranty as only extending to a particular risk or a severable part of the policy [so that] the breach of

---

[36] "Strict enforcement protects insurers by limiting indemnity to cases where the insured has answered all application questions honestly; strict enforcement deters applicants from making false representations; integrity in insurance contracts is promoted, and fraud and perjury are deterred; and a strict rule is simple to enforce." *Id.* at 720.

[37] *Id.* at 718-19, 725.

[38] *Id.* at 725.

[39] *Id.* at 724.

[40] Vlastos v. Sumitomo Marine and Fire Ins. (Eur.) Co., 707 F.2d 775 (3d Cir. 1983).

warranty under one kind of risk will not avoid the policy with respect to other parts of the coverage."[41]

Fifth, even if there is a breach of warranty, it may be construed as a "temporary breach" the cure of which before a loss revives coverage.[42]

Sixth, the traditional doctrine has been undercut by statutes in most states; these statutes vary. One common limitation allows a warranty to operate to avoid coverage only where the breach of warranty is material.[43] Others require that the misrepresentation was made with actual intent to deceive,[44] or that the failure to conform to the warranty contributed to the loss,[45] or some combination of these.[46]

Seventh, and perhaps most dramatically, are incontestability provisions.[47] Life insurance policies and many disability policies, usually under statutory mandate, are incontestable after two years, so that an insurer may not assert defenses such as breach of warranty to defeat payment of the policy proceeds.[48]

Some of the exceptions can fit within the conception of the insurance policy as a contract, particularly a contract that is not presentiated in the policy but instead constructed by broader relations. For example, requiring that the warranty be included in the policy expressly or by express incorporation by reference represents a traditional view of contract. But narrowing interpretations such as in *Vlastos* rest on a broader conception of contract. Many courts today may be less prone to apply formal distinctions

---

[41] JERRY & RICHMOND, *supra* note 32, at 726.

[42] *Id.* at 726-27.

[43] *E.g.*, N.Y. INS. LAW § 3105 (McKinney 2001).

[44] MASS. GEN. LAWS ch. 175, § 186 (2008).

[45] IOWA CODE § 515.101 (2009).

[46] *E.g.*, FLA. STAT. § 627.409 (2014); UTAH CODE § 31A-21-105(2) (2003).

[47] *See* Eric K. Fosaaen, Note, *AIDS and the Incontestability Clause*, 66 N.D. L. REV. 267, 267-77 (1990).

[48] Incontestability clauses were originally included in policies to combat public mistrust of the insurance industry, a mistrust that often was justified. *See, E.g.*, Baumgart v. Modern Woodmen of Am., 55 N.W. 713, 714 (Wis. 1893). But insurers faced a collective action problem; an insurer that included a clause incurred higher costs but did not reap all the benefits of improved reputation of the industry as a whole. That phenomenon, along with exposés of industry abuses, led to the widespread adoption of statutes requiring incontestability clauses. *See* Fosaaen, *supra* note 47, at 269-270.

and doctrines to defeat the policyholder's expectations altogether.[49]

The development of so many exceptions to and restrictions of the doctrine demonstrate unease with its application by courts and legislatures. That unease is best captured in the contract and claim analysis.

In part, the exceptions reflect unease with the exclusive focus on the insurer's conception of the policy at formation. The policyholder's conception focuses not on the policy as representing the agreement but on the written policy and the application process that gives rise to it as the formal elements of a broader, less formal relation. In that relation, loss of coverage for a statement that is ambiguous, for example, is inconsistent with the perception of security.

More importantly, the exceptions demonstrate a concern with insurer agency at the point of performance and the claim dynamics that limit the policyholder's ability to control that agency. This concern focuses on the claim process and the possibility of an insurer using the doctrine opportunistically. An insurer may assert breach of warranty to avoid coverage even if the information misrepresented had no effect on its underwriting. More generally, an insurer may under-invest in underwriting at the point of formation, await high-value claims or claims that are in any way suspect, and then perform an investigation that reveals a policyholder misrepresentation. At its extreme, this is the particularly egregious form of opportunism known as "post-claim underwriting."[50] When a claim is presented, a company can seize on errors by the insured in the application to deny coverage. And some insurers have systematically exploited the doctrines by designing an application process that would make misrepresentations a virtual certainty.[51] The exceptions to the warranty-representation rule respond to the range of these types of behavior.

Jerry and Richmond are themselves skeptical of many of the mitigating doctrines, favoring bright-line rules to control adverse selection and moral hazard. But their analysis demonstrates that the prevailing view favors a focus on claims, with the presence of agency and the potential for opportunism:

> [I]t must be assumed that those who make public policy believe that

---

[49] JERRY & RICHMOND, supra note 32, at 720.

[50] *See* Thomas C. Cady & Georgia Lee Gates, *Post Claim Underwriting*, 102 W. VA. L. REV. 809 (2000).

[51] *See* Conn. Mut. Life Ins. Co. V. Union Trust Co., 112 U.S. 250 (1884); *Baumgart*, 55 N.W. 713; Cady & Gates, *supra* note 50.

> the instances of insurer use of warranties to gain advantage over unsophisticated insureds greatly outweigh the circumstances in which insurers use warranties to reduce costs for the benefit of all policyholders.[52]

B. DURING PERFORMANCE: INTERPRETATION AND REASONABLE EXPECTATIONS

More challenging is the application of the contract and claim analysis to perhaps the largest set of issues in insurance law, the interpretation of the terms of an insurance policy and the associated doctrine of reasonable expectations. This is not the place for a comprehensive theory of interpretation and reasonable expectations.[53] The issues are complex, the case law is voluminous, and the commentary is rich. The contract and claim analysis does provide insight into both particular interpretation doctrines and general approaches to interpretation and the role of reasonable expectations.

A series of related controversies pervades the law of insurance contract interpretation. Those controversies include:

- A preference for a plain meaning approach to interpretation versus a preference for a contextual or functional approach.
- Determining whether a policy is ambiguous solely by using the terms of the policy and a general dictionary versus resorting to extrinsic evidence.
- The choice between a narrow version of the reasonable expectations doctrine in which reasonable expectations function at most as an interpretive tool versus a broad version in which reasonable expectation can trump unambiguous policy language.

The controversies reflect two contrasting visions of interpretation and of contract law more generally. At the level of interpretation, the textualist vision presumes that the parties have embodied their agreement in the express words of the policy, so courts should, to the extent possible, only resort to those words as generally understood to determine the scope of their obligation. The opposed vision suggests that parties express their agreements through words and conduct in commercial and social contexts, so words,

---

[52] JERRY & RICHMOND, *supra* note 32, at 733.

[53] "The rules that courts apply to interpret insurance policies are surprisingly difficult to define." Geistfeld, *supra* note 14, at 371.

conduct, and context are all potentially relevant to supplement the express words of the policy. This dispute reflects more fundamental oppositions in constructing the role of contract law, described at various levels and in various ways, such as between a formalist and a functionalist approach, or between an individualist and collectivist approach.[54]

The insurer and policyholder approaches to formation in the contract and claim analysis resonate with these more fundamental conflicts. The insurer places great emphasis on the express terms of the policy as embodying the substantial terms of its obligation to the policyholder. The insurer generally has a preference for formality—the plain meaning rule—in interpreting the policy. Plain meaning presumes that insurers will draft terms clearly as the basis of their underwriting and by and large those terms will conform to the reasonable expectations of policyholders. The terms of the policy define the risk it has assumed across many such policies and help to stabilize its internal and external relations.[55] If the express terms are uncertain as applied, often they can be made more certain by prior regulatory or judicial interpretations and industry understandings, all of which are within the insurer's knowledge and expertise. Formality, supplemented if necessary, provides more certainty and reduces litigation costs. Both of those elements support the risk allocation system embodied in the policy as one among many. Therefore, the insurer's model favors plain meaning and a focus on express terms rather than extrinsic evidence and fears a broad resort to reasonable expectations as upsetting planning and increasing costs.

For the policyholder, by contrast, the policy provision involves little explicit planning and agreement and instead reflects agreement on a few key terms and blanket assent to not-unreasonable other terms and, more generally, to a relationship of security. Therefore, interpreting the policy terms strictly—terms that the policyholder has neither bargained for, explicitly agreed to, or even read—may disappoint the policyholder's expectations. Instead, the process of interpretation should depart from the express terms in favor of extrinsic evidence[56] and reasonable expectations to

---

[54] *See* JEFFREY W. STEMPEL & ERIK S. KNUTSEN, STEMPEL AND KNUTSEN ON INSURANCE COVERAGE at 4-7 to 4-11; JERRY & RICHMOND, *supra* note 32, at 129-31; E. ALLAN FARNSWORTH, CONTRACTS 419-23 (4th ed. 2004); Jay M. Feinman, *Critical Approaches to Contract Law*, 30 UCLA L. REV. 829, 838-47 (1983).

[55] *See supra* text accompanying note 8.

[56] Extrinsic evidence may include:

more closely honor the true agreement; doing so benefits the individual policyholder, other policyholders who actually suffer a loss, and, in an indirect way, all policyholders whose expectation of security is strengthened.

The contract and claim analysis does more than define the contrasting positions of insurer and policyholder at the point of formation. It also requires a focus on the moment of performance and the dynamics of the claim process at that moment, and therefore demonstrates that interpretation cannot properly be accomplished solely by focusing on the policy as a product of contract formation. The analysis suggests that at the point of performance, both insurer and policyholder are subject to the risk of agency by the other, the claim dynamics affect the risks and the means of controlling them, and the policyholder is at a systematic disadvantage in the process.[57] This is relevant to interpretation questions in three ways.

First, at the point of claim, the insurer is subject to agency by the policyholder, who controls much of the information relevant to the claim. Some terms of the policy may exacerbate or reduce this risk, and interpretation of such terms should be sensitive to the need to promote the flow of information from the policyholder that is contractually required and consistent with the underwriting purposes of the term.

Second, when an insurer drafts a policy term, it looks forward to the point of claim. The insurer can use its power to draft and its knowledge of the tools courts will use in interpreting policies and the way particular provisions have been interpreted to define terms in a way that may be inconsistent with the policyholder's expectations of a relation of security and coverage. Where the insurer adopts a standard form such as an ISO policy,

---

> pre-contractual negotiations, the parties' course of performance under the policy at issue, the course of dealing between the parties with regard to other policies, the drafting history of insurance policies, documents filed with state administrative agencies regarding an insurance policy or term, other versions of the relevant term available on the market, other forms of insurance available on the market, and expert testimony regarding topics such as the custom and practice in the insurance industry and the history, purpose, and function of policy terms and forms of insurance coverage.

RESTATEMENT OF THE LAW LIAB. INS. § 3, cmt. f (AM. LAW INST., Tentative Draft No. 1, 2016).

[57] *See supra* text accompanying notes 19-29.

its knowledge of the tools courts use and their past interpretations of the policy is more important. The agency problem is even more extreme where the insurer drafts and employs unique terms that are narrower than the standard terms and therefore even more to the disadvantage of the policyholder and even more inconsistent with its reasonable expectations.[58] This is true in individual cases and is part of the broader phenomenon of hollowing out coverage and fragmenting risk.

Third, at the point of claim it can exploit the results of its drafting and its advantages in the claim process to take advantage of either clarity or ambiguity in policy terms. Insurers do have an incentive to draft clearly so they can underwrite on that basis. Because of the different positions of insurer and policyholder at the time of formation, some portion of that clarity will be clear drafting that reduces coverage in a way that is inconsistent with widely held expectations of policyholders. In many cases, that drafting will constitute the single plain meaning which courts will enforce.

This is hardly new. In a well-known article, Clarence Morris describes the phenomenon:

American draftsmen-lawyers, sometimes in the hire of fly-by-night companies, proliferated fine print in the nineteenth century fire and life insurance policies. Companies, spurred by competition, debased their product (as the Germans did their linen). Restrictions on coverage, not noticed or not understood by policyholders at the time of issue, became painfully clear after uncovered losses which policyholders would have paid to cover.[59]

Although an insurer has an incentive to draft clearly, it either cannot do so or chooses not to do so in every case. Nevertheless, an insurer may not suffer much or any cost from drafting an ambiguous term. Because of the dynamics of the claim process, a policyholder might defer to its perception of an insurer's expertise and accept the insurer's interpretation of an

---

[58] *Compare* ISO, HO 53 – Homeowners 3 – Special Form, Section I – Conditions, C. Loss Settlement (HO 00 03 05 01, 2000), *with* Farmers Insurance Group, Farmers Smart Plan Home Policy, NEV. DIV. OF INS., 1, 29-30 (last visited Oct. 8, 2018), http://doi.nv.gov/uploadedFiles/doinvgov/_publicdocuments/Consumers/Home/Farmers/56-5640_6-15.pdf (regarding payment for matching of damaged property).

[59] Clarence Morris, *Waiver and Estoppel in Insurance Policy Litigation*, 105 U. PA. L. REV. 925, 926 (1957) (footnote omitted) (Morris also sums up a solution: "The insurance market might have soured had not the law stepped in and afforded consumer protection greater than companies intend to sell.").

ambiguous term as correct, a policyholder might disagree with the interpretation but not have the means to dispute it, or, particularly in a low-stakes case, a policyholder might conclude that it is not worthwhile to do so. If the policyholder pursues a dispute, the insurer's interpretation will prevail in some cases. Where it does not, and the term is interpreted against the insurer, in most cases the result will be a small effect on its underwriting which can be accounted for going forward.[60]

The contract and claim analysis accordingly suggests some insights about the process of interpretation. As a starting point, in interpreting policy language, both of the conflicting models of contract in general and interpretation in particular, and their doctrinal implications, have contributions to make, neither is entirely correct, and each taken to an extreme or considered in isolation produces undesirable results. A pure view of plain meaning is wrong because it ignores the policyholder's conception of formation and the dynamics of the claim process; a too-expansive concept of reasonable expectations similarly ignores legitimate concerns of the insurer at the point of formation.

That suggests that any approach to interpretation needs to be attentive to multiple factors:

- The insurer's conception of the contract embodied in the policy at the point of formation, which favors adherence to the ordinary meaning of the text.
- The policyholder's conception of the contract at the point of formation, which is focused on a relation of reasonable security not fully embodied in the express terms.
- The problem of policyholder agency through the control of information at the point of claim.
- The problem of insurer agency at the point of claim, which tends toward opportunism
- The dynamics of the claim process, in which the policyholder is at a systematic disadvantage.

In interpreting a policy term, a court needs to take account of these factors. Interpretation is never carried out in the abstract; the court evaluates and balances the factors in the context of the particular dispute.[61] The result

---

[60] *See* Michelle E. Boardman, *Contra Proferentem: The Allure of Ambiguous Boilerplate*, 104 MICH. L. REV. 1105, 1124 (2006).

[61] On balancing as the defining characteristic of modern law, *see* Feinman, *supra* note 53, at 838.

of that process may be more or less clear, but it is necessary to effectuate the interests involved.

Consider two examples of how this analysis can be applied, using casebook staples, one of which presents a relatively clear result under the contract and claim analysis and one that requires more complex balancing.

Prudence Life Insurance Co. v. Wooley required the interpretation of the key term under a general disability policy.[62] Derwood Wooley was a chicken farmer who previously had worked as a carpenter, truck driver and construction equipment operator. Wooley purchased a form of "general disability" policy[63] that contained this definition of total disability: "Complete loss of business time due to the inability of the insured to engage in his regular occupation or in any gainful occupation for which he is reasonably fitted by education, training or experience." Wooley suffered a heart attack and the insurer paid benefits for two years and then ceased doing so, asserting that he no longer was totally disabled within the meaning of the policy.[64] At trial the issue was whether Wooley's proof that he could no longer be a chicken farmer was sufficient, or whether the jury also should be charged that the policy required that he be unable to perform any other occupation "for which he is reasonably fitted by education, training or experience."[65] The court adopted the majority rule that a general disability term requires not only that an insured be unable to perform his own occupation but that he also be unable to perform another occupation for which he is suited.[66]

The contract and claim analysis would reach the same result. Both insurer and insured contract in a market in which there is a clear distinction between a general disability policy and an occupational disability policy. The former has what the *Wooley* court referred to as "a 'double-barrel provision,' which requires that disability be shown as inability to follow his regular occupation, or any other occupation for which insured is reasonably fitted by education, training or experience." The latter only has the requirement that the insured be unable to perform his own occupation. In the market for disability insurance, both types are available, the choice between them is readily apparent to the reasonable insured, and the distinction is represented

---

[62] Prudence Life Ins. Co. v. Wooley, 182 So. 2d 393 (Miss. 1966).

[63] *See* JERRY & RICHMOND, *supra* note 32, at 464.

[64] Prudence Life Ins. Co., 182 So. 2d at 395, citing 29A AM. JUR. INS. § 1518 at 622-3-4 (1960).

[65] *Id.*

[66] *Id.* at 396.

by a difference in price to the policyholder and in underwriting to the insurer. At the point of claim any informational advantage possessed by the policyholder can be overcome by medical examination, testing, and investigation by the insurer. There is a potential for opportunism by the insurer, by denying a claim and forcing a disabled insured to litigation to receive benefits. In fact, that potential often has been realized in disability insurance cases.[67] But the potential is in concept not dramatically greater in disability cases than in many other types. On balance, the contract and claim analysis supports the insurer's interpretation of the policy and the result in *Wooley*.

A second example is the burglary provision in mercantile policies, of which the casebook classics are *C & J Fertilizer, Inc. v. Allied Mutual Insurance Co.*[68] and *Atwater Creamery Co. v. Western National Mutual Insurance Co.*[69] The definition of burglary in the policy is the felonious abstraction of insured property from within the premises by a person making felonious entry therein by actual force and violence, of which force and violence there are visible marks made by tools, explosives, electricity or chemicals upon, or physical damage to, the exterior of the premises at the place of such entry.[70]

In the cases, the loss of property through an obvious burglary occurs but there are no such visible marks on the exterior. The conflict in the cases is whether to use a plain meaning approach that bars coverage or to resort to a reasonable expectations approach that might find coverage.

The courts note that for the insurer at the point of formation, there are two reasons for the visible marks requirement: to exclude coverage for "inside jobs" and to encourage policyholders to secure their premises.[71] Both reasons are related to the insurer's risk allocation, designed to cover "real" burglaries and to reduce their incidence. But for the insurer, the clause also looks forward to the point of claim. Some losses caused by an inside job may be fraudulent, and the clause excludes coverage for those. In other cases it will be unclear whether the loss was due to burglary or an inside job, and the effect of the clause's proof requirement is to use an objective standard to

---

[67] *See* Jay M. Feinman, *The Law of Insurance Claim Practices: Beyond Bad Faith*, 47 TORT TRIAL & INS. PRAC. L.J. 693, 716 (2012).

[68] C & J Fertilizer, Inc. v. Allied Mut. Ins. *Co.*, 227 N.W.2d 169 (Iowa 1975).

[69] Atwater Creamery Co. v. Western Nat. Mut. Ins. Co., 366 N.W.2d 271 (Minn. 1985).

[70] *Id.* at 275.

[71] *Id.* at 276.

foreclose a more extended and uncertain inquiry into the nature of the loss and to conveniently exclude coverage in those cases.

From the policyholder's perspective, however, at formation the reasonable understanding of the provision is to pay for a burglary as comports with the general understanding of the term, as not an inside job. At the point of claim, a requirement of objective proof disappoints that expectation. Moreover, the policyholder is at risk of insurer agency because the requirement does more than place the burden on the policyholder to establish the cause of loss; it prevents the policyholder from proving that the cause was an actual burglary. It also gives the insurer discretion in applying the clause favorably to some policyholders and unfavorably to other, and it provides a disincentive to policyholders to pursue claims, particularly in cases involving relatively small claims.

The general disability cases present a relatively clear application of the contract and claim analysis, but the burglary cases are more complex and the resolution is less clear. Because the contract and claim analysis is more complex than, say, plain meaning purports to be, that may sometimes be the result. In individual cases particular facts may be decisive. In *C & J Fertilizer*, for example, the policyholder testified to his understanding of the policy at the time of purchase, that understanding was that burglary but not an inside job was covered, the understanding comported with general usage of the term, and the proof requirement was in a definition rather than an exclusion.[72]

C. AT THE POINT OF CLAIM: FALSE SWEARING AND BAD FAITH

Whatever the substantive issues underlying a claim dispute, either party may assert that the other has violated some standard during the claim process itself. The insurer may assert that the policyholder has violated its obligations by making a false statement in presenting its claim, an issue covered by the false swearing rule. Or the policyholder may assert that the insurer has improperly handled the claim; these issues are resolved under the law of insurance claim practices, what is commonly known as "bad faith" or, in a growing term, the law of extracontractual liability.

1. False Swearing

Most insurance policies explicitly include a term declaring that fraud

[72] *C & J Fertilizer*, 227 N.W.2d at 171-72.

or other false statements by the policyholder in filing a claim permit the insurer to void the policy.[73] Many of those terms require that the false statement concern a material fact or be made with an intent to deceive the insurer.[74] The misrepresentation provision in the most widely used homeowners insurance policy lists three circumstances in the alternative, any of which would result in a loss of coverage, if the policyholder has:

- Intentionally concealed or misrepresented any material fact or circumstance;
- Engaged in fraudulent conduct; or
- Made false statements.[75]

The doctrine that applies to these provisions is the "false swearing" rule. As a general rule "false swearing" by an insured in a proof of loss or other element of the claim process enables the insurer to avoid paying a claim, even if the false swearing concerned only a portion of the loss.[76] Courts vary on the stringency of their application of the false swearing rule.[77] A broad, insurer-favorable version of the false swearing rule has generous standards for materiality and intent, no reliance requirements, and has the effect of avoiding the insurer's obligations under the policy altogether. Narrower versions of the rule require that the insurer have relied on the misrepresentation[78] or that false swearing enables an insurer to avoid coverage only as to the portion of the claim that was misrepresented.[79]

The justification for the broad rule rests on a particular conception of the insurance policy as a contract and on a focus on opportunism by the policyholder. The essential rationale for a broad view conceives of the insurance relation as created and substantially embodied in the insurance policy. Part of the insured's contractual obligation with the insurer is to

---

[73] 13 STEVEN PLITT ET AL., COUCH ON INSURANCE § 197:1 (3d ed. 2018).

[74] *Id.* § 197:33.

[75] INS. SERVS. OFFICE, HOMEOWNERS-3 SPECIAL FORM (2010).

[76] STEMPEL & KNUTSEN, *supra* note 53, § 9.08[C], at 9-221; JERRY & RICHMOND, *supra* note 32, § 83; Versloot Dredging BV and another v. HDI Gerling Industrie Versicherung AG and others [2016] UKSC 45, ¶ 1 (Eng.).

[77] 5af-157f APPLEMAN ON INSURANCE LAW & PRACTICE ARCHIVE § 3587 (2nd ed. 2011).

[78] *Id.* at § 197:4, at 1.

[79] STEMPEL & KNUTSEN, *supra* note 53, § 908[C], at 9-22, 222.

refrain from misrepresentation in the claim process.[80] This element of the analysis is an instance of a principle of insurance law reflected in the insurer's perception of formation, that the relation between insurer and insured is created and substantially defined by their agreement.[81]

The reason such a provision is included in the policy is not only general to contracts; it is specific to insurance because of the risk of opportunistic behavior by the policyholder at the point of claim. A policyholder has an incentive to misrepresent or conceal information from its insurer during the claim process in order to maximize its recovery.[82] Insurers, being aware of this possibility, must invest resources to monitor insureds' behavior and to ferret out their fraud. The false swearing doctrine deters wrongful behavior by policyholders and reduces the need for inefficient monitoring behavior by insurers. In that way, it benefits the pool of policyholders that otherwise would be subject to increased costs of fraudulent payments and inefficient monitoring.[83]

The contract and claim analysis challenges the broad approach to false swearing as partial. The broad approach recognizes the insurer's conception of the contract at the point of formation but fails to recognize the policyholder's conception. A policy term on misrepresentation should be read in light of a reasonable understanding of the insurance relation as shaped both by policy language and more general norms and expectations of coverage and process. The policyholder's expectation of coverage would be disappointed by a broad false swearing rule. Fraudulent behavior by

---

[80] The obligation is clear and specific where the insurance policy contains a provision relating to misrepresentation after a loss. Even if the provision is less specific, it reasonably is interpreted to apply to post-loss conduct as well as to misrepresentations in the course of applying for the insurance.

[81] *See* Abraham, *supra* note 1, at 658.

[82] As the New Jersey Supreme Court stated the concern, "Such misrepresentations strike at the heart of the insurer's ability to acquire the information necessary to determine its obligations and to protect itself from false claims." Longobardi v. Chubb Ins. Co. of New Jersey, 582 A.2d 1257, 1261 (N.J. 1990). *See also* James Davey & Katie Richards, *Deterrence, Human Rights and Illegality: The Forfeiture Rule in Insurance Contract Law*, 2015 LLOYD'S MAR. & COM. L.Q. 314, 318 (2015).

[83] Tom Baker, *Constructing the Insurance Relationship: Sales Stories, Claims Stories, and Insurance Contract Damages*, 72 TEX. L. REV. 1395, 1411 (1994).

policyholders runs a spectrum from the callously deceitful, as the functional equivalent of stealing, to the improper but less ill-spirited, to make up for an inadequacy of record-keeping or a careless decision to under-insure. That behavior may cause an insurer to fail to properly investigate a cause of loss or incur significant additional expense in investigating a claim, or it may have no effect at all. Where the behavior is toward the less deceitful end of the spectrum and it does not affect the insurer's behavior, the loss of the entire value of the policy to the policyholder is too extreme a sanction.

A focus on the dynamics of the claim process also gives a different picture of the risks of opportunism. The risk of policyholder opportunism may be exaggerated, there are other mechanisms in place to deal with it, and there is a related risk of insurer opportunism.

Policyholder fraud is a familiar theme in discussions about insurance, both within the industry and in outreach to the public at large. [84] The empirical claim is that fraud is widespread.[85] The response that this claim justifies is a multi-front war on fraud. Sophisticated predictive analytics trigger identification of potentially fraudulent claims. Insurance companies contain Special Investigation Units to which claims of fraud are referred for more aggressive investigation. Insurance regulators and prosecutors in most states have established distinct units to seek civil and criminal penalties for fraud, and legislation often requires insurers to report suspected cases of fraud to them.[86] All states now make insurance fraud a crime, with two-thirds of the states treating it as a felony.[87] So to the extent that there is a problem, the false swearing doctrine is only one among many potential solutions, reducing its importance.

The false swearing doctrine aims to respond to opportunism by the insured. One might consider the problem of opportunism by the insurer to be entirely separate so that it is irrelevant to the false swearing doctrine and should be addressed through entirely separate doctrines and remedies. But in fact, the two problems are linked. One potential form of insurer opportunism is the assertion of fraud by the policyholder as a reason for not paying a

---

[84] FEINMAN, *supra* note 28, at ch. 10.

[85] According to the Coalition Against Insurance Fraud, "Insurance fraud is one of America's largest crimes—at least $80 billion is stolen each year." Fraud: Why Worry?, COALITION AGAINST INS. FRAUD, http://www.insurancefraud.org/fraud-why-worry.htm (last visited Jan. 6, 2019).

[86] *E.g.*, N.Y. INS. LAW § 405 (N.Y. 2018).

[87] Statutes, COALITION AGAINST INS. FRAUD, http://www.insurancefraud.org/statutes.htm.

claim. An insurer could use allegations of fraud as part of a broader scheme to deny payment of valid claims. Or it could make use of the non-reliance false swearing rule in a parallel way to post-claim underwriting. If an insurer discovers a misrepresentation during the course of its investigation of a claim, it can use the misrepresentation as a basis for denying the claim even if the misrepresentation played no part in its investigation, just as an insurer in past times could use a misrepresentation on the application even if the misrepresentation played no role in its underwriting decision.[88] The doctrine that enforces and evaluates that reason becomes a tool for opportunism, and the severe consequences of a finding of false swearing raises the stakes considerably. Therefore, with respect to false swearing in the claim process, agency and opportunism are present on both sides and the better rule of false swearing would recognize that.

Under the contract and claim analysis, resolving the challenge of both types of opportunism once again requires balancing, here weighing the relative risk and severity of each type. How likely are insureds to control relevant information and at what expense could insurers discover it? If an insurer asserts fraud, how likely is an insured to contest its determination? How likely are insurers to opportunistically deny claims? How often does that behavior take the form of improper assertions that the insured's claim is fraudulent?

Empirical data on that question are hard to come by and subject to interpretation.[89] An analogous instance of balancing insurer, policyholder, and pool interests in cases of misrepresentation involves misrepresentation or concealment at the front end of the insurance relationship, in the application process, as discussed above. Information provided by the insured in the process of applying for an insurance policy should play a significant part in the underwriting decision of the insurer—whether to issue the policy, with what terms of coverage, and at what rate. In the classic example of "post-claim underwriting," however, life insurance companies failed to do proper investigation before issuing the policy; after a claim was filed, they would refuse to pay death benefits, asserting that the insured had misrepresented his physical condition or medical history when applying for

---

[88] See text at notes 32-36 *supra*.

[89] The most authoritative quantitative study of insurance fraud concluded, for example, that the ratio of fraud alleged and reported by insurance companies to actual, provable fraud, was about 25 to 1. Richard A. Derrig, *Insurance Fraud*, 69 J. RISK & INS. 271 (2002).

the policy, which rendered the policy void.[90] These practices caused disproportionate forfeiture because the insured's beneficiaries lost the benefit of the policy because of a minor error, perhaps knowing or perhaps unintentional, that may or may not have affected the insurer's underwriting decision. Even worse, companies sometimes required voluminous but vague disclosures on the application for insurance to set up the misrepresentation argument,[91] a clear instance of insurer opportunism. Over time, legislatures and courts recognized this problem and responded in various ways, such as through doctrines of incontestability, waiver, estoppel, and materiality of misrepresentation.[92] Those doctrines attempt to balance the interests of insurer, insured, and pool in checking agency and opportunism on both sides of the insurance relation.

This suggests the advantage of a false swearing rule that at least has a serious requirement of materiality and includes an element of reliance. If an insurer has not been affected at all by a policyholder's misrepresentation, the entire loss of the relation of security by the policyholder, undermining the policyholder's conception of the contract, is too severe a consequence. Reliance does not need to be immense, but it does need to be tangible. If an insurer loses the opportunity adequately to investigate the cause of a fire[93] or incurs significant additional investigative expenses, that constitutes sufficient detrimental reliance; [94] processing the claim independently of the alleged misrepresentations does not.[95]

The contract and claim analysis not only provides a perspective on a variety of substantive doctrinal issues; it also can be used to reframe elements of the litigation process through which those doctrines are realized. The process of proof in the application of the false swearing doctrine provides an example. Some jurisdictions require that the elements of false swearing be proven by clear and convincing evidence; others use only a

---

[90] *See* Cady & Gates, *supra* note 50, at 813-14.

[91] *E.g.*, Connecticut Mut. Life Ins. Co. v. Union Trust Co., 112 U.S. 250 (1884); Baumgart v. Modern Woodmen of Am., 55 N.W. 713 (Wis. 1893).

[92] *See* Cady & Gates, *supra* note 50.

[93] Allstate Ins. Co. v. Breeden, 410 Fed. Appx. 6, 8 (9th Cir. 2010).

[94] Leander Land & Livestock, Inc. v. Am. Econ. Ins. Co., 2013 WL 5940027, at *6 (D. Or. Nov. 1, 2013).

[95] Leavenworth v. State Farm Fire & Cas. Co., 297 Fed. Appx. 602 (D. Or. Oct. 22, 2008).

preponderance of the evidence standard.[96] The former is the standard ordinarily applied in cases involving the tort of fraud, the latter in cases in which fraud is the basis for avoidance of a contract. The difference follows from the idea that allegations of fraud are more serious than allegations of ordinary breach of contract, and "more evidence should be required to establish grave charges than to establish trifling or indifferent ones."[97]

Combining this framework with the contract and claim analysis suggests that false swearing should require proof by clear and convincing evidence. Indeed, false swearing in the insurance context is potentially a more serious matter than some other types of fraud. The insurance contract properly understood is about security and the consequences for the insured in losing the security of the insurance policy are often severe or even catastrophic. Especially where insurer reliance on the misrepresentation is not required, the trier of fact needs to be more certain that the other elements are met before attaching such drastic consequences, and more of the risk of error in fact-finding should be borne by the insurer. And the threat of insurer opportunism in using allegation of fraud as a strategy to avoid paying claims—exploiting false claims of false swearing, as it were—suggests that courts ought to be cautious in enabling an insurer to use a claim of false swearing to entirely void its obligation under the policy and should assign the risk of error in fact-finding to the insurer.

2. Bad Faith

In first-party bad faith cases, most jurisdictions require something more than a negligent failure to investigate or pay a claim to constitute a violation of claim practices standards, adopting instead the fairly debatable standard.[98] That standard requires the absence of a reasonable basis for denying the claim—that it was not "fairly debatable"—and intent or recklessness as to the absence of a reasonable basis. [99] The rationale for this

---

[96] 13 STEVEN PLITT ET AL., COUCH ON INSURANCE § 197:6 (3d ed. 2018).

[97] Ziegler v. Hustisford Farmers Mut. Ins. Co., 298 N.W. 610, 612 (Wis. 1941) (quoting JONES COMMENTARIES ON EVIDENCE § 563, at 1036 (2d ed. 1926)).

[98] Feinman, *supra* note 67, at 702.

[99] Perhaps the most widely cited formulation of the standard comes from the Wisconsin Supreme Court's decision:

rule is based in part on the potential *in terrorem* effect of bad faith litigation upon the insurer. "'An insurer should have the right to litigate a claim when it feels there is a question of law or fact which needs to be decided before it in good faith is required to pay the claimant.'"[100] Some courts also use a procedural elaboration on the fairly debatable test. To establish bad faith, the policyholder is required to prove that it would have been entitled to summary judgment on the underlying coverage claim.[101]

The fairly debatable rule embodies strongly the insurer's perspective of the contract, that the policy plans in detail the risks covered and excluded. Underlying the fairly debatable rule is a conception that at the time of performance, the policy represents an element of the insurer's portfolio of risk, with its pricing and place determined by the policy terms. As insurers often say, an insurer is obligated to pay what is owed, no less but no more.[102] Indeed, the insurer should be required to pay no more than what is owed; otherwise, it would upset the contractual risk allocation and burden the pool of policyholders.

Of course, the policy language and facts of the loss do not always lead to a clear conclusion about the insurer's obligation. Language of coverage and exclusion may be unclear as applied to the facts of the loss. And in every case the policy includes only general terms about the insurer's

---

> To show a claim for bad faith, a plaintiff must show the absence of a reasonable basis for denying benefits of the policy and the defendant's knowledge or reckless disregard of the lack of a reasonable basis for denying the claim. It is apparent, then, that the tort of bad faith is an intentional one. "Bad faith" by definition cannot be unintentional.
>
> . . . .
>
> Under these tests of the tort of bad faith, an insurance company, however, may challenge claims which are fairly debatable and will be found liable only where it has intentionally denied (or failed to process or pay) a claim without a reasonable basis.

Anderson v. Cont'l Ins. Co., 271 N.W.2d 368, 376-77 (Wis. 1978).

[100] Polizzi Meats, Inc. v. Aetna Life & Cas. Co., 931 F. Supp. 328, 334-35 (D.N.J. 1996) (citation omitted) (quoting Anderson v. Cont'l Ins. Co., 271 N.W.2d 368, 377 (Wis. 1978)).

[101] Pickett v. Lloyd's, 621 A.2d 445, 454 (N.J. 1993).

[102] *E.g.*, Libby v. Farmers Ins. Exch., 2008 WL 2421976 *44 (Cal. App. Div. Super. Ct. 2008).

obligations in the claim process. In those cases, the fairly debatable rule empowers the insurer to dispute coverage, as long as it does so for the purpose of fulfilling its expectations that were created by the policy; that is, without intent to dispute the claim for improper purposes or reckless disregard of the reasonableness of its position.

In this respect the fairly debatable rule captures one conception of the contract. But in doing so, it ignores the form-contract nature of the policy and the policyholder's less determinate and more relational expectation about coverage. It also ignores the policyholder's expectation that, at the point of claim, the insurer will act reasonably. More important, it also ignores the dynamics of the claim process. The rule completely discounts the insurer's agency and the risk of opportunism except at the extreme. Instead, it embodies a conception that only the most egregious intentional acts by the insurer violate the contract; that the vulnerability of the policyholder, the information imbalance, and the economics of litigation do not present bars to finding and pursuing such egregious acts; and that the courts are able to distinguish the intentionally wrongfully from more ordinary behavior.

A smaller number of jurisdictions apply a reasonableness rule of liability.[103] The duty of the insurer to act in good faith in handling an insured's claim is violated when an insurer "fails to deal fairly and in good faith with its insured by refusing, without proper cause, to compensate its insured for a loss covered by the policy"[104] or "when the insurer unreasonably and in bad faith withholds payment of the claim of its insured."[105]

The rule that requires an insurer to act reasonably recognizes that the policy imperfectly embodies the insurance relation. Instead, the policy creates a relation that includes its written terms as well as less determinate expectations of the policyholder and industry and legal norms. The rule also recognizes the dynamics of the claim process, in which there is a risk of insurer opportunism that the policyholder cannot check in the terms of the contract, because it is an adhesion contract, or at the point of claim, because of the dynamics. All of those require that the insurer act reasonably in the claim process.

Reasonableness is not strict liability, however. The reasonableness rule does not ignore the legitimate interests of the insurer as representative of the pool; it only requires adherence to widely understood norms. Where

---

[103] The landmark case on this subject was Gruenberg v. Aetna Ins. Co., 510 P.2d 1032 (Cal. 1973).

[104] *Id.* at 1037.

[105] *Id.* at 1038.

the fairly debatable rule focuses on the risk to the pool if the insurer is deterred from litigating open questions of law or fact, the contract and claim approach demonstrates that the reasonableness rule benefits the pool by providing an appropriate level of incentive with a nontrivial risk of litigation to enforce the standard, a position that increases the probability that the insurer will respect the interests of policyholders in future claims.

CONCLUSION

Insurance law scholars are fond of reconceptualizing their subject. Insurance policies and insurance law have been likened to a means of public utility regulation, a product warranty, a social institution, or, perhaps mostly simply, a thing.[106] This article represents another conceptualization of the subject, and one that may be less foreign to the subject and closer to the reality of the formation and performance of insurance relationships. Insurer and policyholder approach the insurance relation from different perspectives at the moment of creation and the point of claim. Insurance law should recognize those differences and pay particular attention to the dynamics of the claim process in the resolution of insurance law disputes.

---

[106] Abraham, *supra* note 1; Daniel Schwarcz, *A Product Liability Theory for the Judicial Regulation of Insurance Policies*, 48 WM. & MARY L. REV. 1389 (2007); Jeffrey W. Stempel, *The Insurance Policy as Social Instrument and Social Institution*, 51 WM. & MARY L. REV. 1489 (2010); Jeffrey W. Stempel, *The Insurance Policy as Thing*, 44 TORT TRIAL & INS. PRAC. L.J. 813 (2009).

IS U.S. INSURANCE REGULATION UNCONSTITUTIONAL?

DANIEL SCHWARCZ [*]

Abstract: Insurance regulation is ostensibly the primary domain of the states. In practice, however, the most important and powerful entity in insurance regulation is not a state at all, but a non-profit corporation known as the National Association of Insurance Commissioners, or NAIC. Much of the NAIC's power lies in its production of various "handbooks" and "manuals" that have the force of law because they are incorporated by reference in state insurance codes. Under this statutory scheme, when the NAIC updates or changes its various manuals, handbooks, or accounting forms, it also changes state insurance regulation. Because the NAIC is a private entity, it produces these various materials that have the force of law without being bound by any safeguards that ordinarily accompany the production of regulation, whether at the state or federal level. Moreover, the NAIC uses its unique accreditation program to directly pressure state legislatures to delegate this authority to it. This Article argues that this scheme violates basic separation of powers and non-delegation principles embedded in every state Constitution. Under any reasonable version of these principles, the delegation of state regulatory authority to a private entity that directly pressures legislatures to make this delegation and whose actions are not reviewable through any formal judicial or administrative process is unconstitutional. Recognizing this conclusion has the potential to improve state insurance regulation by increasing the accountability of state regulators and the NAIC. But it also carries the risk of undermining state insurance regulation by frustrating efforts to promote uniform national standards. However, this Article suggests that state legislatures can enact reforms that simultaneously remedy the unconstitutional structure of state insurance regulation while preserving the many practical benefits that flow from delegating production of regulatory standards to a single, national entity like the NAIC. In particular, they can establish an entity through an interstate compact that is truly independent from state insurance regulators and that is empowered to review the NAIC's production of regulatory materials that have the force of law.

---

[*] Professor, University of Minnesota Law School. Schwarcz@umn.edu.
For comments and suggestions, I thank Ian Adams, Jay Feinman, Brian Galle, Jeremy Kress, William McCartney, Peter Molk, Maria Ponomarenko, Jim Rossi, Miriam Seifter, Roy Woodall, Robert Williams, David Zaring, and participants in the University of Minnesota's "squaretable" series. For excellent research assistance, I thank Alexander Tibor.

TABLE OF CONTENTS

INTRODUCTION……199
I. STATE DELEGATION OF POWER TO THE NAIC……206
A. OVERVIEW OF THE NAIC ……207
B. THE NAIC'S FINANCIAL STANDARDS AND ACCREDITATION PROGRAM……211
C. STATE DELEGATIONS TO THE NAIC……213
II. THE LAW GOVERNING STATE LEGISLATIVE DELEGATION OF POWERS TO PRIVATE ACTORS……223
A. STATES' NON-DELEGATION DOCTRINES……224
B. THE UNIQUE CASE OF LEGISLATIVE DELEGATIONS TO PRIVATE PARTIES……227
C. KEY FACTORS IN ASSESSING THE CONSTITUTIONALITY OF LEGISLATIVE DELEGATIONS TO PRIVATE ACTORS……229
D. APPLICATION OF PRIVATE NON-DELEGATION FACTORS IN WORKERS' COMPENSATION AND ACCOUNTING DELEGATIONS……239
III. THE UNCONSTITUTIONALITY OF THE U.S. STATE INSURANCE REGULATORY REGIME ……243
A. THE NAIC IS A PRIVATE ACTOR FOR PURPOSES OF THE NON-DELEGATION DOCTRINE……243
B. THE NAIC'S EXERCISE OF DELEGATED AUTHORITY IS NOT SUBJECT TO MEANINGFUL PUBLIC OVERSIGHT……248
C. THE NAIC'S EXERCISE OF DELEGATED AUTHORITY IS NOT INDEPENDENT FROM THE DELEGATING STATUE……255
IV. IMPLICATIONS OF AND SOLUTIONS FOR THE UNCONSTITUTIONAL STRUCTURE OF U.S. INSURANCE REGULATION ……257
A. THE CONSEQUENCES OF ELIMINATING STATES' DYNAMIC CROSS REFERENCES TO NAIC MATERIALS……258
B. A PROPOSED INTERSTATE COMPACT TO ESTABLISH INDEPENDENT REVIEW OF THE NAIC'S EXERCISE OF DELEGATED AUTHORITY……259
CONCLUSION ……262

INTRODUCTION

Insurance regulation is ostensibly the primary domain of the states.[1] In practice, however, the most important and powerful entity in insurance regulation is, without question, not a state at all. Nor is it even a government entity. Instead, it is a private, non-profit corporation known as the National Association of Insurance Commissioners, or NAIC.[2]

In many contexts, the NAIC's role in state insurance regulation is uncontroversial. For instance, the NAIC produces model insurance statutes and regulations. Much like any other model law project,[3] states sometimes adopt these models wholesale, sometimes choose not to adopt them, and sometimes adopt them with significant changes.[4] The NAIC also affords state insurance regulators an opportunity to collaborate with one another, provides both regulators and consumers with an array of services, and conducts various public information campaigns.[5]

But the NAIC's true power lies in its direct production of insurance regulatory materials that have the force of law, a category that includes over a dozen "handbooks" and "manuals."[6] These materials dictate (among many

---

[1] McCarran-Ferguson Act, ch. 20, 59 Stat. 33 (1945) (codified as amended at 15 U.S.C. §§ 1011–1015 (2012)).

[2] *See generally* KENNETH ABRAHAM & DANIEL SCHWARCZ, INSURANCE LAW AND REGULATION (6th ed. 2015); 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).

[3] *See, e.g.*, RESTATEMENT OF LIAB. INS. (AM. LAW INST., Proposed Final Draft No. 2, 2018).

[4] All model laws and regulations are available at *NAIC Model Laws, Regulations, and Guidelines*, NAT'L ASS'N INS. COMMISSIONERS, http://www.naic.org/store_model_laws.htm (last visited Aug. 18, 2018). For each model, the NAIC maintains an up-to-date list indicating which jurisdictions have enacted that model or a substantially similar version.

[5] ABRAHAM & SCHWARCZ, *supra* note 2, at 111-13.

[6] Examples include the (1) Accounting Practices and Procedures Manual, (2) Annual Statement Blank, (3) Annual Statement Instructions, (4) Financial Analysis Handbook, (5) Financial Condition Examiner's Handbook, (6) Insurance Regulatory Information System Ratio Manual, (7) NAIC Uniform Life, Accident and Health, Annuity and Credit Product Coding Matrix, (8) Own Risk and Solvency Assessment Guidance Manual,

other things) the information that insurers and other regulated entities must regularly report to regulators, the methodologies they must use to determine their capital levels, and the accounting standards that they must employ to calculate their assets and liabilities. They also constrain the work of regulators, in addition to regulated entities, dictating the methodologies they must use when conducting financial and market conduct exams.[7]

These documents have the force of law because virtually every state's insurance laws say they do.[8] More specifically, the insurance codes of virtually every state requires insurers and state regulators to adhere to the rules that are detailed in the most recent versions of these NAIC materials.[9] As a result, when the NAIC updates or changes any of its various manuals, handbooks, or accounting forms, it also changes state insurance regulation—without further action by the democratically accountable representatives of the states. This practice is one particularly troubling type of a more general statutory drafting practice known as dynamic incorporation by reference.[10]

---

(9) Purposes and Procedures Manual of the NAIC Investment Analysis Office, (10) Risk Based Capital Forecasting and Instructions, and (11) Securities Valuation Manual. *See* S. 341, 120th Gen. Assemb., 2d Reg. Sess. (Ind. 2018), 2018 Ind. Acts 1167, http://iga.in.gov/static-documents/2/3/f/b/23fbf999/SB0341.04.ENRH.pdf (compiling these).

[7] Examples of such manuals include: NAT'L ASS'N OF INS. COMM'RS, FINANCIAL CONDITION EXAMINERS HANDBOOK, and NAT'L ASS'N OF INS. COMM'RS, MARKET REGULATION HANDBOOK EXAMINATION STANDARDS.

[8] One partial exception is Indiana. *See id.* Indiana's Senate Enrolled Act No. 341 changes all statutory references to NAIC materials so that they refer to the 2017 edition of those materials. At the same time, however, the legislation specifies that the "commissioner may implement" materials updated by the NAIC "in the regulation of the business of insurance" so long as the commissioner reports the amendment to the legislative council and standing committees. *See id.* ch. 1.5, § 1(c).

[9] *See, e.g.*, 40 PA. STAT. AND CONS. STAT. ANN. § 991.2602 (West 2018). Some state statutes do not explicitly reference the most recent versions of NAIC documents. But even in these cases, regulators require insurers to comply with the most recent versions of NAIC materials.

[10] *See* Jim Rossi, *Dynamic Incorporation of Federal Law*, 77 OHIO ST. L.J. 457 (2016). *See also* John Mark Keyes, *Incorporation by Reference in Legislation*, 25 STATUTE L. REV. 180 (2004) (distinguishing among four different types of text that can be incorporated by reference, as well as

Because the NAIC is a private entity, it produces these various materials that have the force of law without being bound by any of the procedural safeguards that ordinarily accompany the production of regulation, whether at the state or federal level.[11] For instance, the NAIC is not required by any law to provide the public with notice and an opportunity to comment on these materials before they are adopted, though it generally does so voluntarily. It also need not disclose information that would be publicly-accessible if held by a public entity. And nothing that the NAIC produces is subject to judicial review or routine oversight by an administrative body.[12]

Even more gallingly, while the NAIC's power to directly set many of the details of state insurance regulation is itself a function of state law, in many cases state lawmakers are effectively compelled by the NAIC itself to delegate this authority to the private entity. The NAIC manages this staggering feat through its Financial Standards and Accreditation Program. Under this program, states can only be accredited if they adopt a set of NAIC model laws, or their substantial equivalent.[13] And it is those very laws that incorporate by reference NAIC manuals and handbooks.

Although the NAIC cannot mandate that states participate in its accreditation program, it has cleverly designed the program so that states effectively have no choice on the matter. That is why every single state is accredited. The NAIC accomplishes this by including a seemingly innocuous provision in the model laws that states must adopt to be accredited: accredited state insurance departments are only permitted to defer to the solvency regulation of an insurer's home state (i.e. its state of domestication)

---

between incorporations by reference that are "static" (fixed in time) and "ambulatory" (linked to the most recent versions of the incorporated text)).

[11] State administrative law is variable. However, it generally follows many of the basic principles of federal administrative law with respect to the availability of judicial review and the requirements for agencies to provide the public with notice and an opportunity to comment on a range of administrative actions.

[12] State administrative law is variable. However, it generally follows many of the basic principles of federal administrative law with respect to the availability of judicial review and the requirements for agencies to provide the public with notice and an opportunity to comment on a range of administrative actions.

[13] *See infra* Section I.B.

if the home state is itself accredited.[14] As a result, any insurer domesticated in a state that lost its accreditation would quickly "redomesticate" to another state.[15] Failing to do so would subject it to financial scrutiny in every state where it sold coverage. Such redomestication requires moving the insurer's principal place of business, as well as the taxes and jobs that come along with it.[16] In a real sense, then, the NAIC – a private entity subject to none of the normal safeguards that ordinarily constrain the administrative state – has developed a complex system that effectively compels states to delegate to it the authority to produce many of the key details of state insurance regulation as it sees fit.

This scheme, I argue, violates basic separation of powers and non-delegation principles embedded in every state constitution. Although state constitutions vary, they all vest in a legislative branch the power to make laws, and they all are understood to limit the legislature's power to delegate this authority elsewhere.[17] Under any reasonable version of this principle, I argue, the delegation of state regulatory authority to a private entity that directly pressures legislatures to make this delegation and whose actions are not reviewable through any formal judicial or administrative process is unconstitutional. The Article is the first in-depth analysis of these

---

[14] *See* MODEL LAW ON EXAMINATIONS § 3(C) (NAT'L ASS'N OF INS. COMM'RS 1999) ("In lieu of an examination under this Act of a foreign or alien insurer licensed in this state, the commissioner may accept an examination report on the company as prepared by the insurance department for the company's state of domicile…only if…the insurance department was at the time of the examination accredited under the NAIC's Financial Regulation Standards and Accreditation Program….").

[15] *See infra* Section I.B.

[16] *See* REDOMESTICATION MODEL BILL § 1 (NAT'L ASS'N OF INS. COMM'RS 2006) ("An insurer that is organized under the laws of any other state and is admitted to do business in this state for the purpose of writing insurance may become a domestic insurer by…and by designating its principal place of business at a place in this state."); MODEL LAW ON EXAMINATIONS (NAT'L ASS'N OF INS. COMM'RS 1999) (noting that virtually every single state has adopted the NAIC Redomestication Model Law, and the small handful that have not have "related activity".).

[17] *See* ROBERT F. WILLIAMS, THE LAW OF AMERICAN STATE CONSTITUTIONS (2009).

constitutional issues, notwithstanding the fact that several prominent former and current officials have alluded to this issue for decades.[18]

The Article's argument unfolds in four Parts. Part I begins by briefly introducing the NAIC's governance structure, funding model, and

[18] Dating as far back as 1991, Roy Woodall – the former independent member of the Financial Stability Oversight Counsel with Insurance Expertise – warned that "national regulation of insurance is the culmination of a state supported regulatory scheme whereby a select few insurance regulators are able to engineer methods by which the NAIC can usurp legislative and judicial powers of the states by expending existing NAIC regulatory vehicles to impose illegal and unconstitutional regulatory jurisdiction and requirements upon the insurance industry in all fifty states – without the benefits of any state or federal oversight or legislative action." S. Roy Woodall, Jr., *The NAIC and "National Regulation,*" Editorial, National Association of Life Companies Newsletter (1991). More recently, Congressman Ed Royce has suggested during oral comments in several congressional hearings that the NAIC has usurped state authority by making regulatory policy without any effective oversight by the states or other public actors. *See* Allison Bell, *Republican Questions Constitutionality of Insurance Regulatory System*, THINKADVISOR (Oct. 25, 2017, 06:29 AM), https://www.thinkadvisor.com/2017/10/25/republican-questions-constitutionality-of-insuranc/?slreturn=20190009212135. Yet a third example of prominent former or current officials questioning the constitutionality of the NAIC's authority comes from former Illinois Insurance Commissioner Nat Shapo. In oral testimony before a committee of Indiana lawmakers, Shapo argued that "Dynamic incorporation by reference—implementing material added to [incorporated by referenced] work product after State's adoption of work product through [Incorporation by Reference]—[is] not allowed" under "state constitutional law" and the non-delegation doctrine. *See* Testimony of Nat Shapo, Katten Muchin Rosenman LLP, before August 16, 2017: Interim Study Committee on Financial Institutions and Insurance. This issue has also been a frequent topic of conversation at meetings of the National Conference of Insurance Legislatures. *See* Ian Adams, *At NCOIL, State Lawmakers Look to Claw Back Power from NAIC*, INS. J., (March 6, 2017), https://www.insurancejournal.com/blogs/right-street/2017/03/06/443636.htm; Ian Adams, *NCOIL, NAIC on Collision Course over Delegation Authority*, INS. J., (July 15, 2017), https://www.insurancejournal.com/blogs/right-street/2017/07/15/457728.htm).

accreditation program. It then explores how states delegate power to the NAIC by incorporating-by-reference the most recent versions of the NAIC's materials. It focuses attention on three notable examples of such dynamic incorporation by reference. The first concerns life insurers' calculation and reporting of their reserves, which determine the capital they must set aside to pay future policyholder claims. Second, Part I describes how the NAIC directs insurers' methods and documentation of their corporate risk management practices. Third, Part I explores how states delegate to the NAIC the power to set the accounting rules that govern insurers' copious financial reporting obligations.

Part II lays the Article's legal foundation by describing state law regarding legislative delegations of power to private entities. Although this law varies across jurisdictions, virtually every state tolerates legislative delegation of power to private parties only in limited circumstances. States generally avoid any bright-line rules on this issue, instead utilizing a variety of overlapping multi-factor tests. Relevant factors include the public or private character of the delegate, the extent to which the delegate's authority is subject to judicial or administrative oversight, and whether the delegate's exercise of authority has significance independent of the delegating statute. Part II explores how these factors play out in two situations that closely parallel states' delegation of power to the NAIC: dynamic incorporation by reference of the American Medical Association's impairment standards in state workers' compensation laws, and state and federal delegations of authority to the Financial Accounting Standards Board (FASB) to set Generally Accepted Accounting Principles (GAAP).

Drawing on Parts I and II, Part III explains why states' delegation of power to the NAIC violates essential separation of powers and due process principles embedded in every state constitution. First, Part III argues that the NAIC is a private entity for purposes of states' non-delegation doctrines. Under the formalistic approach to this issue that some courts employ, this conclusion flows naturally from the fact that the NAIC is chartered as a Delaware corporation founded by state regulators, rather than state legislatures.[19] But even under the functional approach embraced by other courts, the NAIC is a private delegate. This is because state legislatures have limited and fragmented control over the NAIC, a reality that is perhaps best illustrated by the inability of states legislatures to date to successfully reclaim their constitutional authority from the NAIC.

The NAIC's law-making authority is constitutionally problematic for a second set of reasons as well: it is exempt from dedicated and

[19] *See infra* Section III.

independent oversight by state judges or administrate bodies. In fact, none of the NAIC's alterations to its dynamically-incorporated manuals are routinely reviewed by any state court or administrative agency.[20] State insurance regulators' direct participation in the NAIC's internal processes is no substitute for such independent oversight. To the contrary, state insurance regulators operating under the auspices of the NAIC may have substantial interests in using the NAIC's delegated authority in ways that promote their own biased interests. For instance, state insurance regulators may use the NAIC's authority to inflate the scope and complexity of the special accounting principles that U.S. insurers are required to use.[21] Doing so can increase the value of regulators' specialized insurance expertise, limit the risk of perceived encroachment on their turf by federal officials, and improve the NAIC's capacity to fund its operations by selling new publications or services. Alternatively, state regulators can, and do, use the NAIC to raise, pursue, and implement difficult policies in a private forum, away from democratic accountability.[22]

To be sure, state statutes do contain provisions allowing state regulators to depart from dynamically incorporated materials, the most important factor suggesting that the NAIC's scheme may be constitutional. But such departures are not routinely or formally considered by state insurance departments. Nor could they be, given the relative scope of the NAIC's power and the limited resources of most state insurance departments. Even in the rare instances when an individual state insurance department departs from a specific NAIC-produced standard, it is in no position to use this action to influence the NAIC's operations more broadly.[23]

The final, and perhaps most important, reason that states' delegations of powers to the NAIC are generally unconstitutional is that the NAIC's exercise of its delegated authority is practically immune from implicit oversight by state legislatures. This is a result of the NAIC's unique Financial Standards and Accreditation Program, which deprives state lawmakers of any realistic capacity to claw-back their delegations of power to the NAIC by amending state law.[24] As a practical matter, the NAIC uses the threat of doom of a state's domestic insurance industry to compel states

---

[20] *See infra* Section I.
[21] *See infra* Section III.
[22] *See infra* Section III.
[23] *See infra* Section III.
[24] *See infra* Section I.

to delegate to it immense power over both the details of insurance regulation and the larger framework within which those details are generated.

Part IV of the Article considers the implications of the conclusion that much of state insurance regulation rests on an unconstitutional foundation. It first explores both the positive and negative impacts of simply eliminating state delegations of power to the NAIC. Although this approach would increase accountability and decrease bias in the production of state insurance regulation, it would also undermine the uniformity and agility of such regulation. For this reason, Part IV concludes by suggesting that states can constitutionally preserve their delegations of power to the NAIC by creating, through an interstate compact, an independent entity responsible for reviewing the production of new NAIC materials that have the force of law.

I. STATE DELEGATION OF POWER TO THE NAIC

The NAIC is, in many ways, a unique entity in the American regulatory landscape. To be sure, as a private organization of public officials, it resembles any number of other groups, such as the Association of State and Territorial Health Officials or the Association of State Criminal Investigative Agencies.[25] But unlike any other private association of public officials, the NAIC is directly responsible for producing many of the essential details of state regulation. Section A of this Part briefly describes the NAIC's history and structure. Section B then describes the NAIC's unusual "accreditation" program, which is directly responsible for the organization's unique regulatory authority under state law. Section C then explores three notable state delegations of authority to the NAIC, involving life insurers' calculation and reporting of their reserves, insurers' corporate risk management practices and reporting, and insurers' accounting rules.

A. OVERVIEW OF THE NAIC

The NAIC describes itself as "the U.S. standard-setting and regulatory support organization created and governed by the chief insurance regulators from the 50 states, the District of Columbia and five U.S.

[25] *About*, ASS'N OF STATE AND TERRITORIAL HEALTH OFFICIALS, http://www.astho.org/About/ (last visited Nov. 19, 2018); *About*, ASS'N OF STATE CRIMINAL INVESTIGATIVE AGENCIES, https://www.ascia.org/about.php (last visited Nov. 19, 2018).

territories."[26] A group of state insurance commissioners created the organization in 1871 as an unincorporated association.[27] At the time, the NAIC was focused on facilitating states' efforts to regulate multistate insurers by developing a uniform system of financial reporting for these companies.[28] But throughout the twentieth century, the NAIC's importance in state insurance regulation gradually increased, with the organization taking on an increasingly prominent role in crafting model laws and regulations for states to implement and operating as a forum for dialogue among state regulators and the insurance industry.[29]

As the NAIC's role increased, so did its staff and budget. Run on a shoestring with a small staff as recently as the 1980s, today the NAIC has approximately 500 employees spread out over offices in Washington, D.C., New York, and Kansas City.[30] This staff is supported by a budget of over $100 million as well as a reserve of an additional $100 million.[31]

The NAIC sets its own budget without any external oversight. Much of the NAIC's revenue comes from its sale of data, reports, and publications

---

[26] *About the NAIC*, NAT'L ASS'N INS. COMMISSIONERS, https://www.naic.org/index_about.htm (last visited Aug. 25, 2018).

[27] This was shortly after the Supreme Court held in *Paul v. Virginia* that Congress's power to regulate interstate commerce did not extend to the business of insurance. 75 U.S. 168 (1868).

[28] KENNETH MEIER, THE POLITICAL ECONOMY OF REGULATION: THE CASE OF INSURANCE 54 (1988).

[29] *See* Randall, *supra* note 2, at 648. One watershed moment in the NAIC's evolution was its rile in coordinating states' response to *United States v. S.-E. Underwriters Ass'n,* which overruled *Paul v Virginia* by holding that the deferral government could indeed regulate the business of insurance under its Commerce Clause power. 322 U.S. 533 (1994). The case generated substantial concern among states worried about federal encroachment on the regulation and taxation of insurance as well as among insurers concerns about a new source of federal scrutiny. The NAIC ultimately played a major role in proposing the McCarran-Ferguson Act, which cemented the states' authority to regulate the business of insurance and remains the central law in U.S. regulations.

[30] *See* NAT'L ASS'N OF INS. COMM'RS, 2018 NAIC BUDGET 25 (2018), https://www.naic.org/documents/about_budget_2018_budget.pdf?13; *About the NAIC*, *supra* note 15.

[31] *See supra* note 19.

to the insurance industry. For instance, the NAIC's leading source of revenue is its provision of valuation services, which instruct insurers how to value their investments for regulatory reporting purposes.[32] Other major contributors to the NAIC's budget include the sale of publications and insurance data products, transaction filing fees, and its administrative services and license fees, all of which ultimately come out of the pocket of insurance industry members.[33] Although state insurance regulators cannot compel insurers to pay these NAIC fees, they can informally pressure carriers to do so by threatening negative treatment of noncompliant carriers. Among the publications that the NAIC sells to the industry are the very manuals that are dynamically incorporated by reference into state law.[34]

---

[32] The NAIC charges the largest subset of individual carriers $36,000 annually for full access to this database, and ultimately earns approximately $26 million annually in connection with this service. The NAIC earns a roughly similar amount annually from the fees that it charges to insurers for filing their required quarterly and annual statements with the NAIC's central data collection system. This includes NAIC designation and review date, pricing, SIC code, SVO group code, and market indicator. NAT'L ASS'N OF INS. COMM'RS, *supra* note 19, at 2.

[33] *Id.* Although the NAIC does charge its individual members – who consist of the fifty-six state insurance commissioners – an assessment fee, total revenue from this source only comes in at about 2% of the NAIC's annual budget. *See id.*

[34] *See* Lawrence A. Cunningham, *Private Standard in Public Law: Copyright, Lawmaking, and the Case of Accounting*, 104 MICH. L. REV. 291 (2005) (considering whether such materials are entitled to copyright). The NAIC also derives approximately a quarter of its budget from various vendor service units. Both directly and through its controlled corporate affiliate NIPR, the NAIC collects over $25 million annually from its business units which sell their services to the public offices of the same insurance commissioners who are its members and who are the beneficiaries of significant largesse from the NAIC's expenditure of its $100 million budget. This includes annual commissioner-only junkets to resorts in tropical locations like the Virgin Islands every February, and prime domestic locations like Laguna Beach and Coeur d'Alene every July. The NAIC, capitalizing on state budget crunches in the last 20 years, has formed several vendors that serve as a portal for almost all agent and broker licensing transactions, most rate and form filings, billions in premium tax payments, and various other regulatory functions. The NAIC explicitly competes with

Since 1999, the NAIC has been organized as a non-profit corporation that is governed by an Executive Committee consisting of seventeen state insurance commissioners. This Executive Committee is elected by the NAIC's membership, which consists of the chief state government official in charge of regulating the business of insurance in each state, as well as six additional U.S. jurisdictions.[35] The NAIC's day-to-day operations are directed by its Chief Executive Officer and senior management, who are hired and overseen by the Executive Committee.

As a private non-profit corporation, the NAIC is not subject to any state or federal government accountability laws, such as Freedom of Information Acts, Sunshine Acts, Inspectors General requirements, or state Conflict of Interest rules.[36] However, the NAIC does maintain a number of self-imposed policies and practices that overlap with the typical content of these laws. For instance, all NAIC members are required to sign a conflict-

---

private vendors for the no-bid contracts that it receives from its members, and in fact was forced to pay a $1.5 million settlement to a vendor which accused it of predatory behavior, including price fixing. Trade press and a key Congressman have argued that these activities violate a host of state ethics laws, but without a day-to-day supervisor and without any investigative reporters assigned to the NAIC beat, no efforts at accountability have been made.

[35] *See* NAT'L ASS'N OF INS. COMM'RS, BYLAWS OF THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS (2015).

[36] For one example of how this plays out, consider the industry-aggregate data that the NAIC's Auto Insurance Study Group recently collected in connection with its charge to study auto insurance affordability and availability. The NAIC has refused to make this data publicly available, even though it is similar to data reported by the statistical agents to state insurance regulators, which is publicly available. *See* Comments of CFA and CEJ to Auto Insurance Working Group Regarding the August 10, 2018 Draft "Report" Outline (Sept. 1, 2018)(on file with the CEJ) ("By providing the data to the NAIC instead of the states, somehow clearly public information has, inappropriately, become confidential information because the NAIC – despite its quasi-governmental role – is not subject to any state or federal public information law. The NAIC's refusal to make public the data submitted by industry adds fuel to the complaint that the NAIC is unaccountable to legislators and consumers who are impacted by NAIC actions.").

of-interest policy that requires them to "avoid any activity or situation where their personal interest could conflict, or give the appearance of a conflict, with the business operations or regulatory support activities of the NAIC."[37]

The NAIC organizes much of its activity through an elaborate series of committees and sub-committees. These committees are typically staffed by a group of volunteer state insurance regulators, who are heavily supported by NAIC staff.[38] All changes to model laws and regulations are conducted through this committee structure.[39] Changes to the statutorily-referenced materials, such as handbooks and guides, are also conducted through the NAIC's committee structure, with different committees being charged with maintaining and updating different documents.[40]

Industry has substantial sway over the NAIC's operations and practices, a fact that is most obviously visible at the organization's three annual meetings. Under the NAIC's open meeting policy, almost all of the organization's meetings – both in person and via teleconference – are open

---

[37] Although the policy extends to promised offers of future employment, it is commonplace for NAIC members to take high-profile industry lobbying positions shortly after being members of NAIC leadership. In at least some of these cases, individuals have represented the industry in front of the same committees that they chaired as an NAIC officer only months earlier. *See, e.g.*, *Csiszar Named President of PCI; Resigns as S.C. Insurance Regulator, President of NAIC*, INS. J. (Aug. 18, 2004), https://www.insurancejournal.com/news/national/2004/08/18/45061.htm.

[38] *See* Daniel Schwarcz, *Preventing Capture Through Consumer Empowerment Programs*, *in* PREVENTING REGULATORY CAPTURE: SPECIAL INTEREST INFLUENCE AND HOW TO LIMIT IT 365, 365-96 (David A Moss & Daniel Carpenter eds., 2013).

[39] In 2007, the NAIC adopted an internal procedure for model law development, which requires that a parent committee and the NAIC's Executive Committee approve development of the model, as well as the final version of the model, by two-thirds majority vote. *See* PROCEDURES FOR MODEL LAW DEV. (NAT'L ASS'N OF INS. COMM'RS 2013). (2007), https://www.naic.org/documents/committees_models_procedures.pdf.

[40] *See, e.g.*, *Statutory Accounting Principles (E) Working Group*, NAT'L ASS'N INS. COMM'RS, https://www.naic.org/cmte_e_app_sapwg.htm (last visited Jan. 6, 2019) ("The Statutory Accounting Principles (E) Working Group is responsible for developing and adopting substantive, nonsubstantive and interpretation revisions to the NAIC *Accounting Practices and Procedures Manual* (AP&P Manual")) (emphasis in original).

to the industry and other members of the public.[41] A typical in-person committee meeting might consist of around 20 committee members seated at the front of the room, with approximately 200 spectators in the audience, almost all of whom are representing the industry in some fashion. The NAIC derives meaningful revenue from industry participation in its annual meetings, amounting to approximately $3 million annually.[42] Private parties routinely participate actively in committee meetings through the submission of oral and written comments and reports as well as through formal presentations. To help offset this industry influence, the NAIC operates a formal consumer participation program, which facilitates participation in its activities by approximately twenty designated consumer liaisons.[43]

B. THE NAIC'S FINANCIAL STANDARDS AND ACCREDITATION PROGRAM

Individual states need not adopt the NAIC's model laws, and they often choose not to do so when it comes to NAIC models having nothing to do with financial regulation. However, states do indeed uniformly enact the subset of NAIC model laws that are required under the NAIC's Financial Standards and Accreditation Program.[44] This program certifies that individual state departments' solvency regulation meets minimum standards, which requires the department to have "adequate statutory and administrative authority."[45] For an insurance department to be deemed to have adequate legal authority under the program, its state must adopt the subset of NAIC model laws that are accreditation standards, or else they must adopt laws with "substantially similar provisions."[46]

---

[41] NAT'L ASS'N OF INS. COMMISSIONERS, NAIC POLICY STATEMENT ON OPEN MEETINGS (2014), https://www.naic.org/documents/meetings_naic_policy_mtg_801.pdf. However, the NAIC reserves the right to hold closed meetings on a regulator-to-regulator basis for a broad variety of reasons. *Id.*

[42] See NAT'L ASS'N OF INS. COMM'RS, *supra* note 30.

[43] *See* Schwarcz, *supra* note 38.

[44] ABRAHAM & SCHWARCZ, *supra* note 2.

[45] NAT'L ASS'N OF INS. COMM'RS, FINANCIAL REGULATION STANDARDS AND ACCREDITATION PROGRAM 1, 1–17 (2018), https://www.naic.org/documents/cmte_f_frsa_pamphlet.pdf [hereinafter "NAIC Accreditation Standards"].

[46] *Id.* at 9.

States face little practical choice but to adopt the NAIC accreditation standards because failing to do so would result in a substantial reduction in their tax revenue and jobs. Within the various model laws that states must adopt under the accreditation program are provisions allowing state insurance departments to defer to the solvency regulation of an insurer's state of domestication,[47] but only if that state's insurance department is accredited. As a result, insurers operating in multiple states will predictably shift their state of domestication out of a state that lost its NAIC accreditation, because failing to do so would result in it being subject to solvency-oriented scrutiny in every state where it sold coverage. To accomplish such a redomestication, insurers must generally re-designate their "principal place of business" to the new state of domestication.[48] Consequently, a state that lost its NAIC accreditation would also lose the jobs and tax revenue associated with its domesticated insurers. State legislatures, of course, have strong reasons to avoid this outcome.

One recent presentation to New Mexico's Legislative Council by the Chief General Counsel of the New Mexico insurance department is illustrative of the pressure the NAIC accreditation program places on state legislatures. In explaining why, the New Mexico legislature needed to promptly adopt the NAIC's ORSA Model Law – a new accreditation standard – the presentation observes:

The NAIC requires enactment of this bill in order for OSI [the Office of Superintendent of Insurance in New Mexico] to maintain its accreditation with the NAIC: If OSI loses its accreditation, New Mexico insurers that write in other states would have to undergo costly and disruptive examinations by the insurance departments of each state in which they write. This could cause insurers to leave New Mexico and to domicile in another state, resulting in the loss of jobs and tax revenues. Since all 50 states are currently accredited, New Mexico's loss of accreditation would be a national embarrassment and would lend support to efforts to shift insurance regulation to the federal government with a resulting loss in state control and revenues.[49]

---

[47] Technically this is referred to as the insurer's state of domicile, and it is analogous to a corporation's state of incorporation.

[48] See NAIC, Redomestication Model Bill, Model 350.

[49] Vicente Vargas & Margaret Moquin, *Presentation to the New Mexico Legislative Council Service: Own Risk and Solvency Assessment* (Sept. 12, 2017), https://www.nmlegis.gov/handouts/CCJ%20091217%20Item%204%20Own%20Risk%20and%20Solvency%20Assesment,%20Office%20of%20Superintendent%20of%20Insurance.pdf.

The immense pressure that the NAIC's accreditation program places on states is intentional. In the late 1980s and early 1990s, state solvency regulation was subject to blistering criticism at the federal level due to several high-profile insurance insolvencies. A series of federal reports concluded that state insurance solvency regulation was "seriously deficient"[50] and that the NAIC could not compel states to enact needed reforms.[51] The NAIC's accreditation program was directly designed to overcome these problems. It did so, of course, by effectively threatening to regulate into oblivion the insurers of any state that chose not to adhere to the NAIC's new program.

C. STATE DELEGATIONS TO THE NAIC

States delegate a tremendous amount of authority over insurance regulation to the NAIC due to their insurance codes' incorporation by reference of the latest versions of NAIC materials. One recent count identified seventeen such NAIC-produced documents that were dynamically incorporated by reference in Indiana's statutes.[52] A substantial majority of these documents are required by the NAIC's accreditation standards, meaning that they are dynamically incorporated by reference under the laws of every U.S. jurisdiction.[53] Although the scope and significance of these NAIC-produced documents varies considerably, many are hundreds of pages long and control central elements of state insurance regulation. By way of example, this Section reviews three significant state delegations of authority to the NAIC, which govern insurers' calculation and reporting of their

---

[50] COMM. ON ENERGY AND COMMERCE, 101ST CONG., REP ON INSURANCE COMPANY INSOLVENCIES (Comm. Print 1990).

[51] GAO REPORT, INSURANCE REGULATION: ASSESSMENT OF THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS (1991) ("For several reasons, GAO questions whether NAIC's accreditation program can achieve its goal…. NAIC does not have the authority necessary to fulfill its assumed role as a national regulator. As a result, NAIC is unlikely to achieve its stated goal of establishing a national insurance regulatory system. It can neither compel state actions necessary for effective regulation nor, in the long run, can it sustain its reforms.").

[52] *See* note 5, *supra*.

[53] *See* NAIC ACCREDITATION STANDARDS, *supra* note 30.

reserves, methods and documentation of corporate risk management, and accounting rules.

1. Dynamic Incorporation by Reference of the NAIC's Valuation Manual

Perhaps the most significant state delegation of power to the NAIC stems from states' dynamic incorporation-by-reference of the NAIC's Valuation Manual. With a small handful of exceptions, the law of every state in the country includes language identical or substantially similar to the NAIC's 2009 Model Standard Valuation Law (SVL), which dynamically incorporates by reference the NAIC's Valuation Manual.[54] The Valuation Manual, in turn, governs every facet of life insurers' calculation and reporting of their "reserves."[55]

Rules governing life insurers' reserve calculations are among the most important elements of state solvency regulation. Reserves correspond to the amount that insurers must "set aside" on their balance sheet in anticipation of future payouts to insurance policyholders.[56] They operate as the foundation for many other core regulatory tools, the most important of which are capital requirements.[57] Reserve calculations are particularly important for long-tail lines of coverage like life insurance, where there is typically a substantial time gap between when a policyholder pays premiums and when they potentially receive payment on their claims.[58] If insurers are not forced to properly account for their obligations in the distant future, then they may well not be able to pay for those claims when they come due.

The SVL model and the state statutes emulating it do contain some principles regarding the scope of the Valuation Manual and the process that the NAIC must follow to amend the manual. For instance, they indicate that the Valuation Manual should specify the format of reports, information, and data that insurers must submit to state regulators; the assumptions that insurers must use in their reserve modeling; and the procedures that insurers must maintain for corporate governance and oversight of the actuaries who

---

[54] NAT'L ASS'N OF INS. COMM'RS, STANDARD VALUATION LAW § 11 (2010).

[55] *Id.*

[56] *See* ABRAHAM & SCHWARCZ, *supra* note 2, at 121-22.

[57] *Id.*

[58] *Id.* at 292.

develop the reserve models.[59] Additionally, state laws based on the NAIC model SVL provide that individual state commissioners can implement regulations requiring insurers to use procedures that depart from those contained in the model.[60] They also provide that the NAIC can only amend the model via a super-majority vote of its fifty-six voting members.[61]

The latest version of the NAIC's Valuation Manual – last amended in August of 2017 – clocks in at 295 pages and includes detailed and extensive provisions on virtually every element of insurers' reserve calculation. It is organized into five sections. The primary section details how insurers must calculate their reserves using projected asset and liability cash flows across a range of economic scenarios.[62] These projections must incorporate insurers' assumptions about factors such as policyholder mortality, policyholder behavior, and expenses. Insurers are also required by the Valuation Manual to calculate a minimum reserve amount, which is intended to prevent excessively low reserves. The other four sections of the Valuation Manual govern procedural and reporting requirements for insurers. For instance, they require insurers to submit to regulators actuarial opinions regarding the adequacy of reserves as well as reams of data regarding the carriers' mortality, morbidity, policyholder behavior, and expense experience.[63]

Almost every state passed the NAIC's updated SVL model well before the NAIC published this latest version of its Valuation Manual, meaning that these states delegated authority to the NAIC which it actually

---

[59] Standard Valuation Law § 11 (NAT'L ASS'N OF INS. COMM'RS 2010). In addition to life insurance contracts, the SVL also applies to annuity and pure endowment contracts, accident and health contracts, and deposit contracts issued on or after the operative date of the Valuation Manual.

[60] *Id.* The Commissioner is also authorized to require a company to change an assumption or method if the Commissioner determines it is not in compliance with the Act or the Valuation Manual.

[61] Memorandum from the Life Actuarial (A) Task Force, Nat'l Ass'n of Ins. Comm'rs, to the Fin. Regulation Standards and Accreditation (F) Comm., Nat'l Ass'n of Ins. Comm'rs (Nov. 3, 2016), https://www.naic.org/documents/cmte_f_pbr_referal_2009_revisions_standard_valuation_law_820.pdf [hereinafter Task Force Memorandum].

[62] NAT'L ASS'N OF INS. COMM'RS, VALUATION MANUAL (2018).

[63] *Id.* Under the Valuation Manual, the NAIC itself is the experience data collection agent.

used. In fact, many states passed the NAIC's model SVL law between 2009, when it was finalized, and late 2012, when the NAIC published the first version of the Valuation Manual.[64] States that passed the NAIC's SVL model after the NAIC first published the Valuation Manual in 2012 but before the NAIC's latest update of the manual in August 2017 – a category which includes almost all of the states that did not pass the model before late 2012[65] – also delegated authority to the NAIC that it used extensively. Between 2015 and 2017, the NAIC has adopted over fifty different amendments to the valuation manual at five different times.[66]

---

[64] The NAIC model and corresponding state statutes allowed states to incorporate a then-undrafted Valuation Manual by providing that insurers' reserve calculations would only be governed by the manual when two conditions were met. First, the NAIC model and the statutes on which it is based required a super-majority of the NAIC's fifty-six voting members to approve the Valuation Manual. Second, it required a supermajority of U.S. insurance jurisdictions to adopt legislation implementing the SVL revisions. In June 2016, the NAIC certified that these conditions had been met. First, between 2009 and 2016, forty-five states, representing 79.5% of U.S. premium volume, had adopted the 2009 NAIC model revisions to their SVLs or legislation with substantially similar terms and provisions. Second, the NAIC formally adopted the first version of the Valuation Manual in December 2012, and subsequently adopted over fifty different amendments to the Valuation Manual at five different times between 2015 and 2017. As a result of these conditions being met, the Valuation Manual is now law in almost every U.S. state. Starting in 2017, a three-year trial phase of PBR – during which the Valuation Manual is optional for insurers – went into effect in all states that had passed the model legislation. The trial phase for implementation was established in the manual itself, rather than in the SVL revisions. At the start of 2020, PBR will become fully effective and the Valuation Manual will dictate insurers' reserve practices in all states that have passed the model law. *See* Task Force Memorandum, *supra* note 42.

[65] Meanwhile, forty-five of the fifty-one jurisdictions that have adopted the NAIC's SVL did so by the end of 2016, before the latest round of NAIC revisions to the Valuation Manual. *Id.*

[66] *See* NAT'L ASS'N OF INS. COMM'RS, VALUATION MANUAL at i (2018), https://www.naic.org/documents/prod_serv_2018_valuation_manual.pdf (listing amendments through 2016: "The National Association of Insurance Commissioners (NAIC) initially adopted the *Valuation Manual* on Dec. 2,

States have almost uniformly passed the NAIC's model SVL law notwithstanding that the Valuation Manual that it incorporates into state law represents a fundamental change in the character of state solvency regulation. Historically, states required life insurers to use mechanical and relatively simple formulas to calculate their reserves. This approach, however, created a variety of complications due to the increasing heterogeneity and complexity of life insurers' products.[67] Starting shortly before the 2008 financial crisis, state regulators organizing through the NAIC responded to these concerns by launching a Principles-Based Reserving (PBR) initiative.[68] The core idea of PBR was to replace the mechanical rules governing insurers' reserve calculations with a system that allowed insurers to calculate their future obligations to policyholders based on internal, company-specific models. Rather than checking the accuracy of insurers' mechanical calculations, state regulators in this regime would ensure that firms' internal models complied with a range of broad principles, technical specifications, and procedural requirements. The SVL model and Valuation Manual implement this new PBR regime.

States' uniform passage of the NAIC SVL model is largely attributable to NAIC pressure via the accreditation program. Starting in early 2010, an NAIC committee recommended including the 2009 revisions to the NAIC's SVL model in the NAIC's accreditation standards.[69] After years of delay and debate, the NAIC ultimately adopted this suggestion in 2016, but delayed its implementation until January 2020.[70] At present only five jurisdictions have not passed the latest version of the SVL law, and it is

---

2012, with subsequent adoptions of amendments on June 18, 2015; Nov. 22, 1015 [sic]; April 6, 2016; Aug. 29, 2016; and Aug. 9, 2017.").

[67] Robert F. Weber, *Combating the Teleological Drift of Life Insurance Solvency Regulation: The Case for a Meta-Risk Management Approach to Principles-Based Reserving*, 8 BERKLEY BUS. L.J. 35, 105-15 (2011).

[68] This timing is notable. A similar principles-based approach to calculating capital requirements proved disastrous in the crisis, but by the time this became clear, the PBR initiative was already quite far along. *See* Daniel Schwarcz & Steven L. Schwarcz, *Regulating Systemic Risk in Insurance*, 81 U. CHI. L. REV. 1569 (2014).

[69] *See* Task Force Memorandum, *supra* note 61.

[70] *The National System of State Regulation and Principle-Based Reserving*, NAT'L ASS'N OF INS. COMMISSIONERS (July 12, 2018), https://www.naic.org/cipr_topics/principle_based_reserving_pbr.htm.

widely expected that these holdouts will succumb to NAIC pressure by 2020.[71]

NAIC staff have played a central role in the implementation of PBR and will continue to do so for the foreseeable future. For instance, the NAIC maintains substantial actuarial staff to assist state regulators in reviewing individual companies' reserve calculations and documentation. It created a standing Valuation Analysis (E) Working Group to serve as a "confidential forum regarding questions and issues arising during the course of annual principle-based reserving (PBR) reviews or PBR examination" and to refer issues that may require "consideration of changes/interpretations to be provided in the *Valuation Manual*."[72]

2. Dynamic Incorporation by Reference of the Own Risk and Solvency Assessment Manual

State statutory references to the NAIC's "Own Risk and Solvency Assessment Manual" ("ORSA Manual") constitute a second type of state delegation of power to the NAIC. These statutory cross-references derive from the NAIC's Risk Management and Own Risk Solvency Assessment Model Act ("ORSA Model Act"), which the NAIC formally adopted in 2012.[73] The Act specifies that changes made by the NAIC to the ORSA Manual are effective starting in the calendar year after adoption.[74] Since the NAIC designated the Model Act as an accreditation standard, every single state (except one) has adopted the model or a statute with substantially similar language as of March 2018.[75]

---

[71] As of today, fifty-one U.S. jurisdictions have passed these revisions; The five that have not are New York, Alaska, Massachusetts, the District of Columbia, and Puerto Rico. *See* Task Force Memorandum, *supra* note 61.

[72] *Valuation Analysis (E) Working Group, 2018 Charges*, NAT'L ASS'N INS. COMM'RS, https://www.naic.org/cmte_e_valuation_analysis_wg.htm (last visited Aug. 26, 2018).

[73] RISK MGMT. & OWN RISK & SOLVENCY ASSESSMENT MODEL ACT (NAT'L ASS'N OF INS. COMM'RS 2012).

[74] *Id.* § 2.

[75] *See* NAT'L ASS'N OF INS. COMM'RS, STATE LEGISLATIVE BRIEF: THE RISK MANAGEMENT AND OWN RISK SOLVENCY ASSESSMENT MODEL ACT (2018), https://www.naic.org/documents/cmte_legislative_liaison_brief_orsa.pdf.

The ORSA Model Act requires large insurers to maintain an enterprise risk management framework based on the latest version of the NAIC's ORSA Manual. Carriers subject to the Act must regularly assess their risk management framework "consistent with a process comparable to" the NAIC's ORSA Manual.[76] To document their compliance with the risk management processes outlined in the ORSA Manual, insurers covered by the Act are required to annually produce an ORSA summary report. The Act provides that this ORSA summary report – like the ORSA itself and the other required documentation – "shall be prepared consistent with the ORSA Guidance Manual."[77]

The ORSA Model Act does not provide the NAIC with any direction about the process or substance of the ORSA Manual. For instance, it does not contain any substantive guidance on how the NAIC should craft the standards within the ORSA Manual, aside from the implicit suggestion that the manual should cover appropriate risk management practices for insurers. Nor does the Model Act specify any procedure for the NAIC to follow in adopting or revising the manual.

The NAIC adopted the latest version of its ORSA Manual in late 2017.[78] The manual contains a variety of directions to insurers regarding the content, procedures, and documentation of their required risk management practices. For instance, it specifies that insurers must assess and document their Risk Culture and Governance, Risk Identification and Prioritization, Risk Appetite, Tolerances and Limits, Risk Management and Controls, and Risk Reporting and Communication.[79]

One of the most important elements of the manual requires insurers to report a "group risk capital assessment" in their ORSA summary report.[80]

---

[76] Risk Management and Own Risk and Solvency Assessment Model Act § 4 (NAT'L ASS'N OF INS. COMM'RS 2012).

[77] *Id.* § 7(A). In addition, "[d]ocumentation and supporting information shall be maintained" and shall be made available to the commissioner upon the commissioner's request. *Id.*

[78] *See* NAT'L ASS'N OF INS. COMM'RS, NAIC OWN RISK AND SOLVENCY ASSESSMENT (ORSA) GUIDANCE MANUAL, at iii (2017).

[79] *Id.* at 8.

[80] *Id.* at 10–11 ("The analysis of an insurer's group assessment of risk capital requirements and associated capital adequacy description should be accompanied by a description of the approach used in conducting the analysis. This should include key methodologies, assumptions and considerations used in quantifying available capital and risk capital.").

In contrast to the ordinary capital rules that states apply to individual insurance entities, the ORSA Manual's direction for group capital calculations provide insurers with substantial latitude in their calculations. Under the manual, insurers are allowed to select their own methodologies and assumptions for calculating their group capital, so long as they describe and explain their approach.

The ORSA Manual's latitude in specifying how insurers should calculate their group capital may change soon. Many foreign regulators have expressed concern about state insurance regulators' lack of a standardized group capital requirement, and states have responded by developing a variety of much more specific principles for group capital calculations. State regulators have emphasized, however, that they do not plan to implement this new group capital methodology as an independent quantitative requirement, but instead intend to use it solely as an "additional regulatory assessment tool."[81] This strongly suggests that state regulators may implement their new group capital methodology simply by amending the ORSA Manual rather than by establishing a new group capital model law or regulation.

New changes to the ORSA Manual's group capital rules would not be the first NAIC update of the manual. While the NAIC first adopted the ORSA Manual in 2014, it subsequently amended the manual in 2017. The most important changes to the manual created a process for the NAIC to update the manual in the future. Those procedures designated a specific NAIC group as being responsible for updating the manual and contained no requirement that NAIC members as a whole approve changes to the document.

3. Dynamic Incorporation by Reference of the Accounting Practices and Procedures Manual

A third example of state delegation to the NAIC via dynamic incorporation by reference concerns insurers' accounting practices. Every state requires by statute that insurers report their financial information to insurance regulators using a unique set of insurance-specific accounting

[81] *See, e.g.*, David Altmaier, *Group Capital Calculation*, NAIC (2018), https://www.naic.org/insurance_summit/documents/insurance_summit_2018_FR_22.pdf.

rules known as Statutory Accounting Principles ("SAP").[82] Although these accounting rules are termed "statutory," they are not, in fact, contained in any state statute. Instead, they are detailed in the voluminous, multi-volume, NAIC Accounting Practices and Procedures Manual (AP&P Manual), the latest version of which state laws incorporate by reference. As with the Valuation Manual and ORSA Manual, the NAIC's accreditation program requires this delegation of authority to the NAIC as a condition for states to maintain their financial accreditation.[83] This, of course, explains why states

---

[82] The history of the AP&P Manual demonstrates the NAIC's intentional use of the incorporation by reference process to establish itself as a body with pseudo-Congressional power to pass laws for the entire country. Before 2000, the NAIC published a series of Accounting Practices and Procedures Manuals, slim volumes for each different line of insurance, housed in loose leaf binders which allowed for updating. The title of these manuals was incorporated by reference in state statutes, mandating the use of the statutory accounting regime they established. During the 1990s, NAIC members concluded that a full, comprehensive rewrite of the accounting manual was necessary to establish a uniform national regulatory requirement for accounting practices. The new work product was massive. Including subsequent amendments, this amounted to over 1,000 pages of new material. *See* NAT'L ASS'N OF INS. COMM'RS, CODIFICATION OF STATUTORY ACCOUNTING PRINCIPLES STATE IMPLEMENTATION (2000). The NAIC intentionally gave the new manual the same name as the already incorporated by reference accounting manuals, so that, it asserted, the new AP&P Manual would automatically become the law upon NAIC adoption. NAIC members faithfully followed this guidance, sending out bulletins to regulated entities, explaining that a sea change was being made to their accounting requirements, not by lawmaking in their states, but by the decree of the NAIC through the incorporation by reference mechanism; and further explaining that NAIC intended to make changes every year to the Manual which would also automatically become new law in each state. *See id.*

[83] Unlike the valuation and ORSA documents, the NAIC does not maintain a model law or regulation that broadly requires this delegation, though several model laws do indeed dynamically incorporate by reference the AP&P Manual in a narrower context. *See, e.g.*, INVS. OF INSURERS MODEL ACT § 7 (NAT'L ASS'N OF INS. COMM'RS 2017). Instead, the NAIC's Accreditation program directly requires that states mandate companies follow the AP&P Manual, without specifying how exactly they must

have so uniformly delegated to the NAIC the power to set the accounting rules that bind insurers through the AP&P Manual.

The AP&P Manual is voluminous, but – unlike the NAIC's Valuation or ORSA manuals – it is not freely available to the public. Instead, each user must pay approximately $500 to access the manual.[84] The manual covers an immense range of insurance-specific accounting and reporting rules, as suggested by the fact that its table of contents alone is fifteen pages long. Examples of topics covered include the subset of assets that insurers can include on their balance sheets, the proper accounting treatment of anticipated premiums tax benefits, and the accounting treatment of reinsurance transactions.

The special accounting rules detailed in the AP&P Manual are ostensibly intended to better reflect the capacity of insurers to pay their commitments to policyholders if they had to be liquidated, in contrast to GAAP's focus on facilitating outsiders' assessments of a firm's market value.[85] Reflecting SAP's conservatism relative to GAAP, the AP&P manual is often substantially more prescriptive than GAAP. For instance, SAP requires property/casualty insurers to value high-quality bonds at amortized cost rather than market value, whereas GAAP allows insurers to select between these two approaches depending on their anticipated plans for the bonds.[86] Similarly, SAP only allows insurers to include on their balance sheets admitted assets, which can be readily converted to cash.[87]

---

accomplish this result. *See* NAIC ACCREDITATION STANDARDS, *supra* note 45, at 9 ("The department should require that all companies reporting to the department file the appropriate NAIC annual statement blank, which should be prepared in accordance with the NAIC's instructions handbook and follow those accounting procedures and practices prescribed by the NAIC's *Accounting Practices and Procedures Manual*, utilizing the version effective January 1, 2001 and all subsequent revisions adopted by the Financial Regulation Standards and Accreditation (F) Committee.").

[84] *See* Cunningham, *supra* note 34, at 292-93 (considering when private publications that operate as law should be made freely available to the public).

[85] *See* Weber, *supra* note 67, at 53–63.

[86] *See Background on: Insurance Accounting*, INS. INFO. INST. (Mar. 3, 2014), https://www.iii.org/article/background-on-insurance-accounting.

[87] *Id.*

The manual is routinely updated by the NAIC's Statutory Accounting Principles (E) Working Group.[88] The Working Group considers whether each new GAAP item should be adopted or adjusted for insurance in the AP&P Manual.[89] It also maintains a public tool for anyone to propose items to be updated in the manual.[90] By way of illustration, the working group recently considered twenty-seven different proposed revisions to the AP&P Manual and it regularly adopts dozens of revisions to the manual each year.

Notwithstanding state mandates that carriers comply with the latest version of the AP&P Manual, individual states have the authority to depart from the AP&P Manual in two scenarios. First, states can adopt via statute or regulation "Prescribed Accounting Practices" that alter SAP rules for all insurers domiciled in the state. Second, the manual also authorizes state regulators to allow "Permitted Accounting Practices" for individual insurers who request approval for departures from SAP.[91] In either case, insurers must disclose their reliance on these exceptions from SAP in their financial statements.

II. THE LAW GOVERNING STATE LEGISLATIVE DELEGATION OF POWERS TO PRIVATE ACTORS

Just like the federal constitution, every state constitution vests an independent branch of state government with the legislative power. And just like the federal constitution, a corollary of this principle is that the legislature has limited authority to delegate this power elsewhere. Legislative delegations of power to a private actor, as opposed to a government agency, are particularly troubling, as they implicate not just separation of powers principles, but also more fundamental due process concerns.

---

[88] For instance, the initial Codification of SAP in 2001 imposed an initial 73 Statements of Statutory Accounting Principles upon regulated companies. As of today, the number of SSAPs has grown to 10,757.

[89] *See* Deborah L. Lindberg & Deborah L. Seifert, *A New Paradigm of Reporting on the Horizon*, 29 J. INS. REG. 229, 242 (2010).

[90] *Statutory Accounting Principles* € Working Group, NAT'L ASS'N INS. COMM'RS, https://naic.org/cmte_e_app_sapwg.htm (last visited Aug. 26, 2018).

[91] *Statutory Accounting Principles (SAP)*, NAT'L ASS'N INS. COMM'RS, https://www.naic.org/cipr_topics/topic_statutory_accounting_principles.htm (last visited Jan. 6, 2019).

For these reasons, state courts from across the country have invalidated a broad range of legislative delegations to private parties. In doing so, they generally employ what amounts to a multi-factor balancing test that considers (i) the public or private status of the delegate, (ii) oversight of the delegate by public bodies such as the judiciary or a public agency, and (iii) the delegate's independence from the lawmaking function.

This Part overviews this caselaw, abstracting away from the law of any individual state to derive and illustrate the general principles that influence state court scrutiny of legislative delegations to private actors. After briefly reviewing states' generalized non-delegation doctrines in Section A, Section B explores why state delegations to private parties raise distinctive issues. Section C then distills the relevant factors that state courts consider in assessing the constitutionality of delegations to private actors. Finally, Section D illustrates the application of these principles in two contexts that resemble the states' delegation of power to the NAIC: state incorporation of American Medical Association standards in workers' compensation statutes, and state and federal delegations of authority to the Financial Accounting Standards Board to set accounting rules for private entitles.

A. STATES' NON-DELEGATION DOCTRINES

The non-delegation doctrine limits legislatures' constitutional authority to delegate their powers to third parties.[92] It is typically rooted in separation of powers principles.[93] Consistent with this foundation, the vast majority of non-delegation cases concern legislative delegations to executive agencies, courts, or other governmental entities.[94]

---

[92] *See* Gary Lawson, *Delegation and Original Meaning*, 88 VA. L. REV. 327, 335–43 (2002).

[93] *See* Jim Rossi, *Institutional Design and the Lingering Legacy of Antifederalist Separation of Powers Ideals in the States*, 52 VAND. L. REV. 1167, 1190 (1999). *Contra* Joseph Postell, *"The People Surrender Nothing": Social Compact Theory, Republicanism, and the Modern Administrative State*, 81 MO. L. REV. 1003, 1003 (2016) ("[T]he true foundation of the nondelegation principle is the idea of the social compact and the related theory of republican government.").

[94] Jason Iuliano & Keith E. Whittington, *The Nondelegation Doctrine: Alive and Well*, 93 NOTRE DAME L. REV. 619, 641 (2017).

Although the non-delegation doctrine is virtually a dead letter in federal jurisprudence,[95] it is quite robust in state courts.[96] Indeed, between 1940 and 2015, 85% of all non-delegation cases were decided by state, rather than federal, courts.[97] Parties seeking to invalidate a statutory delegation of power in these cases enjoyed a 16% success rate, which stands in stark contrast to the 3% success rate that their counterparts experienced in federal courts over the same time period.[98]

Unlike the federal constitution – which is silent on the topic of non-delegation – most state constitutions directly limit legislatures' powers to delegate their law-making authority.[99] These constitutional provisions come in three basic varieties. Some expressly prohibit any branch of government from exercising another's powers.[100] Other state constitutions prohibit the legislature from "making the passage of any law contingent upon any event or outside authority."[101] A third type of constitutional provision "explicitly

---

[95] *See* Rossi, *supra* note 93, at 1178; Miriam Seifter, *States, Agencies, and Legitimacy*, 67 VAND. L. REV. 443, 452 (2014) (calling the federal non-delegation doctrine "toothless").

[96] *See generally* Rossi, *supra* note 93, at 1187–1201 (surveying state nondelegation doctrine and classifying states' approaches as "weak," "strong," or "moderate"); Iuliano & Whittington, *supra* note 94, at 620 ("[D]espite the doctrine's disappearance at the federal level, it has become an increasingly important part of state constitutional law.").

[97] Iuliano & Whittington, *supra* note 94, at 636. This survey examined a sample of 1,075 non-delegation cases decided between 1940 and 2015.

[98] *Id.*

[99] Keith E. Whittington & Jason Iuliano, *The Myth of the Nondelegation Doctrine*, 165 U. PA. L. REV. 379, 416 (2017).

[100] *Id.* at 416. Whittington and Iuliano cite the Texas constitution as representative: "The powers of the Government of the State of Texas shall be divided into three distinct departments…and no person, or collection of persons, being of one of these departments, shall exercise any powers properly attached to either of the others." TEX. CONST. art. II, § 1.

[101] Whittington & Iuliano, *supra* note 99, at 416. The authors cite Indiana's constitution as an example: "No law shall be passed, the taking effect of which shall be made to depend upon any authority, except as provided in this Constitution," IND. CONST. art. I, § 25.

forbids the legislature from delegating any of its powers" to a variety of actors, including private entities.[102]

Given this variation in constitutional text, it is no surprise that state caselaw on the non-delegation doctrine also varies significantly. One extensive survey grouped states' approaches to the doctrine into three categories, though they do not correspond neatly to the three types of state constitutional provisions on the issue.[103] First, some states uphold legislative delegations when the delegated power is subject to adequate procedural safeguards.[104] Second, a larger group of states requires state legislatures to articulate substantive standards that constrain the exercise of delegated power and guide judicial review of the delegate's actions.[105] Finally, a third group of states employ a balancing test that considers both substantive and procedural restrictions on delegated power in light of various additional factors, such as the subject matter of the underlying statute.[106]

---

[102] Whittington & Iuliano, *supra* note 99, at 416. The authors cite Colorado's constitution as representative: "The general assembly shall not delegate to any special commission, private corporation or association, any power to make, supervise or interfere with any municipal improvement, money, property, or effects, whether held in trust or otherwise, or to levy taxes or perform any municipal function whatever," COLO. CONST. art. V, § 35.

[103] Rossi, *supra* note 93, at 1187-1201. Rossi's survey "updated and refined" an earlier survey by Gary Greco. I*d.* at 1191 n.108 (citing Gary J. Greco, *Standards or Safeguards: A Survey of the Delegation Doctrine in the States*, 8 ADMIN. L.J. AM. U. 567 (1994)).

[104] Rossi, *supra* note 93, at 1191-93; *see e.g.*, Warren v. Marion Cty., 353 P.2d 257, 261 (Or. 1960) (in banc) ("[T]he important consideration is not whether the statute delegating the power expresses *standards*, but whether the procedure established for the exercise of the power furnishes adequate *safeguards* to those who are affected by the administrative action.").

[105] Rossi, *supra* note 93, at 1193-97; *see, e.g.*, *Newport Int'l Univ., Inc. v. Dep't of Educ.*, 186 P.3d 382, 390 (Wyo. 2008) ("The crucial test in determining whether there is an unlawful delegation is whether the statute contains sufficient standards to enable the agency to act and the courts to determine whether the agency is carrying out the legislature's intent.").

[106] Rossi, *supra* note 93, at 1198-1200; *see e.g.*, Cottrell v. Denver, 636 P.2d 703, 709 (Colo. 1981) (en banc) ("[T]he test is not simply whether the

B. THE UNIQUE CASE OF LEGISLATIVE DELEGATIONS TO PRIVATE PARTIES

Courts at both the federal and state levels have long recognized that laws delegating legislative authority to private, rather than public, actors raise unique concerns.[107] Perhaps the most well-known articulation of this view is from the 1936 Supreme Court case *Carter v. Carter Coal Co.*, which involved a federal law authorizing private coal producers and miners to set binding wage and hour restrictions.[108] In finding the law unconstitutional, the Court emphasized that it conferred power onto "private persons" rather than "an official or an official body," and thus constituted "legislative delegation in its most obnoxious form."[109] Although federal caselaw building on this principle is limited, numerous state court decisions have similarly concluded that many, if not most, "private delegations are unconstitutional under the relevant state constitutions."[110]

State courts' skepticism toward legislative delegation to private parties is generally driven just as much by due process and rule of law concerns as by separation of powers principles.[111] Unlike public entities authorized to exercise legislative powers, like executive agencies or courts, "private delegates may not be subject to direct political controls nor to due process, administrative procedure laws, freedom of information laws, or judicial review."[112] Private entities may also labor under conflicts of interest that harm their competitors or other private actors.[113]

---

delegation is guided by standards, but whether there are sufficient statutory standards and safeguards and administrative standards and safeguards, in combination, to protect against unnecessary and uncontrolled exercise of discretionary power.").

[107] *E.g.*, Protz v. Workers' Comp. Appeal Bd., 161 A.3d 827, 837 (Pa. 2017).

[108] Carter v. Carter Coal Co., 298 U.S. 238 (1936).

[109] *Id.* at 311.

[110] Calvin R. Massey, *The Non-Delegation Doctrine and Private Parties*, 17 GREEN BAG 2D 157, 171 (2014).

[111] *Id.* at 167–68.

[112] MICHAEL ASIMOW & RONALD M. LEVIN, STATE AND FEDERAL ADMINISTRATIVE LAW 395 (3d. ed. 2009).

[113] *See Carter Coal*, 298 U.S. at 311.

Despite these concerns, delegation of authority to private entities is sometimes both necessary and beneficial. State governments lacking resources or expertise may look to private organizations for regulatory guidance.[114] In some contexts, a need for uniformity across states may drive legislatures to adopt a national organization's standards.[115] And legislatures may decide it would be expedient to delegate a degree of regulatory power to the private parties subject to regulation.[116]

One of the most common ways in which state legislatures delegate authority to private actors is by incorporating privately-produced rules or standards into statutes. Not all statutory references to private entities' materials implicate the non-delegation doctrine. Statutes that incorporate *pre-existing* sources are perfectly innocuous. In such cases, the legislature has had an opportunity to review and affirmatively adopt the incorporated standards and the reference operates as a mere legislative short-hand.[117] However, when a statute cross-references not just existing materials, but also *prospectively* adopts – sight unseen – future changes made by private actors to incorporated materials, the statute transfers to those actors the capacity to change the law.[118] This is just as much a delegation of legislative power to private actors as more explicit delegation of the type at issue in *Carter Coal*.

---

[114] *See In re* Hansen, 275 N.W.2d 790, 796–97 (Minn. 1978).

[115] *See* Lucas v. Me. Comm'n of Pharmacy, 472 A.2d 904, 911 (Me. 1984) (noting a need for uniform education standards for pharmacists and health professionals).

[116] *See* Tex. Boll Weevil Eradication Found., Inc. v. Lewellen, 952 S.W.2d 454 (Tex. 1997), *as supplemented on denial of reh'g* (Oct. 9, 1997) (invalidating a statute designed to give farmers control over an agricultural pest eradication program).

[117] *See* Bd. of Trs. v. Mayor of Balt., 562 A.2d 720, 731 (Md. 1989). However, some early non-delegation cases suggested that statutes incorporating another jurisdiction's laws, even without dynamic incorporation of changes, were invalid because the practice sidestepped important legislative processes. *See* F. Scott Boyd, *Looking Glass Law: Legislation by Reference in the States*, 68 LA. L. REV. 1201, 1211–12, 1254–55 (2008).

[118] *See Bd. of Trs.*, 562 A.2d at 731; Boyd, *supra* note 117, at 1254–57.

C. KEY FACTORS IN ASSESSING THE CONSTITUTIONALITY OF LEGISLATIVE DELEGATIONS TO PRIVATE ACTORS

Although state legislatures commonly delegate authority to private organizations, the non-delegation doctrine places limits on the practice.[119] State courts have found that a wide variety of delegations to private actors exceed these limits.[120] Just like the state caselaw addressing non-delegation principles generally,[121] the subset of this caselaw focused on delegations to private parties is varied, both within and across states. State courts have developed varying and overlapping multi-factor tests for assessing when legislative delegations of power to private actors are constitutionally permissible,[122] and some have even suggested that all delegations of power to private entities are unconstitutional.[123] This subsection distills from this caselaw several of the most important factors[124] that influence state courts'

---

[119] *See generally* Boyd, *supra* note 117, at 1251–60 (discussing the non-delegation doctrine as a constraint on incorporation by reference); *Tex. Boll Weevil*, 952 S.W.2d at 465–69, 471–72.

[120] *See, e.g.*, Gumbhir v. Kan. State Bd. of Pharmacy, 618 P.2d 837 (Kan. 1980) (university accreditation); Hillman v. N. Wasco Cty. People's Util. Dist., 323 P.2d 664, 670 (Or. 1958) (state electrical code), *overruled on other grounds by* Maulding v. Clackamas Cty., 563 P.2d 731 (Or. 1977); Protz v. Workers' Comp. Appeal Bd., 161 A.3d 827 (Pa. 2017) (workers' compensation); *Tex. Boll Weevil*, 952 S.W.2d 454 (pest-control program).

[121] *See supra* Section II.A.

[122] *Tex. Boll Weevil*, 952 S.W.2d at 470 (recognizing that non-delegation cases "do not yet, when taken together, evince a coherent constitutional standard").

[123] For instance, the intermediate appellate court in Protz v. W.C.A.B. (Derry Area Sch. Dist.), 124 A.3d 406, 412 (Pa. Cmwlth. 2015), held that all delegations of authority to private entities violate the Pennsylvania Constitution. The Pennsylvania Supreme Court ultimately did not reach this issue, though, concluding that the state's incorporation by reference of the AMA's impairment standards could not withstand constitutional scrutiny even if the AMA were a governmental entity. *See Protz v. Workers' Comp. Appeal Bd.*, 161 A.3d at 837.

[124] The list is not intended to be exhaustive, but instead to focus on those factors that are most significant in the caselaw and relevant to states' delegation of power to the NAIC. For instance, in addition to the factors

analysis of legislative delegation to private actors: (1) whether the delegate is a public or private entity; (2) whether the delegate's exercise of authority is directly policed by public officials, including courts or regulators; and (3) the extent to which the delegate is independent from the lawmaking process and exercising objective expertise rather than making policy.

1. Is the Delegate a Private or Public Entity?

For reasons described above, courts universally recognize that legislative delegations of power to private actors raise more significant constitutional concerns than delegations of power to government entities.[125] Application of this principle is straight-forward in most cases, even though

---

discussed in this Section, legislatures may not delegate "inherent government functions" to non-government entities. ASIMOW & LEVIN, *supra* note 112, at 396; *see, e.g.*, State v. Curley-Egan, 910 A.2d 200 (Vt. 2006) (police power); Christ v. Md. Dep't of Nat. Res., 644 A.2d 34, 42 (Md. 1994) (dicta); Paul R. Verkuil, *Public Law Limitations on Privatization of Government Functions*, 84 N.C. L. REV. 397, 424–26 (2006) (discussing non-delegable government functions at the federal level). As a corollary, courts are reluctant to allow delegations to private entities when the delegated power involves criminal penalties. *See, e.g.*, B.H. v. State, 645 So.2d 987, 993 (Fla. 1994); *Texas Boll Weevil*, 952 S.W.2d at 472. Courts may also consider whether a delegation vests both rulemaking and adjudicatory power in the same entity. *Id*. Finally, so long as the legislature "determines the rights, duties, and liabilities of persons and corporations under certain conditions of fact," it may delegate (even to private parties) "the duty of ascertaining when the facts exist which call into activity certain provisions of the law." State v. Gee, 236 P.2d 1029, 1032 (Ariz. 1951) (quoting Borgnis v. Falk Co., 133 N.W. 209, 219 (Wis. 1911)); *accord State v. Wakeen*, 57 N.W.2d 364, 367 (Wis. 1953).

[125] *See* Carter v. Carter Coal Co., 298 U.S. 238, 311 (1936) (labeling delegation to private parties, "legislative delegation in its most obnoxious form"); Bd. of Trs. v. Mayor of Balt., 562 A.2d 720, 730 (Md. 1989) ("[D]elegations of legislative authority to private entities are strictly scrutinized because, unlike governmental officials or agencies, private persons will often be wholly unaccountable to the general public."); *Tex. Boll Weevil*, 952 S.W.2d at 470.

the public/private distinction is itself often hazy.[126] For instance, corporations and professional associations are generally private, whereas entities that are formed by statute, constitution, or regulation are typically public.

But this distinction is less clear when legislatures create ostensibly private entities and grant them legal or regulatory authority. In such cases, courts typically resist formalistic analysis that gives definitive weight to the delegate's charter type. Instead, they typically weigh the relative role of private citizens and government actors in controlling the delegate's decision-making, operations, and objectives to determine whether the delegation is public or private.

This focus on who controls a delegate's operations is illustrated by a Texas Supreme Court case invalidating a statute that created a foundation and delegated to it control over an agricultural pest eradication program. Despite the legislature's creation of the foundation and specification of its objectives, the court deemed the foundation to be private for purposes of the non-delegation doctrine because its board was composed solely of farmers with a direct private interest in the program's implementation.[127] Farmers' control over the foundation rendered the delegation private because "courts have universally treated a delegation as private where 'interested groups have been given authoritative powers of determination.'"[128]

Courts' focus on who controls hybrid public/private entities that are delegated authority is also illustrated by a recent U.S. Supreme Court case applying the federal non-delegation doctrine. In *Department of Transportation v. Association of American Railroads*, the Court rejected a non-delegation challenge to a statute empowering Amtrak to help develop performance and service quality metrics for the broader industry.[129] This result followed from the Court's conclusion that Amtrak was a public, rather than a private, entity for purposes of the non-delegation doctrine, notwithstanding its status as a for-profit corporation.[130] Amtrak, the Court emphasized, was not only created by federal law, but was controlled by

---

[126] *See* Jody Freeman, *The Private Role in Public Governance*, 75 N.Y.U. L. REV. 543, 547 (2000); Gillian E. Metzger, *Privatization as Delegation*, 103 COLUM. L. REV. 1367, 1369 (2003).

[127] *Tex. Boll Weevil*, 952 S.W.2d at 471.

[128] *Id.* at 470–71.

[129] Dept. of Transp. v. Ass'n of Am. R.R., 135 S. Ct. 1225 (2015).

[130] *Id.* at 1232–33.

federal officials who played a major role in directing its objectives and operations.[131] For instance, Amtrak's board is largely appointed by the President, confirmed by the Senate, subject to removal at-will.[132] Moreover, the federal government owns nearly all of Amtrak's stock.[133] Amtrak is also subject to various traditional government oversight tools: the Freedom of Information Act applies to it, and it is required to maintain an inspector general.

In addition to these formal government controls over Amtrak's operations, the Court emphasized that the federal government also holds extensive practical control over the rail company. For instance, Amtrak is required to submit annual reports to Congress, which frequently holds hearings scrutinizing the company's budget, routes, and service. Congress also exercises extensive informal control over Amtrak by subsidizing the company's operations to a tune of $40 billion over the course of approximately four decades. The federal government, the Court concluded, "extensively supervise[s] and substantially fund[s]" Amtrak's "priorities, operations, and decisions."[134] In sum, the federal government's control over Amtrak rendered it a public entity for purposes of the non-delegation doctrine, meaning that Congress's delegation of power to the railroad raised limited issues under the federal constitution.

2. Is the Private Delegate's Exercise of Authority Adequately Policed by Judges or Administrative Bodies?

To the extent that a legislature has indeed delegated authority to a private rather than a public actor, a second key consideration under states' non-delegation doctrines is whether the private delegate's power is adequately policed by judges or administrative bodies. Both state and federal courts have generally tolerated legislative delegations to private entities when public officials exercise sufficient oversight over the private delegate's decision-making.[135] Such oversight can come in varying forms, ranging from

---

[131] *Id.* at 1232 ("[Amtrak] was created by the Government, is controlled by the Government, and operates for the Government's benefit.").

[132] *Id.* at 1231-32.

[133] *Id.*

[134] *Id.* at 1232.

[135] *See* Madrid v. St. Joseph Hosp., 928 P.2d 250, 258 (N.M. 1996); *cf.* Sunshine Anthracite Co. v. Adkins, 310 U.S. 381, 399 (1940) (holding

judicial review of the entity's compliance with substantive or procedural requirements, to direct oversight of the delegate's actions by a government agency.[136]

For instance, courts generally permit delegations to private parties when the delegating statute articulates substantive standards to guide the delegate's exercise of discretion, and compliance with these standards is judicially reviewable.[137] This approach, of course, parallels the rules that govern delegations to public entities, such as agencies.[138] It is therefore hardly surprising that courts often conflate the rules governing these two types of delegations.[139] But consistent with the unique concerns implicated by delegations to private entities, courts sometimes suggest that the substantive constraints on private delegations must be more specific than

---

Congress may give private entities a role in rulemaking so long as the private entity functions subordinately to the government); Pittston Co. v. United States, 368 F.3d 385, 395 (4th Cir. 2004) ("[C]ongress may employ private entities for ministerial or advisory roles, but it may not give these entities governmental power over others."). *See generally* Donna M. Nagy, *Playing Peekaboo with Constitutional Law: The PCAOB and Its Public/Private Status*, 80 NOTRE DAME L. REV. 975, 1059 (2005) ("But court decisions, including by the Supreme Court, demonstrate that governmental oversight of private decision making will generally insulate Congress's private delegations from constitutional challenge.").

[136] *Compare* United Chiropractors of Wash., Inc. v. State, 578 P.2d 38, 39–40 (Wash. 1978) (emphasizing the legislature's obligation to establish standards, guidelines, and procedural safeguards), *with* Tex. Boll Weevil Eradication Found., Inc. v. Lewellen, 952 S.W.2d 454, 473 (Tex. 1997), *as supplemented on denial of reh'g* (Oct. 9, 1997) (analyzing Commissioner of Agriculture's direct oversight over private foundation, among several other factors).

[137] *See, e.g.*, Newport Int'l Univ., Inc. v. Dep't of Educ., 186 P.3d 382, 390 (Wyo. 2008); Proctor v. Andrews, 972 S.W.2d 729, 735–36, 737–38 (Tex. 1998).

[138] *See supra* Section II.A.

[139] *E.g.*, Colo. Polytechnic Coll. v. State Bd. for Cmty. Colls. & Occupational Educ., 476 P.2d 38, 42 (Colo. 1970). *But cf.* Texas Boll Weevil, 952 S.W.2d at 472–73 (establishing separate non-delegation test for delegations to private entities).

those on delegations to public actors.[140] For instance, at least one court has suggested that private delegations should be "narrow in duration, extent, and subject matter."[141]

A second way that public oversight may allow private delegations to pass constitutional scrutiny is if the delegate's authority must be exercised in accordance with judicially-enforceable procedural restrictions.[142] Here too, the caselaw parallels precedent governing delegations to public agencies, though comparison is slightly muddied because private entities are not subject to procedural rules such as state administrative procedure acts and sunshine laws. Procedural restrictions on private delegates' capacity to exercise delegated authority must consequently be contained within the delegating statute. Such judicially-enforceable procedural restrictions on delegations can help prevent arbitrary or self-interested decision-making by the delegate.[143] Because private delegations raise particularly salient concerns of bias, courts reviewing challenges to such delegations often emphasize whether parties affected by the delegate's exercise of authority are involved in the decision-making process, such as through a notice and comment process.[144]

Procedural and substantive restrictions on a private delegate's power are only relevant for purposes of constitutional analysis if they are legally

---

[140] Bd. of Trs. v. Mayor of Balt., 562 A.2d 720, 730 (Md. 1989) ("[D]elegations of legislative authority to private entities are strictly scrutinized. . . ."); *accord* Tex. Boll Weevil, 952 S.W.2d at 469 ("[W]e believe it axiomatic that courts should subject private delegations to a more searching scrutiny than their public counterparts.").

[141] *See Tex. Boll Weevil*, 952 S.W.2d at 472.

[142] *See supra* Section II.A. As with the ordinary non-delegation doctrine, some courts require a combination of procedural and substantive restrictions. *See, e.g.*, United Chiropractors of Wash., Inc. v. State, 578 P.2d 38, 39–41 (Wash. 1978).

[143] *See* Protz v. Workers' Comp. Appeal Bd., 161 A.3d 827, 834 (Pa. 2017).

[144] *See Texas Boll Weevil*, 952 S.W.2d at 472–74 (analyzing statutory requirement that private delegate's board be elected by affected parties); Indep. Electricians & Elec. Contractors' Ass'n v. N.J. Bd. of Examiners of Elec. Contractors, 256 A.2d 33, 42 (N.J. 1969) (noting that private delegate's procedures in adopting and revising its standards reflect the national consensus of interested parties).

mandated and judicially reviewable, rather than voluntarily adopted.[145] This is because the non-delegation doctrine restricts legislatures' ability to delegate power "regardless of the manner in which the recipient wields it."[146] Thus, the fact that a delegate "has opted to use its powers for good," such as by self-imposing procedural restraints, "is no antidote" to a lack of constitutional power.[147]

Judicial review of a delegate's compliance with procedural or substantive restrictions is not the only way that public oversight can legitimize delegations of power to private actors. Direct oversight of a private delegate's decision-making by an administrative agency can also curb arbitrary or self-interested actions sufficiently to avoid the constitutional problems that undergird the non-delegation doctrine.[148] This strategy of administrative oversight of private delegates is central to insulating from challenge a number of federal delegations of power to private entities. For instance, the key private bodies that play a role in securities regulation – including the Financial Standards Accounting Board (FASB), the Public Company Accounting Oversight Board (PCAOB), the New York Stock Exchange (NYSE), and the National Association of Securities Dealers (NASD) – are all directly overseen by the SEC.[149] In each case, federal courts have rejected federal non-delegation challenges to these entities on the basis of such direct oversight by the SEC.[150]

---

[145] Although courts are not always explicit about the assumption that procedural or substantive restrictions must be judicially reviewable, they reliable operate on this assumption. *See, e.g.*, *Protz*, 161 A.3d at 834, 836; *Texas Boll Weevil*, 952 S.W.2d at 472–74. As one court has stated in the context of a public non-delegation case, "a corollary of the doctrine of unlawful delegation is the availability of judicial review." Askew v. Cross Key Waterways, 372 So. 2d 913, 918 (Fla. 1978).

[146] *Protz*, 161 A.3d at 835 n.4.

[147] *Id.*; *cf.* Carter v. Carter Coal Co., 298 U.S. 238, 291 (1936) ("[B]eneficent aims, however great or well directed, can never serve in lieu of constitutional power.").

[148] *See Tex. Boll Weevil*, 952 S.W.2d at 472–73 (describing agency oversight of private delegate as "uneven and incomplete").

[149] Nagy, *supra* note 13535, at 1022, 1057–61.

[150] *See, e.g.*, Todd & Co. Inc. v. Sec. & Exch. Comm'n., 557 F.2d 1008, 1012–14 (3d Cir. 1977); R.H. Johnson & Co. v. Sec. & Exch. Comm'n., 198

Judicial or administrative oversight of a delegate may be constitutionally sufficient when a public official retains discretion in adopting or applying the standards.[151] For instance, if enforcement of a private delegate's standards requires agency officials or judges to exercise their discretion in applying the standard, or to use it as only one factor in their decision-making, then there may be no impermissible delegation of legislative power.[152] In such cases, a government official maintains control over the legal effects of a delegate's decisions, meaning that the delegate does not have unconstrained "power to determine what the law will be."[153] Other courts have suggested that delegations of power to private institutions are more likely to be constitutionally permissible if impacted parties can seek review from public officials of any adverse decision by the delegate.[154]

At least some commentators have suggested that, in addition to judicial or administrative oversight, legislative oversight of a private delegate is sufficient under the non-delegation doctrine.[155] Under this view, the key consideration for assessing the constitutionality of a private delegation is "the ease with which Congress [or state legislatures] could reclaim or amend its delegation."[156] Because legislatures generally do not

---

F.2d 690, 695 (2d Cir. 1952); Arthur Andersen & Co. v. Sec. & Exch. Comm'n., No. 76C-2832, 1978 WL 1073, at *3 (N.D. Ill. Mar. 1978).

[151] *See* Madrid v. St. Joseph Hosp., 928 P.2d 250, 257 (N.M. 1996); Bd. of Tr. of the Emp. Retirement Sys. v. Mayor & City Council of Balt. v. Mayor & City Council of Balt., 562 A.2d 720, 732 (Md. 1989).

[152] *See, e.g.*, *Madrid*, 928 P.2d at 258 ("Where evidence is conflicting, the ultimate decision concerning the degree of a worker's impairment and disability rests with the workers' compensation judge."); *Bd. of Tr. of the Emp. Retirement Sys.*, 562 A.2d at 732 (Md. 1989).

[153] *Madrid*, 928 P.2d at 256.

[154] *See* In re Hansen, 275 N.W.2d 790, 796-797 (Minn. 1978); Newport Int'l Univ., Inc. v. Dep't of Educ., 186 P.3d 382, 390 (Wyo. 2008).

[155] *See* Vikram David Amar, *Indirect Effects of Direct Election: A Structural Examination of the Seventeenth Amendment*, 49 VAND. L. REV. 1347, 1360-84 (1996).

[156] Brian Galle, *Designing Interstate Institutions: The Example of the Streamlined Sales and Use Tax Agreement ("SSUTA"),* 40 U.C. DAVIS L. REV. 1381, 1428 n.240 (2007).

face constraints in clawing back power from private delegates, most such delegations to private actors are unproblematic on this view.[157]

3. Does the Delegate's Exercise of Authority Have Significance Independent of the Incorporating Statute?

Another relevant factor to state constitutional analysis of private delegations is whether the delegate's actions have any significance independent of the statute that delegated authority to it. To the extent that a delegate's exercise of authority is "guided by objectives unrelated to the statute in which [the material] function[s]," then it is less plausible to "construe [it] as a deliberate law-making act" of the type that would potentially violate the non-delegation doctrine.[158] This factor is most clearly applicable to dynamic incorporations by reference, where a statute gives legal effect to both existing and future versions of referenced material.[159] However, courts have also considered a private delegate's independent purpose in cases where the delegate receives a more direct delegation of authority from the legislature.[160]

A private delegate's actions are likely to have significance independent of a legislative delegation when they are motivated by concerns that are not principally legal or regulatory. For example, when a private entity updates standards that are dynamically incorporated by reference in a statute to reflect scientific advances – rather than to influence the way the statute operates – its actions have independent significance.[161] This, of course, is most likely to occur when the putative delegate has expertise that

---

[157] *See id*.

[158] *Madrid*, 928 P.2d at 257; *accord* Lucas v. Me. Comm'n of Pharmacy, 472 A.2d 904, 909 (Me. 1984).

[159] *See* Boyd, *supra* note 117, at 1255–57.

[160] *See* Tex. Boll Weevil Eradication Found., Inc. v. Lewellen v. Abbott, 952 S.W.2d 454, 474–75 (Tex. 1997), *as supplemented on denial of reh'g* (Oct. 9, 1997).

[161] *See, e.g.*, State v. Wakeen, 57 N.W.2d 364, 369 (Wis. 1953) (upholding dynamic incorporation by reference of the United States Pharmacopeia's definition of drug); *Madrid*, 928 P.2d at 259 (upholding incorporation of American Medical Association's physical impairment guidelines).

is tied to a non-regulatory domain, such as science or education.[162] The same conclusion may follow when a private delegate's standards are used in a broad set of materials beyond the challenged statutory regime.[163]

By contrast, private entities that exercise delegated authority for the sole or express purpose of influencing legal or regulatory standards are more likely to face successful non-delegation challenges. Delegates may be so influenced for a variety of reasons, including the prospect that they can reap pecuniary benefits by influencing the law.[164] For this reason, courts are often particularly skeptical of delegations to private entities that hold the prospect of substantially benefiting those parties' finances.[165]

One alternative explanation for courts' consideration of a private delegate's independence from the incorporating statute involves the practical ability of legislatures to claw back power from the private delegate.[166] Independent expert bodies that produce standards that happen to be dynamically incorporated into state law are unlikely to directly pressure state legislatures to retain their delegated authority. This means that the legislature has no practical restrictions on its ability to claw back authority from the delegate. By contrast, when private entities exercise delegated authority for the sole purpose of influencing legal or regulatory standards, they are likely to guard that authority jealously and employ various means to thwart the legislature's practical ability to claw back that authority.

---

[162] *See, e.g.*, Colo. Polytechnic Coll. v. State Bd. for Cmty. Coll. & Occupation Educ., 476 P.2d at 42 (Colo. 1970) (expertise in post-secondary education); *Lucas*, 472 A.2d at 909–11 (pharmaceutical education); *Hansen*, 275 N.W.2d at 796–97 (legal education); *Wakeen*, 57 N.W.2d at 369 (pharmaceuticals).

[163] *See Lucas*, 472 A.2d at 909–11 (listing several uses for American Council on Pharmaceutical Education accreditation standards independent of their use in Maine's pharmaceutical licensure statute).

[164] *See Texas Boll Weevil*, 952 S.W.2d at 472; *cf.* Alexander Volokh, *The New Private- Regulation Skepticism: Due Process, Non-Delegation, and Antitrust Challenges*, 37 HARV. J.L. & PUB. POL'Y 931, 941–42 (2014) ("[D]elegation of power plus pecuniary bias is a due process faux-pas, and it is easy to imagine (or presume) that such bias will be more likely if the delegate is private.").

[165] *See* Carter v. Carter Coal Co., 298 U.S. 238, 311 (1936); *Texas Boll Weevil*, 952 S.W.2d at 472.

[166] *See supra* Section II.C.2.

D. Application of Private Non-delegation Factors in Workers' Compensation and Accounting Delegations

State courts have applied the considerations detailed above to countless different legislative delegations of power to private entities, ranging from organizations devoted to accrediting educational institutions to bodies developing standards to protect individuals' privacy. This subsection focuses on caselaw analyzing delegations to private actors in two settings that closely parallel state delegation of insurance regulatory authority to the NAIC. The first involves state workers' compensation statutes that rely on materials produced by the American Medical Association to help assess a worker's physical impairment. The second focuses on delegations by both federal and state actors to the Financial Accounting Standards Board to set Generally Accepted Accounting Principles.

1. Workers' Compensation Statutes and the American Medical Association's Impairment Guides

State workers' compensation statutes frequently rely on the American Medical Association's (AMA) Impairment Guides to help ascertain the severity of workers' physical disabilities and ultimately their compensation.[167] When these statutes attempt to incorporate future versions of the Guides as promulgated by the AMA, they raise a non-delegation problem.[168] However, courts applying the non-delegation factors above have reached mixed conclusions regarding such statutes' constitutionality.

For instance, in a 2017 case, the Pennsylvania Supreme Court struck down the state's dynamic incorporation by reference of the AMA's

---

[167] *See* Protz v. Workers' Comp. Appeal Bd., 161 A.3d 827, 835–36 (Pa. 2017) ("[T]he General Assembly gave the AMA de facto, unfettered control over a formula that ultimately will determine whether a claimant's partial-disability benefits will cease after 500 weeks."); McCabe v. North Dakota Workers Comp. Bureau, 567 N.W.2d 201, 205 (N.D. 1997).

[168] In *McCabe v. North Dakota Workers Compensation Bureau*, the court avoided the constitutional problems presented by dynamic incorporation by holding that the statute's language does not incorporate future changes to the Guides. As such, the statute did not impermissibly delegate power to the AMA. *McCabe*, 567 N.W.2d 201.

impairment guidelines as an impermissible delegation.[169] This scheme, the court held, violated the Pennsylvania Constitution's vesting of legislative power in the legislature because it did nothing to limit the AMA's arbitrary and capricious exercise of this delegated power, effectively giving it "de facto, unfettered control over a formula" that determines a claimant's recovery.[170] In reaching this conclusion, the court emphasized that the statute failed to declare any policy regarding the Guides' methods for evaluating physical impairment or to prescribe any standards to guide the AMA in creating its methodology.[171] The court also noted a conspicuous lack of procedural safeguards binding the AMA's drafting process, such as notice and comment procedures and judicial review.[172] These factors ultimately led the court to conclude that the state's delegation of power to the AMA would violate the State's constitution even if the AMA were a governmental entity.[173] But the court expressly declined to reject either the intermediate appellate court's conclusion that all delegations of power to private entities violate the Pennsylvania Constitution or the more moderate view that private delegations require "a more exacting form of judicial scrutiny" than delegations to public actors.[174]

By contrast, the Supreme Court of New Mexico upheld the state's dynamic incorporation of the Guides.[175] In *Madrid v. St. Joseph Hospital*, the court stressed that the AMA is a body with medical expertise that produces the Guides based on scientific objectives, rather than solely for use in New Mexico's statute.[176] It also emphasized that the statute made the Guides only one factor in determining a worker's right to compensation, leaving the ultimate decision with the workers' compensation judge.[177] Thus, public officials retained some discretion in applying the Guides, supporting the delegation.

---

[169] *Protz*, 161 A.3d at 841.

[170] *Id.* at 836.

[171] *Id.* at 835–36.

[172] *Id.* at 836.

[173] *Id*. at 838.

[174] *Id*.

[175] Madrid v. St. Joseph Hosp., 928 P.2d 250 (N.M. 1996).

[176] *Id.* at 257–58.

[177] *Id.* at 258; *cf.* McCabe v. N.D. Workers Comp. Bureau, 567 N.W.2d 201, 205 (N.D. 1997).

2. Delegation to FASB to Develop Generally Accepted Accounting Principles

Both federal and state authorities delegate power to the Financial Standards Accounting Board (FASB) to update GAAP. FASB's authority over GAAP stems from the Securities Exchange Act of 1934, which authorized the Securities and Exchange Commission (SEC) to establish a common system of accounting.[178] The SEC initially sub-delegated this authority to the primary trade association of the accounting profession,[179] and later shifted this delegation to FASB, a private, non-profit corporation whose Board is selected by a panel of accounting professionals.[180] FASB Board members are full-time employees of FASB who are drawn from the accounting profession. Although the SEC does not play any direct role within FASB's institutional structure, it devotes extensive resources to monitoring the organization's agenda and operations, through a dedicated SEC Office of the Chief Accountant.[181] Although the SEC has direct authority to overrule FASB, it generally influences FASB decision making more subtly by using suggestions and the implicit threat of a veto.[182]

Because the SEC's delegation of power to FASB is a matter of federal law, there is limited state case law on point. One exception is an intermediate appellate case from Texas, which addressed a non-delegation challenge to a Texas statute that required companies to compute their tax obligations using "generally accepted accounting principles."[183] The Texas Comptroller interpreted this provision to refer to GAAP, as promulgated by FASB. In rejecting the argument that this interpretation amounted to an

---

[178] Securities Exchange Act of 1934, 15 U.S.C. §§ 78a–78qq (2012).

[179] *See* Nagy, *supra* note 135, at 985.

[180] William W. Bratton, *Private Standards, Public Governance: A New Look at the Financial Accounting Standards Board*, 48 B.C. L. REV. 5 (2007).

[181] *Id.* at 36.

[182] *Id. See also* Nahum D. Melumad & Toshiyuki Shibano, *The Securities and Exchange Commission and the Financial Accounting Standards Board: Regulation Through Veto-Based Delegation*, 32 J. ACCT. RES. 1, 2, 7–14 (1994); D. Paul Newman, *The SEC's Influence on Accounting Standards: The Power of the Veto*, 19 J. ACCT. RES. 134, 143 (1981).

[183] Cent. Power & Light Co. v. Sharp, 919 S.W.2d 485, 492 (Tex. App.–Austin 1996).

unconstitutional delegation of power to a private entity, the Texas court emphasized that FASB "operates without reference to any legislative purpose, and it does not make its pronouncements in order to fulfill or effectuate any statute."[184] The Court also noted that the Comptroller's rules specifically did not make GAAP unconditionally binding on companies, but instead instructed companies to depart from GAAP when "the context clearly requires" doing so to avoid a misleading financial statement.[185] Finally, the court reasoned that aggrieved taxpayers could go before the Comptroller to contest their tax liability. All this, the court held, demonstrated that "the Comptroller, not FASB, holds and exercises the properly delegated power to interpret and apply tax laws."[186]

Federal caselaw also makes clear that the SEC's sub-delegation of authority to FASB is constitutional. Although no federal case explicitly reaches this conclusion, federal courts have routinely rejected nondelegation challenges to the SEC's delegation of power to other private entities, such as the National Association of Securities Dealers (NASD). In doing so, they generally emphasize that NASD's decisions are "subject to full review by the S.E.C., a wholly public body, which must base its decision on its own findings."[187] This logic, of course, is equally applicable to FASB. The constitutionality of the SEC's delegation to FASB is only enhanced by the fact that Congress, in the Sarbanes-Oxley Act of 2002, conditioned FASB's authority on it meeting five conditions.[188] These conditions required the organization to be entirely private, maintain procedures ensuring prompt consideration of emerging accounting issues, and to be deemed by the SEC to be capable of improving the accuracy and effectiveness of financial reporting and investor protection.[189] These restrictions on FASB's composition and procedures, as well as the direct role for the SEC in

---

[184] *Id.*

[185] *Id.*

[186] *Id.*

[187] Todd & Co. v. Inc. SEC, 557 F.2d 1008, 1012–14 (3d Cir. 1977). S*ee also* R.H. Johnson & Co. v. SEC, 198 F.2d 690, 695 (2d Cir. 1952). For an argument that the SEC's delegation of power to FASB is indeed unconstitutional. *See* Bruce Edward Committe, *The Delegation and Privatization of Financial Accounting Rulemaking Authority in the United States of America*, 1 CRITICAL PERSP. ACCT. 145 (1990).

[188] Sarbanes-Oxley Act of 2002,15 U.S.C. § 7219(b), (e) (2012).

[189] *Id.*

assessing FASB's competence, render the constitutionality of the SEC's delegation to FASB clear.

III. THE UNCONSTITUTIONALITY OF THE U.S. STATE INSURANCE REGULATORY REGIME

Each state has its own precedents regarding the constitutionality of attempts by its legislature to delegate authority to private actors.[190] Moreover, even within a single state, different legislative delegations of authority to the NAIC pose distinct legal issues, as they vary with respect to relevant factors such as the substantive and procedural guidance that accompanies these delegations as well as state regulators' discretion to depart from dynamically-incorporated NAIC manuals.[191] For these reasons, it is impossible to conclusively assess the constitutionality of all state delegations of authority to the NAIC in every jurisdiction.

Nonetheless, this Section argues that most state delegations of authority to the NAIC raise major constitutional problems under the non-delegation principles of most states. The analysis below explains this conclusion by focusing on the three factors that state courts have generally found to be influential in assessing the constitutionality of legislative delegations to private parties.[192] First, Section A explains that the NAIC is a private entity for purposes of the non-delegation doctrine. Second, Section B shows that the NAIC's exercise of its delegated authority is not subject to any meaningful oversight by the judiciary or individual state insurance departments. Finally, Section C argues that the NAIC's production of dynamically-incorporated materials do not have significance independent of legislative delegations to the organization. The fact that the NAIC actively pressures state legislatures to delegate authority to it through its accreditation program strongly supports this conclusion.

A. THE NAIC IS A PRIVATE ACTOR FOR PURPOSES OF THE NON-DELEGATION DOCTRINE

As a private, non-profit corporation founded and controlled by state insurance commissioners, the NAIC is in some ways at the border of the

---

[190] *See supra* Section II.C.
[191] *See supra* Section I.C.
[192] *See supra* Section II.C.

public/private divide. But when it comes to states' non-delegation doctrines, the NAIC's status as a private entity is relatively clear. From a formalistic perspective, this conclusion follows from the fact that the NAIC is registered as a 501(c)(3) non-profit corporation in the state of Delaware.[193] As a Delaware corporation, the NAIC is not subject to any of the safeguards that ordinarily apply to government bodies, such as state Freedom of Information Acts or Sunshine Laws.[194]

Although some courts confronting non-delegation claims have resisted formalistic categorization of entities that are formed or controlled by legislatures, these cases do not apply to the NAIC. Unlike these cases – which are exemplified by Amtrak and the Texas Agricultural Pest Eradication Foundation[195] – state insurance regulators, rather than state legislatures, founded the NAIC and control its operations.[196] And they

---

[193] *See* NAT'L ASS'N INS. COMM'RS, ARTICLES OF INCORPORATION (Adopted Oct. 1999), https://www.naic.org/documents/about_certificate_of_incorporation.pdf. The fact that the NAIC is a registered non-profit corporation, as compared to Amtrak's status as a for profit corporation, may arguably weigh in favor of its status as a public rather than private entity. Indeed, the D.C. Circuit decision finding Amtrak to be a private entity emphasized its status as a for profit corporation, noting that this mission was at odds with the traditional mission of public entities to advance the common good. *See* Ass'n of Am. Railroads v. U.S. Dep't of Transp., 721 F.3d 666, 677 (D.C. Cir. 2013), *vacated and remanded sub nom.* Dep't of Transp. v. Ass'n of Am. Railroads, 135 S. Ct. 1225, 191 L. Ed. 2d 153 (2015). By contrast, the NAIC's mission is expressly to "serv[e] the public interest" and promote "fundamental insurance regulatory goals" by assisting "state insurance regulators, individually and collectively." *See Mission,* NAT'L ASS'N INS. COMM'RS, https://www.naic.org/index_about.htm (last visited Oct. 4, 2018). As a charitable nonprofit, the NAIC also faces constraints on its expenditure of funds and must disclose information that private entities do not. But unlike virtually any other non-profit, the NAIC does not file Form 990 annual disclosures about its budget and activities, relying on an IRS private letter exempting it from this requirement. *See* Letter from Kevin M. McCarthy, NAIC President, to Edward R. Royce, U.S. House of Representatives (Mar. 20, 2012), https://www.naic.org/documents/committees_ex_grlc_120320_royce_letter.pdf.

[194] These laws only apply to government entities.

[195] *See supra* Section II.C.1.

[196] *See supra* Section I.A.

formed it not to serve some independent public purpose, but instead to operate as an association that could assist them in performing their professional responsibilities.[197] No court has ever held that a private corporation founded by non-legislative officials to operate as a professional association is a public entity for purposes of the non-delegation doctrine.

Even for courts inclined to embrace a less formalistic approach to the public/private distinction, the NAIC's private status for purposes of the non-delegation doctrine is clear. Recall that courts employing such a functional approach typically focus on the government's control of the delegate's decision-making, operations and objectives.[198] Because it is state legislatures to whom state Constitutions delegate the legislative power, it is the legislature's control over a delegate that is the focus of this inquiry.[199] Thus, Amtrak was a public entity because Congress played a central role in its operations and delegated to the President authority to appoint its Board.[200]

Under this type of functional approach to the public/private divide, the NAIC is almost certainly a private entity because no state legislature exercises direct control over it. This conclusion follows from three considerations. First, any control that state legislatures have over the NAIC is fragmented among 56 jurisdictions.[201] This is significant, as individual states' non-delegation doctrines are rooted in their individual constitutions.[202] Thus, the relevant question for any individual state is not whether states in the aggregate exercise sufficient control over the NAIC to render it a public entity. Instead, the relevant question is whether the government of the specific state where a case is filed sufficiently controls the NAIC. Fragmentation of state control over the NAIC means that the answer to this question must be "no." To analogize, if the Minnesota legislature were to delegate authority to an Iowa agency, this delegation would best be understood as private rather than public under the Minnesota Constitution, because an Iowa agency is not democratically accountable to the people of Minnesota.

---

[197] *Id.*

[198] *See supra* Section II.C.1.

[199] *See id.*

[200] *See id.*

[201] As discussed in Section I, the NAIC's voting membership consists of the fifty states plus six additional jurisdictions. *See supra* Section I.A.

[202] *See supra* Section II.A.

Fragmented control of the NAIC by fifty-six different state insurance commissioners also undermines the organization's accountability to any individual state legislature. State legislatures have limited incentives to directly monitor and attempt to exert control over national organizations like the NAIC, even if they might plausibly be able to do so through their influence over state insurance departments.[203] This is but one example of a familiar tragedy of the commons problem: the costs of any such oversight would be borne entirely by the state, but the benefits would be diffused nationally.[204] By contrast, the federal government's control over Amtrak, for instance, allowed it to pursue a unified objective with respect to the railroad.[205]

A second reason that the NAIC is a private entity even under a functional approach to the non-delegation doctrine is that, unlike other hybrid public-private entities, the NAIC is not subject to any supplemental laws that imbue it with public features. Cases that have found ostensibly private corporations like Amtrak to be public entities have highlighted the unique constraints that legislatures imposed on these entities.[206] To illustrate, Amtrak was required by statute to comply with the Freedom of Information Act, to maintain an Inspector General, and to regularly submit formal reports to Congress.[207] Even the Texas Boll Weavel foundation – which the court ultimately deemed private – was subject to public safeguards, such as a

---

[203] *See* Daniel Schwarcz, *A Critical Take on Group Regulation of Insurers in the United States,* 5 U.C. IRVINE L. REV. 537, 550 (2015) (noting limited incentives of states insurance regulators to devote sufficient attention to matters of national or international concern, like systemic risk).

[204] Although state legislatures try to overcome these coordination problems through organizations like the National Conference of Insurance Legislatures (NCOIL), these efforts only prove the larger point: NCOIL is universally understood to be a less prominent and important organization than the NAIC, a telling fact given that state legislatures are generally supposed to have oversight responsibilities over state regulators.

[205] *See supra* Section II.C.1.

[206] *See id.*

[207] *See* Dep't of Transp. v. Ass'n of Am. R.Rs., 135 S. Ct. 1225, 1232 (2015).

requirement that it publish its rules and the prospect of dissolution by a public official.[208] No such requirements apply to the NAIC.

Finally, unlike the cases finding privately-chartered corporations to be public for purposes of the non-delegation doctrine, states do not play a meaningful role in funding the NAIC. To the contrary, state funds ultimately contribute a tiny fraction to the NAIC's budget.[209] The vast majority of the NAIC's revenue instead stems from its sale of services and publications to the insurance industry.[210] This is significant, as it means that states have limited informal control over the NAIC's actions flowing from their financial backing of the organization.[211]

The NAIC, in sum, is a private entity for purposes of states' non-delegation doctrines. Under a formalistic analysis, this conclusion flows naturally from the fact that the NAIC is chartered as a Delaware corporation founded by state regulators, rather than state legislatures. From a more functional perspective, states' fragmented control over the organization means that it is not controlled by or accountable to any individual state. State legislatures also lack any indirect authority over the NAIC as it is not subject to any supplemental public safeguards and it is funded almost entirely by its sale of services and publications to the insurance industry.

---

[208] *See* Tex. Boll Weevil Eradication Found., Inc. v. Lewellen, 952 S.W.2d 454, 470-471 (Tex. 1997), *as supplemented on denial of reh'g* (Oct. 9, 1997).

[209] *See supra* Section I.A.

[210] *See supra* Section I.A.

[211] Although the insurance industry clearly exercises much less control over the NAIC's operations than did the private farmers in the *Boll Weavel* case, their influence on the NAIC is different in kind than ordinary industry influence on state agencies. The NAIC's open meeting policy has no parallel for government agencies, where the default assumption is that meetings among staff will be "closed" to the industry. This practice – coupled with the fact that so much of the NAIC's work takes place through meetings conducted within the committee structure – ensures that the industry has a major voice in virtually every facet of the NAIC's operations. So too does the fact that the NAIC's conflict of interest policy is much weaker than almost any individual states, allowing in the most extreme cases for NAIC officers to switch within months from chairing an NAIC committee to representing industry interests before that committee.

B. THE NAIC'S EXERCISE OF DELEGATED AUTHORITY IS NOT SUBJECT TO MEANINGFUL PUBLIC OVERSIGHT

Unlike other private entities that are permissibly delegated legal authority by state legislatures, the NAIC's exercise of delegated authority is not subject to meaningful oversight by either state judiciaries or administrative agencies.[212] This point is straight-forward with respect to judicial oversight, as the NAIC's decision-making is not judicially reviewable.[213] But the lack of NAIC oversight by state insurance departments requires more explanation given the dominant role of state regulators in directing the organization and producing its work product.[214] Subsection One first explains why state regulators' direct role in producing the NAIC's dynamically-incorporated materials does not constitute public oversight of the type that is relevant for purposes of states' non-delegation doctrines. Subsection Two then suggests that individual state regulators' capacity to depart from NAIC-drafted materials in specified circumstances also does not result in sufficient public oversight of the NAIC under non-delegation caselaw.

1. State Regulators' Direct Role in Developing NAIC Materials Does Not Constitute Public Oversight

When legislatures delegate lawmaking authority to private organizations, they often task state agencies with monitoring and overseeing this exercise of authority.[215] Public officials in these schemes do not directly control the private delegate's decision making. Instead, they maintain their independence from the delegate to ensure that it is exercising its legislatively-delegated authority effectively, fairly, and efficiently. To illustrate, Congress authorized the SEC to sub-delegate authority over accounting rules to FASB.[216] But FASB itself is comprised entirely of private individuals with accounting expertise, rather than any SEC officials.[217] The role of the SEC in this scheme is to actively monitor how FASB exercises its delegated authority to ensure that its deliberations and determinations are not

---

[212] *See supra* Section II.C.2.
[213] *See supra* Introduction.
[214] *See supra* Section I.C.
[215] *See supra* Section II.C.2.
[216] *See supra* Section II.D.2.
[217] *See supra* Section II.D.2.

unfairly biased or inadequately sensitive to relevant public policy concerns.[218]

The NAIC turns this structure on its head. State insurance regulators do not independently oversee the NAIC's exercise of authority. Instead, they directly exercise this authority through their participation in the NAIC's internal processes.[219] Thus, state insurance regulators acting under the auspices of the NAIC set the terms of the Valuation, AP&P, and ORSA manuals, relying only on private parties, like NAIC staff and industry, to advise them in this process rather than to exercise this authority directly.[220] By directly exercising the authority delegated to the NAIC, public officials produce rules with the force of law while avoiding any independent oversight whatsoever. State regulators' exercise of the NAIC's delegated authority is also exempt from any of the other constraints that ordinarily accompany officials' public actions, such as laws governing conflicts of interest and transparency.[221]

This lack of independent oversight undermines the due process values that are at the heart of courts' skepticism of private delegations.[222] Independent oversight of private delegates' exercise of authority promotes due process for a variety of reasons. Perhaps most importantly, it limits the risk of biased decision-making by private delegates, a concern that courts repeatedly emphasize in the caselaw examining the enhanced constitutional concerns associated with private delegations.[223]

---

[218] *See supra* Section II.D.2. Similarly, the American Medical Association's impairment standards ultimately are applied by state actors–Workers' Compensation Administrative Law Judges–who are not themselves AMA members. *See also supra* Section II.D.1.

[219] *See supra* Section I.

[220] *See supra* Section I.

[221] *See supra* Section I.

[222] *See supra* Section II.B.

[223] *See supra* Section II.B. Of course, other Due Process values are also served by independent oversight of a private delegate's exercise of power. For instance, independent oversight helps ensure that rules with the force of law are evaluated from two independent perspectives, thus reducing the potential influence of group think or hidden biases. Just like a student cannot reliably grade her own work, state regulators cannot meaningfully oversee the production of materials that they themselves produce.

The risk that the NAIC will exhibit bias in exercising its delegated power is notable. State insurance regulators operating under the auspices of the NAIC may have substantial interests in using their delegated authority to expand the NAIC's power and improve its finances. For instance, state insurance regulators may use the NAIC's authority to inflate the scope and complexity of statutory accounting principles.[224] Doing so can increase the value of regulators' specialized insurance expertise, limit the risk of perceived encroachment on their turf by federal officials,[225] and improve the NAIC's capacity to fund its operations by selling updates AP&P manuals.[226]

State regulators' exercise of authority through the NAIC may be biased in other ways as well. For instance, state regulators can, and do, increasingly use the NAIC to raise, pursue, and implement difficult policies in a private forum, away from democratic accountability. By increasing the scope of issues that are regulated through NAIC manuals, rather than via ordinary administrative actions within individual insurance departments, state regulators can avoid the ordinary costs and difficulties associated with

---

[224] There are good reasons to be skeptical that effective insurance regulation truly requires unique accounting principles as detailed and extensive as those found within statutory accounting. For an overview of how statutory accounting differs from GAAP, *see Background on: Insurance Accounting*, INS. INFO. INST., https://www.iii.org/publications/insurance-handbook/regulatory-and-financial-environment/background-on-insurance-accounting (last visited, Oct. 8, 2018).

[225] For instance, insurance companies that are not publicly held only report their financial status using statutory accounting. However, many of the regulatory tools used by federal regulators are specifically designed for GAAP reporting. This fact has substantially complicated the Federal Reserve's ability to regulate insurance-focused savings and loan holding companies. *See generally Legislative Review of H.R. 5059, The State Insurance Regulation Preservation Act Before the U.S. H. of Reps. Comm. on Financial Servs. and the Subcomm. on Hous. & Ins*., Insurance Summit (2018) (testimony of Daniel Schwarcz, Professor of Law, University of Minnesota Law School).

[226] As discussed above, the NAIC sells access to the AP&P manual to help fund its operations. *See supra* Section I. There is a good argument that the AP&P manual should not be protected by intellectual property laws given its status as state law. *See* Cunningham, *supra* note 34.

complying with their individual states' administrative laws.[227] For instance, rather than promulgating new regulations regarding group capital requirements – a controversial and complex topic[228] – states can simply avoid any legal process by inserting new rules on this topic into the ORSA guidance manual.[229]

Even if state regulators' participation in the NAIC were somehow construed to constitute public oversight of the organization, this would still likely not satisfy state constitutional requirements. This is because, as noted above, the relevant perspective for purposes of evaluating non-delegation principles is that of an individual state, not states collectively.[230] And from the perspective of any individual state, its public officials will generally play a minimal or non-existent role in exercising the NAIC's authority. The NAIC's individual committees are comprised of regulators from a variety of different states.[231] As such, when those committees approve of changes to materials that are dynamically incorporated by reference, public officials from any single state will, at most, play only a limited role in producing or reviewing these materials.

While laudable, the NAIC's efforts to promote involvement of various stakeholders in its deliberations does not alter this analysis. Recall that the NAIC actively encourages industry and consumer stakeholder participation in its operations, both by maintaining a robust open meetings policy and by covering the costs of consumer-representatives to participate in its deliberations.[232] But none of these efforts come close to constituting the type of oversight that constitutional principles generally demand for

---

[227] Robert Williams coined the term "substance creep" to describe this phenomenon in a talk describing some of the potential risks associated with states' dynamic incorporation-by-reference of NAIC materials.

[228] *See* Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance, Sept. 22, 2017, E.U.-U.S., T.I.A.S. 18-404 [hereinafter Covered Agreement]. *See generally* Schwarcz, *supra* note 203. Recently, the United States agreed in a "covered agreement" with the E.U. The agreement creates an expectation that state insurance regulators will develop and implement a group capital "requirement or assessment."

[229] *See supra* Section I.C.2.

[230] *See supra* Section III.A.

[231] *See supra* Section I.

[232] *See supra* Section I.A.

private delegations. The reason is simple: stakeholders who participate in the NAIC's deliberations have no formal authority to vote on or otherwise directly influence the organization's work product. Indeed, NAIC consumer representatives have complained public and privately for years that the NAIC merely pays lip service to consumer interests while generally doing little to promote real change.[233] As such, their participation in the NAIC's operations cannot coherently be considered oversight.

Also, praiseworthy but irrelevant for purposes of constitutional analysis are the NAIC's various internal procedures for publicly exposing working drafts and voting on changes to these materials. As discussed above, a private delegate's voluntarily-adopted procedures for exercising its authority have nothing to do with the power that the legislature has delegated to that entity.[234] Because compliance with these standards is not legally mandated, the NAIC can always change, or simply ignore, these internal rules with no consequence.

2. State Insurance Departments' Capacity to Depart from NAIC Manuals Does not Result in Meaningful Oversight of the NAIC

The only plausible way that individual state insurance departments can be understood to exercise public oversight over the NAIC is through their authority to depart from dynamically-incorporated NAIC materials in specified circumstances. State insurance departments' capacity to authorize such departures varies by topic and state. However, a common structure –

---

[233] *See, e.g.*, Comments of CFA and CEJ to Auto Insurance Working Group Regarding the August 10, 2018 Draft "Report" Outline, CONSUMER FED'N OF AM. (Sept. 1, 2018), https://consumerfed.org/wp-content/uploads/2018/09/cfa-cej-comments-naicautowg.pdf. One notable exception is that the NAIC consumer liaison program seemingly had a large impact on the organization's implementation of the Affordable Care Act. *See* Timothy Jost, *Reflections on The National Association of Insurance Commissioners and Implementation of the Patient Protection and Affordable Care Act*, 159 U. PA. L. REV. 2043 (2011).

[234] Consumer Federation of America, *supra* note 204; Jost, *supra* note 204; *cf.* Carter v. Carter Coal Co., 298 U.S. 238, 291 (1936) ("[B]eneficent aims, however great or well directed, can never serve in lieu of constitutional power.").

reflected in both the Valuation and AP&P Manuals[235] – is that individual state insurance departments can either promulgate regulations authorizing departures from specific provisions within dynamically-incorporated NAIC manuals for all insurers, or else they can permit such departures for individual insurers who apply for exemptions.[236]

State Departments' limited authority to depart from NAIC manuals is in some ways comparable to other types of public oversight of private delegations that Courts have found significant. For instance, as described earlier, one court tolerated a state's prospective incorporation by reference of GAAP in part because aggrieved taxpayers could contest their tax liability before the state Comptroller.[237] And a key element of the SEC's oversight over FASB and other private delegates is its capacity to veto individual rules,[238] an authority that is comparable to individual insurance departments' authority to depart from portions of dynamically incorporated NAIC manuals.

Notwithstanding these similarities, individual states' capacity to depart from NAIC-produced material should not be deemed sufficient public oversight of the NAIC to stave off a non-delegation challenge. This is for two fundamental reasons. First, state insurance departments' actual capacity to depart from NAIC materials is extremely limited as a practical matter. Second, individual states' authority to depart from NAIC materials does not empower them to more broadly influence the NAIC's exercise of its delegated authority.

Consider first the practical limits on states' capacity to depart from NAIC materials that are dynamically incorporated by reference into state law. Unlike other public overseers of private delegates, individual state insurance departments must promulgate regulations to reject rules contained within dynamically-incorporated NAIC materials.[239] Doing so, of course, is time consuming, costly, and itself subject to judicial challenge. By contrast, states need merely do nothing to accept the NAIC's exercise of delegated authority. This scheme inhibits state insurance departments' oversight of the

---

[235] *See supra* Section I.C.

[236] In the statutory accounting context, the former are referred to as prescribed practices, whereas the latter are referred to as permitted practices.

[237] *See supra* Section II.D.2 (describing Cent. Power & Light Co. v. Sharp, 919 S.W.2d 485 (Tex. App. 1996)).

[238] *See supra* Section II.D.2.

[239] *See supra* Section I.C.

NAIC by making it both costly and difficult. Consistent with this fact, state insurance departments almost never promulgate rules departing from dynamically incorporated NAIC materials.

To be sure, states are empowered to authorize specific departures from NAIC rules for individual insurers without promulgating regulations.[240] But this power to grant individual exemptions to insurers cannot be understood to constitute oversight of the NAIC's delegated power. Instead, it simply allows insurance departments to recognize individual instances where the NAIC's rules may not be appropriate.[241] Moreover, this type of individualized exercise of discretion requires insurers to affirmatively request an exemption; it is not a necessary incident of the NAIC's exercise of delegated power. By contrast, courts that have authorized workers' compensation statues that dynamically incorporate AMA impairment standards have emphasized that administrative law judges must apply these standards using their discretion in order for them to have the force of law.[242]

States' capacity to meaningfully exercise their authority to depart from dynamically incorporated NAIC materials is also limited by the sheer scope of these materials. As described above, states delegate an immense array of different authorities to the NAIC, encompassing not just the rules governing accounting, reserving, and corporate governance, but also a wide range of additional topics.[243] In many ways, the NAIC essentially controls all aspects of financial regulation of U.S. insurers: The entire accounting system comes from NAIC in the AP&P Manual, and the entire method of analyzing and examining insurers' finances and governance is found in the Financial Condition Examiners Handbook and Financial Analysis Handbook. [244] States simply do not have the practical bandwidth to

---

[240] *See supra* Section I.C.

[241] *See supra* Section I.C.

[242] *See supra* Section II.D.1.

[243] *See supra* Section I.

[244] There is nothing discrete about NAIC's involvement in setting regulatory policy. Instead, by design, the NAIC has since 1990 attempted to "establish a national system of uniform insurance regulation" with itself at the center. Today, that goal is described in the current "About the NAIC" tagline used in all its official statements, which concludes with the description that "NAIC members, together with the central resources of the NAIC, form the national system of state-based insurance regulation in the U.S." *See*, *About the NAIC*, *supra* note 15.

meaningfully monitor the NAIC's actions across all of these domains.[245] Perhaps reflecting this difficulty of effectively monitoring expansive delegations of power to private actors, at least one court has suggested that the scope of a state's delegation of power to a private entity is itself relevant to whether it is constitutionally permissible.[246]

Apart from these practical limits on state insurance departments' capacity to depart from dynamically incorporated NAIC materials, any such departures do not, in fact, operate as a form of oversight over the NAIC. The mere fact that one or even several states exercise their authority to depart from NAIC-produced materials does not empower those states to influence the NAIC more broadly. Even in such cases, the NAIC's manuals have the force of law in the vast majority of U.S. jurisdictions. The upshot of this reality is that, unlike other public watchdogs of private parties who are delegated authority, states have limited capacity to transform their veto authority into soft power that can influence the NAIC's actions. Compare, for instance, the power that an individual state wields vis a vis the NAIC relative to the SEC's veto power over FASB. As noted above, the SEC doesn't need to use its veto authority in order for it to dramatically influence FASB's decision-making, because the veto threat is typically enough.[247] No individual state can similarly transform whatever veto authority it has into a broader capacity to oversee the NAIC's operations.

C. THE NAIC'S EXERCISE OF DELEGATED AUTHORITY IS NOT INDEPENDENT FROM THE DELEGATING STATUE

Even state statutes that dynamically incorporate by reference materials that are produced by private organizations without any meaningful public oversight may not violate Constitutional non-delegation principles. At least some courts have approved of such legislative delegations when the

---

[245] *See Improving U.S. Insurance Regulation*, BIPARTISAN POLICY CTR. 26, 28 (Apr. 2017), https://bipartisanpolicy.org/wp-content/uploads/2017/04/Improving-U.S.-Insurance-Regulation.pdf (noting that many state insurance departments have too few resources to effectively regulate their markets).

[246] *See* Tex. Boll Weevil Eradication Found., Inc. v. Lewellen, 952 S.W.2d 454 (Tex. 1997), *as supplemented on denial of reh'g* (Oct. 9, 1997).

[247] *See supra* Section II.D.1; William W. Bratton, *Private Standards, Public Governance: A New Look at the Financial Accounting Standards Board*, 48 B.C. L. REV. 5 (2007).

private organization is an independent, expert body, as illustrated by the conflicting caselaw on workers' compensation statutes that dynamically incorporate by reference impairment standards produced by the American Medical Association.[248] At first blush, states' prospective incorporation-by-reference of the NAIC's materials may seem defensible under this precedent; the NAIC undoubtedly possesses a massive amount of insurance expertise, both among its direct employees and as a result of its network of state insurance regulators.[249]

But unlike any of these cases where courts have approved of prospective statutory incorporation by reference of a private expert body's standards, the NAIC's production of these standards is not independent of the law-making process. To the contrary, the entire purpose of the NAIC's production of dynamically-incorporated materials is to set the terms by which state insurance regulation operates. Unlike, for instance, the AMA's impairment standards – which can help medical professionals perform their professional obligations for reasons having nothing to do with workers' compensation – the materials contained in the various dynamically-incorporated NAIC materials have no independent purpose aside from state insurance regulation. To illustrate, statutory accounting principles require different accounting standards than GAAP ostensibly to facilitate regulators' capacity to assess whether an insurer will be able to pay its future claims.[250] Similarly, the NAIC's valuation manual exist solely to ensure that carriers meet regulatory expectations in setting aside appropriate funds to pay future claims.[251]

Not only are the NAIC's dynamically incorporated materials created for the express purpose of binding insurers and insurance regulators, but the NAIC actively pressures states to adopt these standards through its accreditation program. The pressure that the NAIC's accreditation program places on states to delegate authority to the NAIC is described in detail in Part I.[252] The key point here, though, is that this type of pressure directly undermines any plausible claim that the NAIC's dynamically-incorporated materials are produced from some reason independent of their legal authority. It is one thing for a private organization to exercise delegated authority for the sole purpose of influencing legal rules. But independence is

---

[248] *See supra* Section II.D.1.
[249] *See supra* Section I.
[250] *See supra* Section I.B.
[251] *See supra* Section I.B.
[252] *See supra* Section I.

even more lacking when an organization like the NAIC exercises this power only after actively pressuring states to delegate this authority to them.

In fact, the NAIC's accreditation program strikes at the heart of the constitutional concerns that motivate states' non-delegation doctrines by undermining state legislatures' practical ability to claw back power from the NAIC.[253] Simply put, the NAIC faces no practical risk that state legislatures will limit its authority when it uses that authority to further inflate its prominence in state insurance regulation, enhance its revenue, and allow state regulators to fundamentally alter state insurance law without any legally-mediated public accountability. At the end of the day, no state can make a realistic threat that it will reverse its delegation of authority to the NAIC, because doing so would trigger significant tax and employment repercussions for the state. Rather than legislatures delegating authority to the NAIC, the NAIC has – in a quite real sense – successfully constructed a scheme where it delegates to itself the authority to shape insurance regulation as it sees fit, with no public accountability or legally-mandated process.

Ultimately, a substantial portion of U.S. insurance regulation rests on a constitutionally-shaky foundation. As a private entity that is not controlled by state legislatures and unaccountable to any independent public authority, the NAIC's direct exercise of delegated power violates core principles of every states' constitutions. The question, of course, becomes what should states do about this problem.

IV. IMPLICATIONS OF AND SOLUTIONS FOR THE UNCONSTITUTIONAL STRUCTURE OF U.S. INSURANCE REGULATION

Recognizing the unconstitutional foundations of U.S. insurance regulation would complicate the capacity of states to effectively regulate insurers. But it would not undermine states' insurance regulation writ large. This Part explains that conclusion. First, Part A briefly considers both the positive and negative impacts of simply eliminating state delegations of power to the NAIC. Although this approach would increase accountability and decrease bias in the production of state insurance regulation, it would also undermine the uniformity and agility of such regulation. For this reason, Part B suggests one approach to preserving states' reliance on the NAIC while instituting safeguards that would ensure constitutional protections: creating an interstate insurance compact that would be staffed by

[253] *See supra* Section II.C.

independent experts in insurance regulation and responsible for reviewing the production of new NAIC materials that have the force of law.

A. THE CONSEQUENCES OF ELIMINATING STATES' DYNAMIC CROSS REFERENCES TO NAIC MATERIALS

The unconstitutional structure of state insurance regulation is easily remediable. State insurance laws could simply be revised – either directly by state legislatures, or judicially, by courts severing the unconstitutional portions of these laws – so that they only cross-referenced versions of NAIC materials that were finalized before those state laws were enacted.[254] This would mean that NAIC changes to statutorily cross-referenced materials would only have the force of law to the extent that state legislators, after having a chance to review these changes, approved of these materials.[255] State legislatures wishing to delegate this review process to their state insurance departments could easily do so by directly empowering them to adopt via regulation updated versions of cross-referenced NAIC materials.

These reforms would increase the NAIC's accountability and transfer power back to states, where it rightly resides under the current US insurance regulatory framework. In doing so, these reforms could have a substantial impact on the substance of the materials the NAIC adopted in its various manuals. Controversial changes would likely prompt much closer legislative or regulatory scrutiny which, in turn, would have a disciplining effect on what the NAIC chose to include in these materials, leading it to shy away from shoe-horning controversial or substantive provisions into its manuals and guides. This reform would also assure impacted parties of the opportunity to challenge any elements of the NAIC-produced materials that they objected to through the ordinary safeguards built into state legislative or regulatory processes.

---

[254] *See supra* section II.B (discussing the fact that non-prospective cross-references are not delegations of power, but simply legislative short-hand).

[255] In most cases, states could presumably will to do this through omnibus legislation that would be adopted without serious controversy or debate. For this approach to work, the NAIC would be forced to revise its accreditation program standards to clarify that updated NAIC-produced manuals, guides, and the like need only be adopted by states after a reasonable period of time for review and evaluation of those materials by state legislators.

At the same time, this approach could have significant drawbacks by undermining the uniformity and agility of state insurance regulation. A substantial benefit of the NAIC's dynamic incorporation by reference approach is that it allows state insurance regulation to quickly and uniformly respond to emerging regulatory issues. Moreover, states' lack of uniform insurance regulation has proven to be a substantial problem in a variety of settings. Such inconsistencies increase the costs of compliance for insurers,[256] create the prospect of regulatory arbitrage,[257] and potentially undermine the effectiveness of state insurance regulation.[258] For these reasons, it is worthwhile to consider whether reforms to the structure of state insurance law and regulation could simultaneously preserve the NAIC's role in drafting dynamically-incorporated materials for state law while limiting the constitutional infirmities of this approach.

B. A PROPOSED INTERSTATE COMPACT TO ESTABLISH INDEPENDENT REVIEW OF THE NAIC'S EXERCISE OF DELEGATED AUTHORITY

Eliminating state delegations of power to the NAIC would clearly have both costs and benefits. But there is a potential way for state legislatures to avoid this tradeoff by constitutionally delegating power to the NAIC. In particular, they could create, through an interstate compact, an independent public entity that would be tasked with reviewing the NAIC's exercise of delegated authority.

As discussed above, state delegations of power to private entities are generally constitutionally permissible if they are subject to independent oversight by state courts or agencies.[259] But simply applying this approach to the NAIC could create substantial practical problems if the NAIC's revisions of dynamically incorporated materials were independently reviewed in each state, then many of the benefits of consolidating the

---

[256] *See* MARTIN F. GRACE & ROBERT W. KLEIN, THE FUTURE OF INSURANCE REGULATION IN THE UNITED STATES 13–51, 117–43 (Brookings Inst. & Geor. State Univ. eds., 2009).

[257] *See* FEDERAL INSURANCE OFFICE, HOW TO MODERNIZE AND IMPROVE THE SYSTEM OF INSURANCE REGULATION IN THE UNITED STATES (2013).

[258] *Id.*

[259] *See supra* Section II.C.

production of these standards at the NAIC might be lost. The rules of state insurance regulation contained in dynamically incorporated materials could be rejected or revised by individual states, potentially leading to the same patchwork of rules that motivated creation of the NAIC accreditation program in the first place.[260]

An interstate compact could allow states to avoid these practical problems while simultaneously assuring that their delegations of power to the NAIC are constitutionally compliant. In particular, states could use an interstate compact to create a new multistate public entity whose sole responsibility would be to independently review the NAIC's exercise of delegated authority. In this sense, the new entity's role would resemble the SEC's oversight of FASB or even state courts' oversight of state agencies under basic administrative law principles. Thus, the new entity created by interstate compact could focus on assessing whether the NAIC's production of materials that have the force of law adhered to various procedural and substantive constraints. Such review, as in both ordinary administrative law and the SEC's oversight of FASB, would presumably be deferential in recognition of the NAIC's expertise.[261] Subjecting the NAIC's exercise of delegated authority to review by an independent, multistate entity created by interstate compact would almost certainly solve the constitutional problems embedded within the current U.S. insurance regulatory framework. As discussed at length above, oversight by an independent, public entity is usually sufficient to insulate delegations of power to a private entity from constitutional scrutiny.[262] Meanwhile, there is little doubt that state legislatures could constitutionally delegate oversight of the NAIC to a new multistate entity that they created by interstate compact, rather than to their own state courts or agencies. It is well established that state legislatures can, via interstate compact, constitutionally create a multistate public agency to formulate regulatory standards.[263] It seemingly follows that states could also constitutionally empower such a multistate entity with responsibility for scrutinizing a private delegate's development of regulatory standards.[264]

---

[260] *See supra* Section I.B.

[261] *See supra* Section II.D.1.

[262] *See supra* Section II.C (explaining that delegations to private actors are generally constitutionally if the private actor's exercise of authority is subject to independent, public scrutiny).

[263] *See* Amica v. Wertz, Civil Action No. 15-cv-1161-WJM-CBS (2018).

[264] To be sure, this proposal is still subject to the concern – invoked above with respect to the NAIC – that public officials from one state are not

This proposed approach would not only meet state constitutional requirements, but it would preserve the practical benefits associated with consolidating the production of financial regulatory standards within the NAIC. The NAIC would continue to be in charge of updating materials that are dynamically incorporated by reference in state law, thus avoiding any substantial disruption in the mechanics of state insurance regulation. For similar reasons, the proposed approach would also continue to take advantage of the NAIC's expertise and knowledge in producing the detailed rules of insurance regulation.

Using an interstate compact to create a new multistate entity with a role in insurance regulation is not without precedent. To the contrary, in 2004 participating states created an Interstate Insurance Product Regulation Commission (IIPRC) as "a joint public agency." The IIPRC began operating in 2006 and, as of September 2014, 44 states had enacted legislation agreeing to the Compact, representing over 70% of national premium volume.[265] Consistent with its public status, the IIPRC is legally required to adhere to a number of procedural requirements. For instance, it must follow "a rulemaking process that conforms to the Model State Administrative Procedure Act of 1981" and provide advance written notice of its intent to adopt new standards.[266] Similarly, any standards it promulgates can be judicially challenged in much the same manner as ordinary regulations.[267]

The key difference between the proposal here and the IIPRC is that the new multistate public entity proposed here would be responsible for overseeing the NAIC's production of regulatory rules with the force of law, rather than creating those rules itself. As such, it would need to be structured

---

politically accountable to the populations of other states. But this criticism would be muted in the context of a public entity that was affirmatively created by state legislatures to ensure that the NAIC's exercise of delegated authority was itself reasonable.

[265] The IIPRC reviews policy forms based on uniform rules that it promulgates in coordination with the NAIC. IIPRC product rules are initially devised by NAIC and IIPRC committees and subjected to a sixty-day public comment period. To be adopted, they must be approved by 2/3 of the IIPRC management committee, made up of 15 member states representing a cross-section of states, and then 2/3 of all member states. *See* ABRAHAM & SCHWARCZ, *supra* note 2; Elizabeth F. Brown, *Will the Federal Insurance Office Improve Insurance Regulation?*, 81 U. CIN. L. REV. 551, 563 (2012).

[266] Amica v. Wertz, Civil Action No. 15-cv-1161-WJM-CBS.

[267] *Id.*

differently from the IIPRC. Perhaps most importantly, unlike the IIPRC, the proposed multistate entity would need to be independent of the NAIC and state insurance regulators. Consistent with the entity's adjudicative role, this could be accomplished by staffing it with a rotating panel of state appellate judges.

An alternative approach to remedying the unconstitutional structure of state insurance regulation would be to entirely relocate the production of materials that have the force of law from the NAIC to the newly-created multistate entity. This proposal – which would hew closely to the IIPRC approach – would more directly solve the constitutional infirmities of the present state insurance regulatory system by shifting states' delegations of power to a public multistate entity, rather than by subjecting the NAIC's exercise of delegated authority to oversight by that entity. As such, its structure could directly mirror the IIPRC, both with respect to applicable procedural requirements and membership. The most significant drawback of this approach is that it could substantially disrupt the current processes for producing materials that are dynamically incorporated by reference in state law.

But whatever the details, creating a new single, publicly-accountable, entity to play a role in overseeing or producing uniform regulatory standards represents one promising approach to addressing the unconstitutionality of the present state-based regulatory scheme while preserving most of its benefits.

CONCLUSION

Despite ubiquitous rhetoric emphasizing the primacy of states in insurance regulation, the NAIC in many ways operates as a national regulator of the business of insurance. But unlike any other regulator, the NAIC is completely unaccountable to legislatures or judicial officers, either at the state or federal level. The NAIC's accreditation program further undermines its accountability, allowing it to effectively compel states to preserve and expand its delegated authority. This unconstitutional structure has allowed the NAIC to broaden its power, size, and reach, in ways that often have dubious social value. It is now time for states to take back their power from rogue state insurance regulators by holding the NAIC accountable. Doing so need not undermine the structure of state insurance regulation. By using the interstate compact process to create a public entity that would review the NAIC's actions that have the force of law, states can reign in the NAIC's excessive power while preserving the capacity of state insurance regulation to produce uniform and agile standards.

CONNECTICUT INSURANCE
LAW JOURNAL

The Connecticut Insurance Law Journal is published at least twice per year. Domestic subscriptions are $28.00 per year, international subscriptions are $32.00 per year. Back issues and back volumes are available (for any volume up to and including Volume 12) for $15.00 per issue or $25.00 per volume; international orders add $3.00 per issue or $5.00 per volume.

Absent timely notice of termination, subscriptions are renewed automatically. To subscribe to the Insurance Journal or order back issues online, please visit our website located at www.insurancejournal.org, or you may fill out the form below and mail to:

Connecticut Insurance Law Journal
Attention: Administrative Editor
55 Elizabeth Street,
Hartford, CT 06105;
cilj@uconn.edu

Please Print below and complete reverse:

Contact Name: _____

Contact Title: _____

Organization: _____

Department: _____

Address: _____

_____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

E-Mail: _____

Additional Comments: _____

Check all that apply:

☐ I would like to order (number) _____ subscriptions at $28.00 per subscription ($32.00 for international orders).

☐ I would like to order (number) _____ complete set(s) of back issues (Volumes 12-23) at $150.00 per set ($165.00 for international orders).

☐ I would like to order the following back volumes or back issues at $15.00 per issue, $25.00 per volume (international orders are $18.00 per issue and $30.00 per volume). Please list volume, issue and quantity for each.

Examples: 4 copies, Volume 3, Issue 2
2 copies - Volume 6

_____
_____
_____
_____